**Framingham Orthopedic Associates, Inc.** Acct #: _____

Primary Care Phys. Name: _____

PCP Address & Tel. #: _____

## Patient Information

Last Name | First: | Initial: | Sex | Age: | DOB:

Street Address | City: | State: | Zip:

Home Telephone Number: | Patient's Social Security #:

Patient's Employer: | Employer's Address:

Work Telephone Number: | Cell Phone Number:

## Billing Name & Address (if different from patient)

Last Name | First Name: | Initial:

Relationship to Patient: | Social Security Number:

Street Address | City: | State: | Zip:

Home Tel. #: | Work Tel. #: | Cell Phone #:

## Insurance Information

Insurance Company Name: | Certificate #: | Group #:

Subscriber's Name (if not the patient): ☐ Male ☐ Female DOB:

Relationship to Patient: | Subscriber's Employer:

Employer's Address:

## Other Information

Work related injury? Yes ☐ No ☐ Date of injury or onset of problems:

Auto Accident? Yes ☐ No ☐

Liability Claim? Yes ☐ No ☐ Attorney's Name:

Insurance Co. Address:

Address: Telephone:

Adjuster's Name: Claim #:

## Authorization for Billing, Payment and Treatment

| | | |
|---|---|---|
| Authorization to pay benefits to Physician: I hereby authorize payment directly to the undersigned physician of the surgical and/or medical benefits, if any, otherwise payable to me for the service as described. | Signed: | Date: |
| Authorization to release information: I hereby authorize the undersigned physician to release any information acquired in the course of my examination or treatment. | Signed: | Date: |
| Medicare Waiver (Age 65 or older): I request that payment of authorized Medicare benefits be made to me or on my behalf to Framingham Orthopedic Associates, Inc. for any services furnished me. I authorize any holder of medical information about me released to the Health Care Financing Administration (HCFA) and its agent any information needed to determine these benefits payable for related services. | Signed: | Date: |

## Remarks or Notes

HIPAA

ACKNOWLEDGEMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES: By signing this form, I acknoledge the receipt of Framingham Orthopedic's "Notice of Privacy Practices," which provides me with detailed information about how Framingham Orthopedic Associates, Inc. may use and disclose my protected health information for the purposes of treatment, payment, and health care operations. I have the right to request, in writing, how they use and disclose my protected health information for the purposes of treatment, payment, or health care operations and that the practice is not required by law to grant my request. However, if the practice does decide to grant my request, the practice must adhere to the approved restrictions unless it is an emergency situation or it is in direct conflict with state or federal laws or regulations.

Signed:_____ Date:_____