David Thomas, FNP-BC, RNFA

Midwest Bone & Joint Center, P.C.
Chris Main, DO
Board Certified Orthopedic Surgeon

1706 Prospect Dr.
PO Box 402
Macon, MO 63552
P: 660-385-1006
F: 660-385-1028

Date ______________________________ Home Phone ______________________________
Cell Phone ______________________________

PATIENT INFORMATION FORM

Last Name ______________________________ First Name ______________________ Middle ______________

Street Address ____ Apt _______________

City __________________________ State ______ Zip ___________ E-mail _________________________________

Date of Birth ___________________________ Age __________ SSN ___________________________________

Race: □White □African American □Hispanic □Multiracial □Other □Patient Declines
Ethnicity: □Non-Hispanic □Hispanic/Latino □Unknown □Patient Declines

Employer ____ Work Phone ________________________________

Address ____ State _____________ Zip_________

Spouse's Name _____________________ DOB ______________ Spouse Phone ______________________________

Emergency Contact ____________________________ Relationship __________________ Phone ________________
(not in your household)

Pharmacy Name ____ City __________________________________

Referring Physician ______________________________________ Phone ___________________________________

Family Physician __________________________ Send copy of note? □Yes □No Phone ____________________

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
Policy Number:	Policy Number:
Group:	Group:
Effective Date:	Effective Date:
Policy Holder:	Insured Name:
Policy Holder SSN:	Policy Holder SSN:

Work Related injury □Yes □ No Auto or Accident □Yes □No

Guarantor Information
Please complete the section below if someone other than the patient is responsible for the bill.

Name ____ SSN ______________________ DOB _____________

Street Address ____City _____________ State ______ Zip___________

Phone ______________________________________ Relationship to patient__________________________________

Employer____

CONSENT & RELEASE

To the best of my knowledge, the information on the opposite side of this form is true and accurate.

I understand that Midwest Bone & Joint Center, PC, utilizes telemedicine technology.

I understand that Midwest Bone & Joint Center, PC, will pre-certify all surgeries and MRI services for all insurance/Medicare plans (including Worker's Compensation) that require it. It is my responsibility to know the benefits of my insurance.

I hereby authorize payment directly to Midwest Bone & Joint Center, PC, of all insurance/Medicare coverage for surgery, and/or office charges, and I authorize them to release any information necessary to process insurance benefits on my behalf. I also authorize the release of my medical records to any insurance company with whom I have health insurance coverage.

I understand that provider and office fees are due and payable when services are rendered. I understand that I am fully responsible for all charges and any balance due after payment by insurance, and that insurance coverage does not necessarily guarantee payment of charges. I also understand that any account balance over 90 days will be assessed a finance charge, and/or billing charges.

A copy of your insurance card(s) and driver license is required.

HIPAA AUTHORIZATION

I have been informed by Midwest Bone & Joint Center, PC, that the "Notice of Privacy Practices" is available in the waiting room for review. I understand that I have the right to ask questions in order to seek clarification.

RELEASE OF INFORMATION

I authorize Midwest Bone & Joint Center, PC, to discuss my Protected Health Information with the following individuals.

Name	Relationship	Phone

I authorize Midwest Bone & Joint Center, PC, to:

Leave a message on home answering machine ☐Yes ☐No

Leave a message at my place of employment ☐Yes ☐No

I agree to the terms above and authorize treatment by the provider(s) in this office.

Patient's signature ______________________________ Date ______________

Print patient's name ____

MEDICARE SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Chris Main, DO; David Thomas, FNP-BC, RNFA (Midwest Bone & Joint Center, PC) for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) any information needed to determine these benefits or the benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance: is indicated in Item 9 of the CMS-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient's signature ______________________________ Date______________