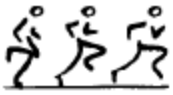

Fondren Orthopedic Group L.L.P.

Patient Name:_____ Clinic ID#:_____

Insurance Company:_____ SS#_____

Provider Number:_____ Statement Group:_____

RELEASE OF INFORMATION: I hereby authorize Fondren Orthopedic Group, L.L.P. to release any or all information acquired in the course of my examination and/or treatment.

I understand this may include the release of any medical or other information required in the processing of claims for payment. I also authorize the release of information to another doctor or health care facility to which the patient may be transferred or referred.

MEDICARE - PATIENT'S CERTIFICATION: I certify that the MEDICARE information given by me is correct. As this office does accept assignment with Medicare, this information will be used for the purpose of processing my Medicare claims for payment. I understand, due to government regulations, that if Medicare coverage is available to me, I must inform my physician. I also understand, if in addition to Medicare, I am covered under an EMPLOYER GROUP HEALTH INSURANCE, LIABILITY, NO-FAULT, WORKERS' COMPENSATION, or any other insurance which may be responsible for payment, I must inform this office.

I have read and understand the above statement regarding MEDICARE coverage.

_____MEDICARE is my Primary coverage.

_____MEDICARE is my Secondary coverage.

_____I do not have MEDICARE/HMO.

_____I do not have MEDICAID/HMO.

_____I understand this office normally files insurance for surgical procedures only. Payment is required today for all services.

_____ This is NOT a Work Related condition, injury or symptom.

_____ This IS a Work Related condition, injury or symptom.

ASSIGNMENT OF BENEFITS: I hereby authorize payment to the Fondren Orthopedic Group, L.L.P. of the surgical and/or medical benefits, if any, otherwise payable to me for services I have received.

FINANCIAL OBLIGATION: The undersigned hereby unconditionally guarantees full and prompt payment of all charges incurred as a result of services rendered to me during the course of my medical treatment.

_____ _____

Signature or Insured/Guardian Date Witness Date

Patient's Name:_____ Doctor's Name: _____

Date of birth: _____

Purpose of visit: _____

Due to: ☐ **Illness**

Date of onset: _____

Due to: ☐ **Injury**

Date of injury: _____

Where injury occurred: _____

_____

Have you seen a doctor for this illness or injury?

☐ **Yes** . . . . . if yes:

☐ **No**

Approximate date: _____

Doctor's name: _____

Address: _____

_____

Phone number: _____ – _____

Was this related to an automobile accident?

☐ **Yes** . . . . . if yes:

☐ **No**

Insurance Company: _____

Agent name: _____

Address: _____

_____

Phone number: _____ – _____

Patient Signature: _____ Date: _____