Mid-State Orthopaedic & Sports Medicine Center

New Patient Registration Form

Patient Information

__ Dr __ Miss __ Mr __Ms __ Sir __ Other

Patient's legal name: (Last) ________________ (First) ____________ (MI) ____ Previous Name ____________________

Home address ____

City ____ State _____________ Zip ________________________________

Mailing address (city, state, zip) ____

Home phone _______________________ Cell phone _______________________ Work phone _________ ext _______

Date of birth __________________ Sex __ M __ F __ Transgender

Marital status __ Married __ Single __ Divorced __ Widowed __ Legally separated __ Other

Social security number _________________________ Email address ______________________________________

Language ______________________ Race _______________________ Ethnicity ______________________________

Employer name ____________________________ Address ____

Occupation ________________________ Job duties ____

Employment status __ Full time __ Part time __Homemaker __ Self-employed __ Retired __ Active military

Student status __ Full-time student __ Part-time student __ Not a student

Emergency contact: Last name ____________________________ First name ________________________________

Phone number ___________________ Relationship to patient ____

Contact address ____

City _________________________________ State _________________ Zip ____________________________________

Responsible Party Information

__ Check if information is the same as above

Responsible party name (Last) ________________________ (First) __________________ (MI) __________________

Date of birth _____________________ Social security number ____

Phone number _________________________ Email address ____

Sex __ M __ F __ Transgender

Address ____

City ____________________________ State _________________ Zip ____

Employer _____________________________________ Employer phone number ______________________________

Primary Insurance Information

Insurance company _______________________________________ Phone number _____________________________

Name of insured _______________________________________ Patient relationship ______________________

Subscriber ID (Policy #) _________________________ Group ID __________________ Co-pay amount ___________

Effective date _______________________ Date of birth _____________________

Secondary Insurance Information

Insurance company _______________________________________ Phone number _____________________________

Name of insured _______________________________________ Patient relationship ______________________

Subscriber ID (Policy #) _________________________ Group ID __________________ Co-pay amount ___________

Effective date _______________________ Date of birth _____________________

I agree that the information supplied on this form is accurate and up to date to the best of my knowledge.

Patient (or responsible party) Signature _____________________________ ***Date*** _____________________________

3444 Masonic Drive
Alexandria, LA 71301
Phone: (800) 832-7325
(318) 473-9556
Fax: (318) 441-8351

Consent for treatment

I consent to treatment necessary for the care of the patient listed on the front of this sheet. My relationship to this patient is:

Self Spouse Child Other

Release of information and payment policy

I hereby authorize my insurance company/companies to pay directly to Mid State Orthopaedic & Sports Medicine Center any proceeds payable under the terms of my policy/policies. This is an irrevocable assignment and I understand and agree to pay any unpaid balance not covered by my insurance policy. This obligation is to be paid by me. In the event my account is turned over for collection, I hereby agree to pay all collection costs and fees.

I am personally responsible for all charges for treatment rendered at Mid State Orthopaedic & Sports Medicine Center and insurance contractual relationships are between the insurance company and myself.

It is the policy of Mid State Orthopaedic & Sports Medicine Center to assist the patient in obtaining the maximum benefit from their insurance companies. However, we do not withhold our statement or wait until settlements are made before requesting payments.

I acknowledge full financial responsibility for services rendered by Mid State Orthopaedic & Sports Medicine Center.

I agree that Mid State Orthopaedic & Sports Medicine Center may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.

Further, I give my consent to Mid State Orthopaedic & Sports Medicine Center to release any medical information to my referring physicians, insurance companies, or attorneys.

Signed ________________________________ Date _______________

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Payment Authorization of Medical Benefits

Date: ______________________

Patient: __________________________________

I request that payment of authorized medical benefits be made either to me or on my behalf to **Mid State Orthopadic & Sports Medicine Center** for any services furnished to me by that provider.

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Signature of patient or authorized representative:

Signed ___________________________________ Date ________________

I acknowledge that the notice of privacy practice from Mid State Orthopaedic & Sports Medicine Center is available and it is my responsibility to request a copy and read its contents.

Signature of patient or authorized representative:

Signed ___________________________________ Date ________________

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Release of Information Agreement

Date: ______________________

Patient: __________________________________

I am authorizing that the following individuals (if any) may have access to information about my medical condition at this clinic.

Name: ___________________________________ Relationship: ______________________________

Name: ___________________________________ Relationship: ______________________________

Name: ___________________________________ Relationship: ______________________________

Name: ___________________________________ Relationship: ______________________________

( ) No individual is authorized to access my medical information.

Signature of patient or authorized representative:

Signed ___________________________________ Date ________________

Relationship to patient: ____

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Payment Authorization of Medicare Benefits

Date: ______________________

Patient: __________________________________ DOB: ______________________

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Mid State Orthopaedic & Sports Medicine Center for any services furnished to me by that provider.

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Signature of patient or authorized representative:

Signed ___________________________________ Date ________________

I acknowledge that the notice of privacy practice from Mid State Orthopaedic & Sports Medicine Center is available and it is my responsibility to request a copy and read its contents.

Signed ___________________________________ Date ________________