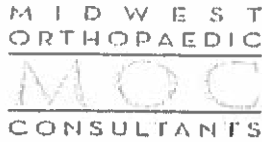

MIDWEST ORTHOPAEDIC CONSULTANTS

Please complete this entire form, and present your insurance cards for billing purposes.

PATIENT INFORMATION SHEET

Patient Name: ______________________ Last First MI

Address: ______________________

City, State, Zip: ______________________

Sex: _____ Birth Date: ____________ Age: ______

Social Security #: ______________________

Home Phone: (_____) ______________________

Cell Phone: (_____) ______________________

Work Phone: (_____) ______________________

Email Address: ______________________

Emergency Contact
Name & Phone: ______________________

Pharmacy Name: ______________________

Pharmacy Location: ______________________

Primary Care Physician: ______________________ Last First

Office Location: ______________________

Referring Physician: ______________________ Last First

Office Location: ______________________

WORK-COMP

Adjuster/RN Name: ______________________

Insurance Company: ______________________

Contact Phone: ______________________

Is your visit due to a work related incident? Yes No

If you answered yes to the questions above, please provide the date, and a brief description of the accident and your injury:

____

____

____

PRIMARY INSURANCE CARRIER:

Ins. Co. Name: ______________________

(if PPO or HMO please identify Plan) ______________________

Policy Holder Information:

Name: ______________________ Last First MI

Policy Holder Sex: M ☐ F Birth Date: ______________________

Policy Holder Social Security # : ______________________

Policy Holder relationship to patient: ☐ Self ☐ Spouse ☐ Parent

Insurance ID Number: ______________________

Group Number: ______________________

Employer: ______________________
(of Ins Policy Holder)

Address: ______________________

City, State, Zip: ______________________

Phone: (_____) ______________________

SECONDARY INSURANCE CARRIER:

Ins. Co. Name: ______________________

(if PPO or HMO please identify Plan) ______________________

Policy Holder Information:

Name: ______________________ Last First MI

Policy Holder Sex: ☐ M ☐ F Birth Date: ______________________

Policy Holder Social Security # : ______________________

Policy Holder relationship to patient: ☐ Self ☐ Spouse ☐ Parent

Insurance ID Number: ______________________

Group Number: ______________________

Employer: ______________________
(of Ins Policy Holder)

Address: ______________________

City, State, Zip: ______________________

Phone: (_____) ______________________

I authorize the release of all medical information necessary to process my insurance claim. I assign all medical and/or surgical benefits including major medical benefits to which I am entitled to **Midwest Orthopaedic Consultants**. I understand that regardless of my insurance, I am financially responsible for the fees for services rendered and all collection and attorney fees if applicable. A photocopy of this assignment is considered as valid as the original. This assignment will remain in effect until revoked by me in writing. If the balance is not paid at the time of service, for whatever reason, it is agreed that our office is extending credit to you as a courtesy. If credit is extended, you authorize our office and/or our agents to access your consumer credit report.

Patient Signature:
(Parent/Guardian) ______________________ **Date:** ______________________

**PATIENT ACKNOWLEDGEMENT OF RECEIPT
OF THE NOTICE OF PRIVACY PRACTICES**

By signing this form, I am acknowledging the right to review the Notice of Privacy Practices of Midwest Orthopaedic Consultants. A copy of the Privacy Practices is available in the lobby for the patient review. Copies are available upon request.

E-PRESCRIBING

MIDWEST ORTHOPAEDIC CONSULTANTS is in the process of implementing e-Prescribing in each of our offices. E-Prescribing is a federally mandated initiative that requires all physicians prescribe in this manner by 2011. E-Prescribing software sends prescriptions over the internet to your pharmacy in a safe, secure way, through the same technology used by credit card companies. This helps protect the privacy of your personal information. E-Prescribing software also lets your doctor see important information – like drug interactions and your prescription history.

The benefit to you:

- Less confusion over handwritten prescriptions or unclear phone calls
- Reduced possibility of medical errors
- Less chance of adverse drug reactions
- Fewer trips to drop off at the pharmacy
- A safer, faster, easier way to get your prescription filled

Patient Consent:

☐ **Approve Authorization** ☐ **Decline**

CANCELLATION/NO-SHOW POLICY

MIDWEST ORTHOPAEDIC CONSULTANTS makes every attempt to provide prompt medical service to our patients. We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family.

We require a 24-hour advance notification for the cancellation of a scheduled appointment, EMG or MRI.

Failed office appointments or "No-Shows" will be assessed a $30.00 administration fee not covered by your insurance.

Failed EMG or MRI appointments or "No-Shows" will be assessed a $100.00 administration fee not covered by your insurance.

AUTHORIZATION TO ACCESS THE COMMUNICATOR PATIENT PORTAL

The patient portal found on the MOC website grants the patient access to the health records of the patient. This also allows you to send a message to the doctors through the portal. After consenting, you will receive an e-mail with a link that will bring you to the setup of the patient portal. **An e-mail is required in order to gain access to the patient portal; if no e-mail is given your access will be declined.**

☐ Approve Authorization ☐ Decline

Patients Name: ______________________________

Date of Birth: ______________________________

E-mail Address: ______________________________

Patient Signature: ______________________ **Date signed:** ______________

MIDWEST
ORTHOPAEDIC
MOC
CONSULTANTS

10719 W. 160th Street • Orland Park, Illinois 60467 • (708)226-3300 • (708) 226-3500
4220 W. 95th Street • Oak Lawn, Illinois 60453 • (708) 226-3300 • (708) 226-3500

Release of Medical Information

My medical care may be discussed with: ☐ Yes ☐ No

Name: ____________________
DOB: ____________________
Relation: ____________________

Name: ____________________
DOB: ____________________
Relation: ____________________

*I understand that I may revoke this authorization at any time in writing, except to the extent that action has already been taken in reliance upon the authorization.

Test Results may be left on my answering machine/voice mail. ☐ Yes ☐ No

Appointment information may be left on my answering machine/voice mail. ☐ Yes ☐ No

If Applicable, for personal representative of the patient:

Print name of personal representative: ____________________

Describe personal representative relationship: ____________________

Signature of personal representative: ____________________

Signature of patient: ____________________

Date: ____________________

*Please note we do require documentation for personal representatives.

MIDWEST
ORTHOPAEDIC
MOC
CONSULTANTS

HEALTH CARE CONSENT

1. **To Treat.** I, for myself (or the patient named below), hereby consent to such diagnostic procedures and medical treatment as necessary and appropriate for my condition or illness in a department of Midwest Orthopaedic Consultants, hospital or for a course of outpatient treatment in the judgment of my physician(s), to be performed by Midwest Orthopaedic Consultants' physicians, nurses and other healthcare providers/staff. I understand that physicians, nurses and other healthcare providers in training may, under the supervision of appropriate personnel, participate in my treatment and I consent to such involvement in my care.
2. **Responsibility for Payment.** In consideration of services to be rendered by/at Midwest Orthopaedic Consultants, the undersigned agrees, as patient or guarantor for patient, to pay Midwest Orthopaedic Consultants for all services, facilities and supplies provided to me or the patient at the established rates, including any deductible, copayment or charges not covered by third party payors. I accept responsibility for any costs, including attorneys' fees, incurred in the collection of these charges. I understand that if I do not consent to release of records or later revoke such consent, I am fully responsible for payment of all charges for diagnosis and treatment received. I certify that the information given by me for purposes of payment for this treatment is, to the best of my knowledge, complete and accurate. I understand that if I am having difficulty in meeting my payment responsibilities to Midwest Orthopaedic Consultants, financial contract arrangements are available upon request.
3. **Assignment of Benefits.** In consideration of services rendered at/by Midwest Orthopaedic Consultants, I hereby assign and authorize direct payment to Midwest Orthopaedic Consultants, any insurance, health plan, or third party payor benefits otherwise payable to me or on my behalf for these services.
4. **Medicare Payment & Assignment of Benefits (if applicable).** I request that payment of authorized Medicare benefits be made on my behalf for services furnished to me at Midwest Orthopaedic Consultants and I assign such benefits to Midwest Orthopaedic Consultants. I certify that the information given by me in applying for such benefits is correct. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed for payments of such benefits. I authorized Social Security Administration to release information about my entitlement to benefits to Midwest Orthopaedic Consultants providing services to me.
5. **Release of Medical Information for Payment.**
   A. **General Release for Payment.** I hereby authorize Midwest Orthopaedic Consultants to release any and all pertinent information obtained in my medical records including HIV, mental health, and/or substance abuse to third party payers responsible for payment of patient charges including, but not limited to, insurance companies, health benefit plans, employers involved in approval of benefit claims, government agencies or intermediaries representing any of the above.
   B. By initialing in the space below, I do not consent to the release of medical information concerning HIV, mental health, substance abuse diagnoses or treatment, if any, to third party payors and understand that I am personally responsible for payment for services. HIV ______ Mental Health ______ Substance Abuse ______
6. **Duration & Revocation of Authorization for release of information for billing.** This authorization to release information related to payment expires upon satisfactory payment of the bill. This authorization (or the refusal under paragraph 5B) may be revoked at any time by written notice to the Medical Records Department (with no effect on prior disclosures). If I revoke this authorization prior to satisfactory payment, I understands and accept that I am personally responsible for payment of all outstanding charges.
7. **Personal Belongings.** I assume full responsibility for all items of personal property including, but not limited to, eyeglasses, hearing aids, dentures, jewelry, currency and all other valuables. I hereby release Midwest Orthopaedic Consultants of responsibility and liability for those valuables and items of personal property.
8. **Credit Card Payment Authorization.** I hereby authorize Midwest Orthopaedic Consultants to use my credit card for copays, co-insurance, non-covered services, or other balances that are my financial responsibility if not paid within 45 days of service.
   Credit Card Type ________________ # ________________________ Expiration ____________.
9. **Interest.** 1.5% interest will be accrued, per month, on balances due as described above after the aforementioned 45 days.

I have read and understand the above terms of treatment and confirm that I am the patient or authorized to sign on the patient's behalf.

Patient Name: ______________________________ Date: ______________________

Patient Signature: ______________________________ Witness Signature ______________________
(or patient/legal guardian/personal representative) (If not signed by patient)