PATIENT INFORMATION

Sterling Doster, M.D. Gregory Fox, M.D. Erich Weidenbener, M.D.

Dale Dellacqua, M.D. Alex Meyers, M.D. Michael Pannunzio, M.D.

TODAY'S Date: _____ Name (Last, First, Middle): _____
Address: _____ City: _____ ST: _____ ZIP: _____
Home Phone ( ) _____ Work Phone ( ) _____ Mobile Phone: ( ) _____
SSN: _____ - _____ - _____ Age: _____ DOB: _____/_____/_____ Marital Status: M S D O
Sex: _____ Employer: _____ Referring Doctor _____
Person to Contact in case of emergency:_____Phone: ( ) _____
Person to Contact other than relative: _____Phone: ( ) _____

INSURANCE POLICY INFORMATION (Please present insurance card at time of check-in)

Primary Plan Name: _____ Billing Address: _____ Zip: _____
Phone: ( )_____ Group # _____ Ins ID # _____ Co-pay $ _____
Card Holder's Name (Last, First, MI) _____ Address (Street, City, ST, Zip) _____
Insured's Employer: _____Employer Insurance Plan: Yes / No Date of Birth _____
Secondary Plan Name: _____ Address (Street, City, ST, Zip) _____
Phone: ( ) _____ Group # _____ Ins ID # _____ Co-pay $ _____
Insured's Employer: _____ Employer Insurance Plan:Yes / No Date of Birth _____/_____/_____

RESPONSIBLE PARTY FOR BILLING, IF DIFFERENT FROM PATIENT

Name (Last, First, MI): _____Date of Birth _____ Age: _____
Address: (Street #, City, ST, Zip) _____ Phone: ( ) _____
Social Security # _____/_____/_____ Sex: M / F Marital Status: M S D O Relationship to Patient: _____
Employer: _____ Employer Address: _____ Phone ( ) _____

By my signature below, I am entering into an agreement with Bloomington Bone and Joint Clinic P.C. as Follows:

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures; others pay a percentage of the charge. It is your responsibility to pay any deductible amounts, co-insurance or other balances not paid for by your insurance company, any "out-of-network" expenses.

IN ORDER TO CONTROL YOUR COST OF BILLING, WE REQUEST PAYMENT AT THE TIME OF SERVICE. If this account is assigned to collection and/or suit, the prevailing party shall be entitled to reasonable attorney fees, cost of collections and/or collection agency fees, to which may be added pre-judgment an/or post judgment interest at the current legal rate. Ninety (90) days after date of service any unpaid amounts will be assessed late payment charges of 0.5% monthly.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portion(s) of the patient's record. I hereby assign all medical and/or surgical benefits under the terms of my insurance payable to: Bloomington Bone and Joint Clinic, P.C. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

The staff of this office pledges to provide the finest care our capacities allow. Complications are seldom seen in the many surgical procedures performed, however, it should be understood that even small surgical procedures can scar, occasionally bleed and rarely become infected or incite allergic response.

I authorize the Bloomington Bone and Joint Clinic, P.C. to release information regarding my medical condition and treatment to my insurance company, attorney, employer and/or any other health care professional involved in my medical care.

I authorize Bloomington Bone and Joint Clinic, P.C. or their representative to take clinical photographs of me, to be kept as part of my medical record.

Signature: _____ Date: _____