

Heartland Hand & Spine Orthopaedic Center, P.A.
PATIENT INFORMATION

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Patient Name: _____

Date of Birth: _____

--EMPLOYMENT INFORMATION--	--SPOUSE INFORMATION--
Employer's Name _____ Phone _____ Employer Address _____ City _____ St _____ Zip _____	Spouse Name _____ DOB: _____ SS# _____ Work Phone: _____ Cell Phone: _____ Email: _____

PATIENT CONFIDENTIALITY

I hereby authorize the release medical information to _____
relationship _____. I hereby authorize Heartland Hand & Spine to leave information on my voicemail
at (Check all that apply) _____ HOME _____ WORK _____ CELL

PATIENT SIGNATURE _____ Date _____

AUTHORIZATION AGREEMENT

I authorize the release of my medical records as needed to any physician, facility or other provider of services that Heartland asks to participate in my medical treatment.

PATIENT SIGNATURE _____ Date _____

ASSIGNMENT OF BENEFITS/FINANCIAL AGREEMENT

I hereby authorize Heartland Hand & Spine (HHS) to bill my insurance company for payment of benefits on my behalf. I authorize HHS to release medical information required by my insurance company to process my claims. HHS will submit my claims and reconcile my account by the terms of their contract with my insurance company. I understand and agree that I am responsible for all fees for services provided to me by HHS not covered by my insurance. I agree to provide HHS with current insurance, personal address and billing information and will notify HHS of any changes in a timely manner.

The patient understands they are responsible for complying with all requirements of their insurance plan and any failure to do so may result in denial or non-payment of healthcare claims, and that the patient will be financially responsible for all fees for services provided by HHS and its representatives.

PATIENT SIGNATURE _____ Date _____

MEDIGAP AUTHORIZATION

I hereby authorize payment of my Medigap benefits to Heartland Hand & Spine for all claims filed on my behalf. This authorization applies to all services until it is revoked by me or my representative.

BENEFICIARY SIGNATURE: _____ Date _____

Medicare Number _____ Medigap Insurer _____

Phone _____ Address _____

PATIENT SIGNATURE _____ Date _____