SOMERS ORTHOPAEDIC SURGERY & SPORTS MEDICINE GROUP, P.L.L.C.

664 Stoneleigh Ave., Ste. 300
Carmel, NY 10512
(845) 278-8400

667 Stoneleigh Ave., Ste. 116
Carmel, NY 10512
(845) 230-5178

400 Westage Bus. Ctr. Dr. Ste. 106
Fishkill, NY 12524
(845) 227-2228

657 E. Main St., Ste. 3
Mt. Kisco, NY 10549
(914) 666-5550

2 Victory Court
Newburgh, NY 12550
(845) 565-1454

PATIENT REGISTRATION FORM

PLEASE PRINT CAREFULLY

Confidential

PATIENT NAME _____

DATE OF BIRTH _____ AGE _____ SEX _____ SOCIAL SECURITY _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

ADDRESS: _____
MAILING ADDRESS / STREET APT No.

_____
CITY STATE ZIP CODE

TELEPHONE: HOME #: ( ) - MOBILE # ( ) -

EMAIL ADDRESS: _____ **MAY WE EMAIL YOU? ( ) YES ( ) NO**

EMPLOYER / OCCUPATION _____

ADDRESS: _____
MAILING ADDRESS / STREET APT No.

_____
CITY STATE ZIP CODE

TELEPHONE: ( ) - EXTENSION: _____

EMERGENCY CONTACT _____ **TELEPHONE:** ( ) -
PRINT NAME & RELATIONSHIP

SPOUSE *(If you are covered under your Spouse's Insurance)*

NAME _____

DATE OF BIRTH / /

SOCIAL SECURITY # _____

EMPLOYER _____

TELEPHONE ( ) -

PARENT / LEGAL GUARDIAN *(For Minors)*

NAME _____

DATE OF BIRTH / /

SOCIAL SECURITY # _____

EMPLOYER _____

TELEPHONE ( ) -

If you think you may be Pregnant, please inform the Physician.

First Name: _____ Middle Initial ___ Last Name _____

Date Of Birth: _____

Date of Appointment: _____ MD: _____

SOMERS ORTHOPAEDIC SURGERY & SPORTS MEDICINE GROUP, P.L.L.C.

664 Stoneleigh Ave., Ste. 300
Carmel, NY 10512
(845) 278-8400

667 Stoneleigh Ave., Ste. 116
Carmel, NY 10512
(845) 230-5178

400 Westage Bus. Ctr. Dr. Ste. 106
Fishkill, NY 12524
(845) 227-2228

657 E. Main St., Ste. 3
Mt. Kisco, NY 10549
(914) 666-5550

2 Victory Court
Newburgh, NY 12550
(845) 565-1454

PATIENT REGISTRATION FORM

PLEASE PRINT CAREFULLY

Confidential

INSURANCE INFORMATION

We will need a copy of your Insurance Card(s). Please present your Insurance Card(s) to the Receptionist.

PRIMARY INSURANCE

_____

PLAN _____

ID / POLICY # _____

SUBSCRIBER _____
(SELF or PRINT NAME & RELATIONSHIP)

ADDRESS _____

_____

_____

SECONDARY INSURANCE

_____

PLAN _____

ID / POLICY # _____

SUBSCRIBER _____
(SELF or PRINT NAME & RELATIONSHIP)

ADDRESS _____

_____

_____

Complete If Your Injury is Work - Related

WORKER'S COMPENSATION CARRIER

_____

ADDRESS _____

_____

EMPLOYER _____

CASE REPRESENTATIVE _____

CARRIER CASE # _____

WORKERS COMP. BOARD # _____

DATE OF INJURY ____ / ____ / ____

BODY PART RT LT

Complete if your injury resulted from an automobile accident

NO FAULT CARRIER

_____

ADDRESS _____

_____

POLICY HOLDER _____

POLICY # _____

ATTORNEY _____

FILE # _____ TEL # _____

DATE OF ACCIDENT ____ / ____ / ____

First Name: _____ Middle Initial ___ Last Name _____

Date Of Birth: _____

Date of Appointment: _____ MD: _____

SOMERS ORTHOPAEDIC SURGERY & SPORTS MEDICINE GROUP, P.L.L.C.

664 Stoneleigh Ave., Ste. 300
Carmel, NY 10512
(845) 278-8400

667 Stoneleigh Ave., Ste. 116
Carmel, NY 10512
(845) 230-5178

400 Westage Bus. Ctr. Dr. Ste. 106
Fishkill, NY 12524
(845) 227-2228

657 E. Main St., Ste. 3
Mt. Kisco, NY 10549
(914) 666-5550

2 Victory Court
Newburgh, NY 12550
(845) 565-1454

OUR PRACTICE PAYMENT POLICY

MANAGED CARE / HMOs

We participate with most HMOs. It is the Patients or Authorized Representative (Parent or Legal Guardian for Minors) responsibility to provide Somers Orthopaedic Surgery & Sports Medicine Group, P.L.L.C. with his or her insurance information, Copy of the Insurance Card(s) and Referral. If the Referral is not available at the time of visit, then you will be required to pay for the visit. If you are able to obtain a valid Referral after the visit, you will be reimbursed for the payment (*less co-pay*) you made for the services rendered. Payment for co-pay's will be collected at each visit.

MEDICARE

Our participation in Medicare includes Physician and X-Ray Services. Medicare Patients are responsible for payment of the Medicare 20 % Co-insurance and the Medicare Deductible when applicable.

WORKERS' COMPENSATION / NO - FAULT

It is the Patients responsibility to bring all Workers' Compensation / No - Fault Insurance and Attorney Information with them at the time of the visit.

PRIVATE INSURANCE

If you are not covered under any of the above Insurance Plans, Payment for the Initial Consultation Fee, Office Visit and / or X-Ray(s) is required on the day of your appointment. We will mail you an itemized Receipt to submit for Reimbursement to your Insurance Company if requested.

UPDATES

It is the patient's responsibility to notify Somers Orthopaedic immediately of any change in their insurance or Empoyment Status to ensure accurate submission of claims.

PAYMENT

Payment may be made by cash, Check or Credit Card. We accept American Express, Discover, MasterCard and Visa.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS:

I have completed this Patent Registration Form and state that all of the information I have provided is valid and true. I have read and understand the Payment Policy of Somers Orthopaedic Surgery & Sports Medicine Group, P.L.L.C.

I understand that payment is due on the date service are rendered and that if my Insurance Carrier does not pay the balance in full, I am personally responsible for the remaining Balance and I will pay any Balance promptly.

I hereby authorize Somers Orthopaedic Surgery & Sports Medicine Group, P.L.L.C. to release any information acquired by them for purposes of Treatment, Payment and Healthcare Operations. I hereby authorize Payment(s) to go directly to Somers Orthopaedic Surgery & Sports Medicine Group, P.L.L.C.

PATIENT NAME: _____ **D.O.B.** _____

AUTHORIZED REPRESENTATIVE / PARENT / LEGAL GUARDIAN _____
(PRINT NAME & RELATIONSHIP)

SIGNATURE _____ **DATE** _____
PATIENT / AUTHORIZED REPRESENTATIVE / PARENT / LEGAL GUARDIAN - *For Minors*)

First Name: _____ Middle Initial ___ Last Name _____

Date Of Birth: _____

Date of Appointment: _____ MD: _____

SOMERS ORTHOPAEDIC SURGERY & SPORTS MEDICINE GROUP, P.L.L.C.

664 Stoneleigh Ave., Ste. 300
Carmel, NY 10512
(845) 278-8400

667 Stoneleigh Ave., Ste. 116
Carmel, NY 10512
(845) 230-5178

400 Westage Bus. Ctr. Dr. Ste. 106
Fishkill, NY 12524
(845) 227-2228

657 E. Main St., Ste. 3
Mt. Kisco, NY 10549
(914) 666-5550

2 Victory Court
Newburgh, NY 12550
(845) 565-1454

Confidential

AUTHORIZATION QUESTIONNAIRE

PLEASE PRINT CAREFULLY

AUTHORIZED REPRESENTATIVE(S):

Please list the family members or other persons, if any, whom we may inform about your general medical condition & your diagnosis (including treatment, payment and healthcare operations) and who may pick up copies of medical records, radiology films, prescriptions and recieve telephone calls such as appointment reminders on your behalf.

Spouse: _____ Other: _____

Parent: _____ _____

Son / Daughter: _____ _____

EMERGENCY CONTACT(S):

Please list the family members or significant others, if any, whome we may inform about your medical condition ***ONLY IN AN EMERGENCY:***

Name: _____ Telephone Number: ( ) -

Name: _____ Telephone Number: ( ) -

Name: _____ Telephone Number: ( ) -

BILLING / CORRESPONDENCE:

Please print the address of where you would like your billing statements and / or correspondence from our office to be sent ***if other than your home address:***

Address: _____

_____

TELEPHONE MESSAGES / APPOINTMENT REMINDERS

Please print the telephone number where you would like to receive calls about your appointments, test results, or other health care information *if other than your home telephone number:*

Telephone Number: ( ) -

Telephone Number: ( ) -

Please be aware that a cell phone is not a secure and private line.

It is our office policy to call scheduled patients to confirm appointments. May we leave messages such as appointment reminders on your telephone answering machine (at home) or voicemail (at work)?

☐ Yes ☐ No

PATIENT NAME: _____

PARENT / LEGAL GUARDIAN: _____
(if minor)

SIGNATURE OF PATIENT / PARENT / GUARDIAN: _____

First Name: _____ Middle Initial ___ Last Name _____

Date Of Birth: _____

Date of Appointment: _____ MD: _____

SOMERS ORTHOPAEDIC SURGERY & SPORTS MEDICINE GROUP, P.L.L.C.

664 Stoneleigh Ave., Ste. 300
Carmel, NY 10512
(845) 278-8400

667 Stoneleigh Ave., Ste. 116
Carmel, NY 10512
(845) 230-5178

400 Westage Bus. Ctr. Dr. Ste. 106
Fishkill, NY 12524
(845) 227-2228

657 E. Main St., Ste. 3
Mt. Kisco, NY 10549
(914) 666-5550

2 Victory Court
Newburgh, NY 12550
(845) 565-1454

Statement of Discrimination

Somers Orthopaedic Surgery & Sports Medicine Group, PLLC, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Somers Orthopaedic Surgery & Sports Medicine Group, PLLC, cumple con las leyes federales de derechos civiles y no discrimina por raza, color, origen nacional, edad, discapacidad o sexo.

I hereby acknowledge receipt of the Notice of Privacy Practices.

_____
Signature

_____
Print Name

_____
Date

* This acknowledgement reflects the proposed modifications to § 164.520 of the privacy standards as set forth by the Department of Health and Human Services at 67 Fed. Reg. 14814 (March 27, 2002). It applies to health care providers with direct treatment relationships. This acknowledgement, or some other form of acknowledgement (e.g., initials), can be on a cover sheet to be retained by the provider, on a separate list apart from the notice, or otherwise.