OrthoVirginia
West End Orthopaedic Clinic

Patient Check-In Form

Name of Physician to see today: _____
Name of Physician who sent you here today: _____
Name of your Family Practice doctor: _____
Body Area being seen for today: _____
(i.e. right leg, left hip, etc.)

Problem? Y N Date Problem Began: _____
Injury? Y N Date of Injury: _____
Work Injury? Y N Date of Injury: _____
Auto Accident? Y N Date of Accident: _____ State of Accident: _____

Patient Name _____ ____ _____
First *M* *Last*

Address _____
_____

Phone Number(s) (If child, phone numbers for parent)
Home: (___)_____ Office: (___)_____ Cell: (___)_____
Email: _____ May we contact you by email? Y N

Date of Birth: ___/____/_____ SSN: _____
Marital Status: _____ Sex: ____ Occupation: _____

Employer: _____
Employer Address: _____
_____
City *State* *Zip*
Employer Phone: (____)_____

Emergency Contact(s): _____
_____
Name *Phone #*

Primary Insurance Name: _____
Policyholder Name: _____
Date of Birth of Policyholder: ____/___/_____
Relationship of Policyholder to Patient: _____
Policyholder SSN (One Net only): _____
Policyholder Employer/Address (One Net only): _____
_____

Secondary Insurance Name: _____
Policyholder Name: _____
Date of Birth of Policyholder: ____/___/_____
Relationship of Policyholder to Patient: _____

OrthoVirginia
West End Orthopaedic Clinic

Medical Services Contract

West End Orthopaedic Clinic

Right to Choose your Testing Facility

During the course of your treatment, you may require additional procedures or diagnostic services. West End Orthopaedic Clinic (WEOC) and one or more of its physicians may have a financial interest in the facility to which you may be referred for additional medical services. You have the right to select another organization or entity for the purpose of obtaining such medical services.

Financial Responsibility

I hereby authorize West End Orthopaedic Clinic [hereinafter referred to as WEOC] to render medical services to me or _____, my spouse, minor child or other. I authorize direct payment of any insurance to WEOC. WEOC may file a claim with any and all policies of insurance I have but [with exception of Medicare] is not required to do so. If for any reason the insurance company payment is not made timely it is my responsibility to pay all fees and charges in connection with the treatment. It is further my responsibility to provide accurate insurance information and to secure all necessary prior approvals, authorizations, and referrals prior to services being provided.

Third Party Payments

In the event the medical services provided arise out of an occurrence for which a third party may be responsible I hereby grant WEOC an irrevocable lien on any recovery, whether by settlement or verdict, against said third party in an amount equal to the total of all sums due plus contract interest and attorney's fees, if applicable. I further authorize my attorney and/or insurance company to pay any financial recovery or balance due directly to WEOC. I understand that WEOC will not hold my account open during any period of litigation or negotiation and may pursue collection against me during that period.

Health Information

I understand that health information in my or my child's medical record may be released in accordance with WEOC's Notice of Privacy Practices, a copy of which has been provided to me. I further authorize the exchange of medical information with the hospital and the centers for Medicare/Medicaid services, if applicable. This information may be transmitted to or from WEOC by any means available, including fax or electronic transmission.

Collection Costs

If my account or that of the individual I am guaranteeing should be placed with an attorney for collection, I agree to pay, in addition to all other amounts I owe, an attorney fee equal to 25% of my outstanding balance and other costs associated with collection. If any indebtedness is not paid in full within 60 days of the day in which it is due I agree to pay a service charge of 1.5% per month [18% per annum]. All returned checks will incur a returned check fee of $40.00.

Print Patient Name:_____ Date:_____

Responsible Party/Guarantor Signature:_____