ROBERT P. SOTTA, MD

PATIENT INFORMATION

Name: _____ Sex: ( )M ( )F

Address: _____ Date of Birth: _____ Age: _____

_____

City, State, Zip: _____ Social Security #: _____

Home: _____ Marital Status: ( )Married ( )Single ( )Divorced

Work: _____ Referring Physician: _____

Cell: _____ Primary Physician: _____

PATIENT EMPLOYMENT INFORMATION

( )Employed ( )Retired ( )Unemployed ( )Other

Employer's Name: _____

Employer's Phone: _____

Occupation: _____

EMERGENCY CONTACTS

Name Relationship Phone

_____

_____

RESPONSIBLE PARTY ***(If patient is under 18 years of age)***

Name: _____ Employer: _____

Address: _____ Home Phone: _____

_____ Work Phone: _____

City, State, Zip: _____ SSN: _____ DOB: _____

PRIMARY INSURANCE

Insurance Company: _____

ID#: _____

Group/Policy #: _____

Subscriber Name: _____

Subscriber Phone#: _____

Relationship to Patient: _____

Subscriber's Employer: _____

Subscriber's SSN: _____

Subscriber's Date of Birth: _____

SECONDARY INSURANCE

Insurance Company: _____

ID#: _____

Group/Policy #: _____

Subscriber Name: _____

Subscriber Phone#: _____

Relationship to Patient: _____

Subscriber's Employer: _____

Subscriber's SSN: _____

Subscriber's Date of Birth: _____

WORK-RELATED OR MOTOR VEHICLE INJURY

Only applicable if injury is result of work or auto accident

Insurance Carrier: _____ Address: _____

Phone: _____ City, State, Zip: _____

Claim#: _____ Date of Injury: _____ Employer at time of injury: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

(Please read and sign)

I attest that the information I have given here is correct and true to the best of my knowledge. I hereby assign benefits to be paid directly to the doctor, and authorize him to furnish information regarding my illness to my insurance carrier. ***I understand that I am responsible for any amount not paid for by my insurance.***

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE

OFFICE POLICIES & FINANCIAL AGREEMENT

I am committed to providing you with the best possible services and I also want you to understand our policies regarding professional fees, your financial responsibility, and my billing practices. Please feel free to ask the office staff for clarification should you have any questions. A copy of this signed financial agreement will be made available to you at your request.

PROFESSIONAL FEES

The fee schedule is based on prevailing standards in the community and in compliance with Medicare.

WORKERS COMPENSATION/MOTOR VEHICLE ACCIDENT

Patients who are being seen for a Workers' Compensation claim or motor vehicle accident will be responsible for any services that are denied. Your claim with the insurance company does not guarantee payment.

REFERRALS

The patient or legal guardian (of a minor) is responsible for obtaining any referral required by their primary care physician to a specialty physician as outlined in their agreement with their insurance company. This may include X-ray, diagnostic procedures, physical therapy, medication, surgical procedures and any treatment done in addition to the office visits.

FINANCIAL AGREEMENT

Many people believe when they use their health insurance it is the insurance company that owes the doctor for his or her services. This is NOT the case. The health insurance contract is between you and your insurance company. Therefore, YOU are responsible for payment of all fees regardless of any insurance coverage. As a courtesy to the patient, we will bill all insurance companies if orthopedic services are covered. If you are using your health insurance, you must supply us with complete information about your coverage and a copy of your health insurance card. If you belong to a managed healthcare plan, all co-payments are due at the time of service. Most health insurance plans do not cover 100% of the cost for medical treatment. If your insurance has not paid for covered services within 60 days of the service, you will need to make full payment to this office and be reimbursed when the insurance pays.

All services (i.e. supplies, not eligible at the time of services) that are not a covered benefit per the contract with your insurance company, is due upon receipt of your billing statement or payable according to an agreement that you have made with the billing office. You will receive a monthly statement showing any balance due.

Patients who are not insured are expected to pay fees in full at the time of service unless other arrangements have been made with the business office. You will receive a monthly statement showing any balance due. All checks returned to our office for non-sufficient funds will incur a $30.00 charge for the processing fee.

Please sign and return this form to the receptionist

I acknowledge that I am financially responsible for all charges whether or not they are covered by insurance. If I am using my health insurance benefits, I hereby assign my insurance to Robert P. Sotta, M.D. and I authorize Robert P. Sotta, M.D. and his staff to provide to my insurance company any information regarding myself or my minor child that is required or necessary for the submission of a claim for services provided by them. I understand I have access to any and all information provided. I agree to the above terms and conditions.

_____

Please print patient name

_____ Date:_____

Sign here