

**SOUTHWEST ORTHOPEDIC  
GROUP, LLP**

DATE: \_\_\_\_\_

DR. NAME: \_\_\_\_\_

**PATIENT DATA**

\_\_\_\_\_ SOCIAL SECURITY NO.: \_\_\_\_\_  
Last Name First Name Middle  
\_\_\_\_\_ MALE OR FEMALE Marital Status: M S W D  
Date of Birth Age  
\_\_\_\_\_ HOME PHONE: \_\_\_\_\_  
Home Address Apt. No.  
\_\_\_\_\_ WORK PHONE: \_\_\_\_\_  
City State Zip Code  
Occupation: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_  
Referred By: \_\_\_\_\_ OFFICE NO.: \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION:**

\_\_\_\_\_ PHONE NO.: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_  
NAME

**EMPLOYER INFORMATION:**

\_\_\_\_\_ PHONE NO.: \_\_\_\_\_  
EMPLOYER NAME  
\_\_\_\_\_ Address City State Zip Code

**GUARANTORS INFORMATION:**

\_\_\_\_\_ Social Security Number Date of Birth  
Last Name First Name Middle  
Patient's Relationship to Policy Holder: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_  
Home Address Apt. No. City State Zip

**INSURANCE INFORMATION**

**PRIMARY INSURANCE:**

\_\_\_\_\_ Customer Service No: \_\_\_\_\_  
Name of Primary Insurance  
\_\_\_\_\_ ID NUMBER \_\_\_\_\_ GROUP NO.

**SECONDARY INSURANCE:**

\_\_\_\_\_ Customer Service No: \_\_\_\_\_  
Name of Secondary Insurance  
\_\_\_\_\_ ID NUMBER \_\_\_\_\_ GROUP NO.

AUTHORIZATION TO PAY BENEFITS OF PHYSICIAN: I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE UNDERSIGNED PHYSICIAN OF THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY OTHERWISE PAYABLE TO ME FOR HIS SERVICES. I UNDERSTAND THAT THIS AUTHORIZATION DOES NOT RELEASE ME FROM MY PERSONAL RESPONSIBILITY FOR PAYMENT OF ALL CHARGES WITHIN 50 DAYS. AUTHORIZATION TO RELEASE INFORMATION: I HEREBY AUTHORIZE THE UNDERSIGNED PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

# ***SOUTHWEST ORTHOPEDIC GROUP, LLP***

## **Review of Notice of Privacy Practices**

### **Acknowledgement:**

I acknowledge that I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

\_\_\_\_\_  
**Patient or Personal Representative  
Signature**

\_\_\_\_\_  
**Date**

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient: \_\_\_\_\_.

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### **Financial Policy Statement**

It is the policy of Southwest Orthopedic Group, L.L.P. to bill your insurance carrier as a courtesy to you; however, you are responsible for the entire bill. We require that arrangements for payment of your estimated share be made today. The insured/patient is responsible for any co-payments at the time service is rendered. If your insurance carrier does not remit payment within sixty (60) days, the balance will be due in full from you. If your insurance pays in excess of the balance of your account, we will refund the credit.

If any payment is made directly to you for services billed by Southwest Orthopedic Group, L.L.P., you recognize an obligation to promptly remit same to Southwest Orthopedic Group, L.L.P.

The above does not apply for those patients that are considered Workers' Compensation. However, be advised as a Compensation patient that you may be held responsible for your charges in the event that your claim is controverted.

I understand and agree that if I fail to make any of the payments for which I am responsible for in a timely manner, after such default and upon referral to a collection agency or attorney by Southwest Orthopedic Group, L.L.P., I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees. The above information has been read and explained to me. **I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.**

\_\_\_\_\_  
**Patient or Responsible Party**

\_\_\_\_\_  
**Date**