Orthopaedic Associates
of Central Maryland

PATIENT REGISTRATION FORM

Patient Name: ____
Last First MI

DOB: ____/________/_____ Age: _____________ Sex: ______________ Marital Status: ______________________

Home Phone: ______________________ Work Phone: ______________________ Cell: _______________________

Address: ___________________________________ City: _____________________ State: _________ Zip: ________

Social Security No.: _________________________ Occupation: ____

Employer: ___________________________________ Employer Address: ___________________________________

E-mail Address: ____

Emergency Contact: __________________________________ Phone: ___________________________________

1St Date of Symptoms: _______________

PRIMARY INSURANCE CO: Name of Subscriber: _____________________________ DOB: ____/______/____

____ Patient ____ Spouse ____ Parent ____ other (If other, list relationship to subscriber) ____

Address of Subscriber: ____ City: ___________________ State: _______ Zip: _________

Home Phone: ____ Work Phone: _____________________________________

Employer Name: ___________________________ Employer Address: ____

Insurance Company Name: ___________________________ Address: ____

SS No.: ___________________________Policy No.: ________________________ Group No.: ______________________

Phone No.________________________ Referral Required: Yes / No

SECONDARY INSURANCE CO: Name of Subscriber: _______________________ DOB: ____/________/_____

____ Patient ____ Spouse ____ Parent ____ other (If other, list relationship to subscriber) ____

Address of Subscriber: ____ City: ____________________State ______Zip: _________

Home Phone: ____ Work Phone: ____

Employer Name: ____________________ Employer Address: ____

Insurance Company Name: ___________________________ Address: ____

SS No. ___________________________ Policy No.________________________ Group No.________________________

Phone No.________________________ Referral Required: Yes / No

REG. BY: __________________________ **DATE**: ______________________

OACM EMPLOYEE

Telephone : (410) 644-1880 Fax: (410) 646-3623

3421 Benson Avenue
Suite 100
Baltimore, Maryland 21227

10710 Charter Drive
Suite 300
Columbia, Maryland 21044

Assignment of Insurance Benefits:

As the patient whose name appears below, I hereby authorize Orthopaedic Associates of Central Maryland, P.A. to file on my behalf for payment of any medical benefits arising out of any policy of insurance covering me and hereby assign the benefits of Orthopaedic Associates of Central Maryland, P.A. for application on the patient's bill. I certify that the information reported with regard to my insurance coverage is accurate and complete and further authorize the release of any necessary information, including medical information, for this or any related claim of medical benefits. I permit a photocopy of this authorization to be used in place of the original.

I understand that I am liable for payment to Orthopaedic Associates of Central Maryland, P.A., all co insurance, co-pays, and deductibles as required by my insurance policy and participating agreements (if any) between the insurance carrier and Orthopaedic Associates of Central Maryland, P.A. Further, I will be responsible for payment of charges not covered by my insurance.

FINANCIAL RESPONSIBILITY:

Payment is requested at the time services are rendered. If expensive or extended treatment is anticipated, arrangements may be made for a payment plan. All professional services rendered are charged to the patient and the patient (or guardian) is responsible for all fees regardless of insurance carrier. We will bill charges to the primary insurance carrier and will bill the remaining amount to the patient. Payment for charges which are the patient's responsibility are to be paid within thirty days. The patient and/or guarantor signing below accepts responsibility for payment. Should the patient's account be referred to an attorney for collection, the patient and/or guarantor shall pay attorney's fees of 15% of the amount due and costs of collection. The undersigned also agrees to be responsible for and to pay a finance charge at the annual percentage rate of 18% of the unpaid balance of all sums due to Orthopaedic Associates of Central Maryland, P.A. Our staff will gladly assist you with any aspect of this policy.

I have read, understand, and accept the above conditions.

____

Patient

____

Guarantor/ Guardian
(Other than Patient)

____

Date

Orthopaedic Associates of Central Maryland's "Notice of Privacy Practices" provides information about how we may use and disclose protected health information about you. Please acknowledge receipt of this office's Notice of Privacy Practices by signing below:

____ ___________________________________

Signature Date

Telephone : (410) 644-1880 Fax: (410) 646-3623

3421 Benson Avenue
Suite 100
Baltimore, Maryland 21227

10710 Charter Drive
Suite 300
Columbia, Maryland 21044