BOLDER ORTHOPEDICS

Insurance:

Your insurance is a method for you to receive reimbursement for fees you have paid to the physician for services rendered. Having insurance is NOT a substitute for payment. Many companies have fixed allowances or percentages based upon your contract with them, NOT with our office. It is your responsibility to pay your deductibles, co-insurance and co-pays. We will do all we can to assist you in receiving reimbursement, but YOU are responsible for your bill. Unpaid patient balances will be collected prior to all patient appointments.

Primary Insurance Company's Name: ____________________

Street Address: ____________________ City: ____________________

State: ____________________ Zip: ____________________ Phone: ____________________

POLICY #: ____________________ **GROUP #:** ____________________

Name of Policy Holder**:** ____________________ Relationship to Patient**:** ____________________
[LAST NAME] [FIRST NAME \ LEGAL] [MI] *If patient write SAME"

Home Address: ____________________ City: ____________________ State:__________ Zip:__________
POLICY HOLDER

Phone: (___)____________________ SS # ___ ___ ___ **-** ___ ___**-**___ ___ ___ ___ Sex: M [ ] F [ ] Date of Birth: ____________
***** CONFIDENTIAL MANDATORY INFORMATION ****** MONTH / DAY / YEAR

Employer: ____________________ Occupation: ____________________

Is this a COBRA Policy? Yes [ ] No [ ]

Secondary Insurance Company: ____________________

Street Address: ____________________ City: ____________________

State: ____________________ Zip: ____________________ Phone: ____________________

POLICY #: ____________________ **GROUP #:** ____________________

Name of Policy Holder**:** ____________________ Relationship to Patient**:** ____________________
[LAST NAME] [FIRST NAME \ LEGAL] [MI] *If patient write SAME"

Home Address: ____________________ City: ____________________ State:__________ Zip:__________
POLICY HOLDER

Phone: (___)____________________ SS # ___ ___ ___ **-** ___ ___**-**___ ___ ___ ___ Sex: M [ ] F [ ] Date of Birth: ____________
POLICY HOLDER ***** CONFIDENTIAL MANDATORY INFORMATION ****** MONTH / DAY / YEAR

Employer: ____________________ Occupation: ____________________

Workman's Compensation: Does WC cover this visit? Yes [ ] No [ ] *If yes see receptionist for a separate form

Auto Accident: Please note that Auto Insurance has limits and your primary insurance information is required.

Is this an Auto Claim? Yes [ ] No [ ] Date of Auto Injury: ____/____/________
MONTH / DAY / YEAR

Auto Insurance: ____________________ Phone: (____)____________ Claim # ____________________

Claims Address: ____________________ City: ____________________ State: __________ Zip: __________

Claims Adjuster's Name: ____________________ Claims Adjusters Phone: (____)________________ ext: ______
FIRST & LAST

Claims Adjusters Fax #: (____)____________________

Assignment of Benefits:
Your signature is necessary for us to process any insurance claims and to ensure payment of services rendered. I authorize release of all medical information necessary to process my insurance claims or that is pertinent to my medical care. I assign all medical and/or surgical benefits, including major medical benefits to which I am entitled to the above named physician or clinic. The assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered valid as the original.

I UNDERSTAND THAT I AM FINANCALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND THE FINANCIAL POLICY AND I UNDERSTAND IT.

Patient Signature: ____________________ Date: ____________________

Responsible Party: ____________________ Date: ____________________