Patient Registration

ALTA ORTHOPAEDICS

Name: _____ Age: _____ Birth Date: _____

Sex: _____ Social Security #: _____ Email: _____

*Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Separated

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell Phone #: _____

Employer: _____ Occupation: _____Work Phone #: _____

Primary Care Physician: _____ Phone #: _____

Referring Physician: _____ Phone #: _____

Spouse/Parent: _____ Phone #: _____

Primary Insurance: _____ Secondary Insurance: _____

*Card Holders Name: _____ *Card Holders Birth Date: _____

*Card Holders Social Security #: _____

* Information requested by your insurance to process your claim

Emergency Contact: _____ Phone #: _____

Payment Policy: Payment is due at the time services are rendered, unless other arrangements have been made. Insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. It is your responsibility to pay any deductible, co-insurance, or any balance not paid by your insurance. **Alta Orthopaedics accepts some HMO plans.** Please check with your insurance carrier directly to see if we are currently accepting their insurance plan.

Patient Authorization: I hereby authorize the release of any medical information necessary to process my insurance claim. Payers require social security numbers to process their claims. I agree to be billed as self pay if I do not furnish this information. I hereby authorize payment of medical benefits to the named provider for services rendered. I also authorize Palmetto GBA to release information regarding Medicare claims submitted by the named provider.

HIPPA Notice of Privacy Practices: We are required by law to maintain the privacy of, and provide individuals with the HIPPA Regulations of our legal duties and privacy practices with respect to health information. If you have any objections to this form, please speak with our HIPPA Compliance Officer. The patient signature acknowledges receipt of this notice.

Appointment cancellation policy: Please give us 24 hours notice if you are unable to make your appointment. Our practice charges a $45 fee for all missed appointments.

Notice to Consumers: Medical doctors are licensed and regulated by the Medical Board of California at (800) 633-2322 or www.mbc.ca.gov

Signed: _____ **Date:** _____