Firstcare Orthopaedics, Inc.

493 Blackwell Road, Suite 115, Warrenton, VA 20186
540.341.7758 Office *540.341.7792 Fax*

PATIENT INFORMATION

NAME _____ D.O.B. _____ GENDER (circle) M F

ADDRESS _____
ADDRESS CITY STATE ZIP CODE

PHONE (H) _____ PHONE (OTHER) _____

DATE OF INJURY (Workers Comp Only) _____

REFERRING PHYSICIAN _____ PURPOSE OF VISIT _____ (circle) Left Right

EMPLOYER (If student please specify) _____ WORK NUMBER_____

EMPLOYER ADDRESS _____

EMERGENCY CONTACT _____ RELATIONSHIP _____ PHONE_____

PRIMARY INSURANCE INFORMATION

INSURANCE CO. _____ POLICY # _____

GROUP # _____ INSURANCE PHONE_____

SUBSCRIBER'S NAME _____ **SUBSCRIBER'S DOB**_____

INSURED'S ADDRESS (If Different) _____

WORKMANS COMP CASE # _____ ADJUSTER _____

SECONDARY INSURANCE INFORMATION

INSURANCE CO. _____ POLICY # _____

GROUP # _____ SUBSCRIBER _____

PHONE _____ MEDICAID ID# _____

I hereby assign all medical benefits, Medicare, private insurance and any other health plans to which I am entitled to Firstcare Orthopaedics, Inc. I also authorize the release of any and all information, including Medical records; to secure payment to Firstcare Orthopaedics, Inc., for services rendered. I further understand that you will submit my claim to my insurance on my behalf. I am also aware that my insurance may or may not cover all or any of the services that you provide. All expenses which are not covered by my insurance(s) are my personal responsibility. I also agree that any balance owed shall be made in a timely manner and that 1.5% interest may be added monthly for unpaid balances. I will also be responsible for any additional fees added if referred to a collection agency due to my account being delinquent. If any payment is made directly to you for services billed by us, you agree to promptly remit this payment to Firstcare Orthopaedics, Inc. A Workers Compensation patient will be responsible for charges if claim(s) for services is/are denied. I understand that I have the right to choose my provider of service. I also permit a copy of this authorization to be used in place of the original, and request that payment under the healthcare program be made directly to Firstcare Orthopaedics, Inc., and accept the medical product and service as consideration in full of this agreement. I have read, and fully understand, the above information.

PATIENT SIGNATURE _____ DATE _____