LAKELANDS ORTHOPAEDIC & SPORTS MEDICINE CLINIC ,PA

102 GREGOR MENDEL CIR	100 COMMERCIAL DRIVE	300 RIDGE MEDICAL PLAZA	207B HOLIDAY ROAD
GREENWOOD SC 29646	ABBEVILLE SC 29620	EDGEFIELD SC 29824	MCCORMICK SC 29835

KING CHRISTIAN GRAY CATHCART TIMMS POWELL PATTERSON JESSICA GARY

PATIENT INFORMATION

DATE: _____ MISYS ACCOUNT#: _____ NP/OPNP/ERNP/EREP

PATIENT NAME _____ DATE OF BIRTH _____ SSN# _____
LAST FIRST MIDDLE

MAILING ADDRESS _____ CITY _____ COUNTY _____ STATE ____ ZIP _____

HOME PHONE ( ) _____ WORK PHONE _____ CELL PHONE _____

PATIENT EMPLOYER _____ EMERGENCY CONTACT _____

PARENT/GUARANTOR INFORMATION

GUARANTOR NAME & ADDRESS _____

GUARANTOR DATE OF BIRTH _____ SSN# _____ EMPLOYER _____

MEDICAL INFORMATION

REFERRING PHYSICIAN _____ CALLER _____ PHONE# _____

DIAGNOSIS/PROBLEM LEFT/RIGHT _____FAMILY DOCTOR _____ FAXING RECORDS YES/NO

XRAYS: YES/NO MRI: YES/NO CT: YES/NO OTHER: YES/NO PATIENT SEEN IN ER ON _____ SELF/EXPRESS CARE/ABBEVILLE/EDGEFIELD

CALLED FOR MEDICAL RECORDS DATE _____ TIME _____ NAME _____ RCVD YES NO

APPT DATE _____ TIME _____ DOCTOR _____ MADE BY _____ PACKET MAILED _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____ ID# _____ GROUP# _____

INSURED NAME _____ INSURED DOB _____ INSURED SSN# _____

SECONDARY INSURANCE _____ ID# _____ GROUP# _____

WORKERS COMPENSATION

IF YOUR INJURY IS THE RESULT OF AN ACCIDENT THAT HAPPENED ON THE JOB, PLEASE COMPLETE THIS SECTION

EMPLOYER _____ EMPLOYER ADDRESS _____

CONTACT PERSON'S NAME _____ PHONE# _____ DATE OF INURY _____

HOW DID INJURY HAPPEN _____

_____

HIPPA INFORMATION

A copy of the Notice of Privacy Practices for Lakelands Orthpaedic & Sports Medicine Clinic, PA is available at the front desk. Please list names and phone numbers of any individual with whom we may discuss your health or medical care.

_____

I agree that Laklands Orthopaedic & Sports Medicine Clinic, PA may request and use my prescription medication history from other health care providers or third party pharmacy benefit payors for treatment purposes. _____(INTIAL PLEASE)

FINANCIAL AGREEMENT

I agree to pay the portion of my bill <u>at the time of service</u> that will not be paid by my insurance company, including any deductibles and/or co-payment. I understand that I will be billed the remainder of my balance if any insurance company does not pay Lakelands Orthopaedic & Sports Medicine Clinic, PA. promptly.

<u>PATIENTS WITHOUT INSURANCE ARE REQUIRED TO PAY $300 AT FIRST VISIT AND $50 CO-PAYMENT AT EACH FOLLOW UP VISITS</u>

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record. I hereby assign all medical benefits to which I am entitled, including <u>MEDICARE, PRIVATE INSURANCE,</u> and other health plans, to Lakelands Orhtopaedic & Sports Medicine Clinic, PA. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure payment.

My signature below certifies that I have read and fully understand the above financial agreement.

Signature of Patient or Guarantor _____ Date _____