WELCOME!

Patient Information

PATIENT'S NAME First	Middle	Last	Maiden	Today's Date / Nickname?

Address	City	State	Zip	Home Phone

Sex M F	Date of Birth	Age	Social Security Number	Marital Status S M W D Sep
			_____ - _____ - _____	

Patient's Employer	Patients Occupation	How Long

Employer Address	City	State	Zip	Work Phone

Emergency Contact other than Spouse	Relationship to Patient	Home Phone

Address	City	State	Zip	Work Phone

Primary Care Physician	Address	Phone

Spouse Name	Social Security Number	Date of Birth
	_____ - _____ - _____	

Spouse Employer	Employer Address	Work Phone

Insurance Information

Name of Insured	Relationship to Patient	Date of Birth

Insurance Company Name	Contract Number	Group Number	Phone Number

Insurance Company Address	Deductible Amount	Co-Pay Amount or % Amount

Do you have additional insurance? ☐ **Yes** ☐ **No** **If YES, please continue to fill out the additional insurance information.**

Name of Insured	Relationship to Patient	Date of Birth

Insurance Company Name	Contract Number	Group Number	Phone Number

Insurance Company Address	Deductible Amount	Co-Pay Amount or % Amount

Responsible Party

Person Responsible for this Account	Relationship to Patient

Address	City	State	Zip	Home Phone

Financial Institute	Responsible Party Employer	Work Phone

Driver's License Number	Social Security Number	Date of Birth
	_____ - _____ - _____	

Auto Accident and/or Workers' Comp Information

Is this visit related to an auto accident? ☐ Yes ☐ No	Date of Accident	Claim No.	Claim Representative's Name

Auto Insurance Company Name and Full Address	Phone Number

Is this a work related accident? ☐ Yes ☐ No	Date of Accident	Claim No.	Claim Representative's Name

Workers' Comp Insurance Company Name and Full Address	Phone Number

PLEASE COMPLETE AND SIGN PAGE 2 AS PART OF THIS DOCUMENT ➡

IF YOU DO NOT HAVE INSURANCE COVERAGE

I understand that I am responsible for any charges at the time of service, unless prior arrangements are made.

Signature of Responsible Party _____ Date _____

IF YOU HAVE BLUE CROSS BLUE SHIELD OF MICHIGAN

I understand Sports Medicine & Joint Care West Michigan participates with BCBS of Michigan and that they will bill for any covered services. I also understand that I am responsible for any deductible and co-pays that my policy has (all BCBS policies have deductible and co-pays). I understand that if I have BCBSM-MASTER MEDICAL that I am responsible for paying at the time of service unless prior arrangements are made and that the checks from BCBS come direct to me.

Signature of Responsible Party _____ Date _____

IF YOU HAVE MEDICARE

I understand Sports Medicine & Joint Care West Michigan participates with Medicare Part B. I request that payment of authorized Medicare benefits be made to Sports Medicine & Joint Care West Michigan for any services furnished by Sports Medicine & Joint Care West Michigan. I authorize any holder of medical or other information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits for related services. I also authorize benefits be paid to Sports Medicine & Joint Care West Michigan from any secondary insurance I may have.

Signature of Responsible Party _____ Date _____

IF YOU HAVE A HMO

I understand Sports Medicine & Joint Care West Michigan participates as a specialist with my HMO, with proper referral from my primary care doctor and will bill any changes I incur. I also understand that I am responsible for any co-pays at the time of service.

Signature of Responsible Party _____ Date _____

AUTHORIZATION AND ASSIGNMENT

My signature below will authorize payment of my medical benefits to Sports Medicine Joint Care West Michigan. This assignment will remain in effect until revoked in writing. A photocopy of this assignment is as valid as the original. I also authorize Sports Medicine Joint Care of West Michigan to release information to physicians, attorneys, insurance carriers or employers as necessary for my medical treatment or the processing of my claim. I understand that I am financially responsible for any balance left on my account. Payment arrangements can be made prior to my visit.

Signature of Responsible Party _____ Date _____

PRIVACY ACKNOWLEDGEMENT

My signature below indicates I have received a copy of the Privacy Notice for Sports Medicine Joint Care West Michigan.

Signature of Responsible Party _____ Date _____