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Patient Information

Date: ________________

Name: Last _________________________________ First_____________________________ MI _____

Gender: Male Female Status: Single Married Divorced Widowed Separated

DOB: ______ /_______ / ______ SS#______________________ Driv Lic# ________________________

Mailing Address ____

City ____________________________ State ________________ Zip Code ________________

Phone ______________________________ Home Mobile Work

Email ____

Occupation_____________________________ Employer_____________________________________

Supervisor/HR Contact _________________________________Phone ____________________________

Emergency Contact ____

Relationship_______________________________________ Phone______________________________

General Information

Primary Doctor ____

Address ____

Phone: ______________________________ Fax ____

Referring Doctor ____

Description of Problem ____

Cause of Injury ____ Auto Work Other

Date of Injury ______ /_______ / _______ Claim#_______________________________

Adjusters Name ____________________________________ Phone______________________________

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Insurance Information

Primary Insurance ________________________________ Phone ________________________________

Group # ___________________________________ ID# ____

POLICY HOLDER or SUBSCRIBER: Self Other (if other, please complete below)

Name: Last _______________________________ First ___________________________ MI ________

Phone_______________________________ Home Mobile Work

Relationship to Patient_______________________________ Policy Holder's DOB_____/_____/______

Employer ____

AUTHORIZATION BENEFIT ASSIGNMENT - FINANCIAL RESPONSIBILITY - RELEASE OF INFORMATION

I authorize ***Orthomotion Inc***. to release to the insurance carrier, any information needed for the payment of any claim. I authorize and hereby assign payment directly to ***Orthomotion Inc.*** from my insurance carrier or third party payer.

I agree to pay any applicable co-payments, co-insurance and/or deductible amounts for which I am responsible under my insurance policy at the time of service. I understand that my insurance benefits may not cover all charges and that I am responsible for those charges not covered by my health insurance or third party payer. All bills for services are due upon receipt, and any balance that remains unpaid for 30 days or longer will be charged a $35 late fee.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees in addition to my outstanding balance. I understand that my credit card number will be kept on file for any applicable fees to be charged in the event of non-payment. A photocopy of this authorization is to be considered as valid as the original.

By my signature, I authorize ***Orhomotion Inc.,*** to release all information necessary, including medical records, to secure payment.

____ ________________________________

Responsible Party Signature **Date**

2995 Baseline Rd, Suite 304, Boulder, CO 80303 - 305 505 5596 - 720 507 0643

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