LOUISVILLE ORTHOPAEDIC SURGERY CENTER, PLLC
4130 DUTCHMANS LANE
SUITE 200
LOUISVILLE, KY 40207
(502)897-1794

TO RECEIVE MEDICAL TREATMENT ALL QUESTIONS MUST BE ANSWERED

Patient Name: _____
First Middle Last

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

Home Phone: _____ **Cell Phone:** _____

Work Phone: _____ **Emergency Phone:** _____

Social Security #: _____ **Age:** ____ **Date of Birth:** _____ **Marital Status:** ____

Student-Full/Part Time (circle one) Name of School: _____

Employer: _____ **Occupation:** _____

Address: _____ **Phone Number:** _____

We must have all necessary insurance information – We will make a copy of your insurance card

Spouse/Responsible party's name (if minor): _____ **Social Security #:** _____

Address, if different from patient: _____

Spouse/Responsible party's employer and occupation: _____ **Phone:** _____

Primary Insurance Company: _____**Policy #:** _____

Subscriber Name: _____ **Subscriber date of birth:** _____ **Group #:** _____

Secondary Insurance Company: _____ **Policy #:** _____

Subscriber Name: _____ **Subscriber date of birth:** _____ **Group #:** _____

PLEASE READ THE FOLLOWING INFORMATION-THE RESPONSIBLE PARTY MUST SIGN ALL STATEMENTS BELOW

CONTRACT TO PAY FOR MEDICAL SERVICES: I authorize treatment and agree to pay when services are rendered or I hereby authorize insurance payment directly to Drs. Ernest A. Eggers, Donald T. McAllister, Norman V. Lewis, Richard A. Sweet, Thomas R. Lehmann, George E. Quill, Jr., Scott D. Kuiper, Ty E. Richardson, Robert A. Goodin, J. Steve Smith, Lori L. Edmonds, ARNP, Melissa D. Taylor, PA-C, Kate S. Hamilton, PA-C, Christina L. Fields, ARNP or Louisville Orthopaedic Surgery Center, PLLC. If charges are more than paid by insurance company, I agree to pay the difference.

It is your responsibility to be informed regarding your insurance coverage. We will make every effort to assist you in obtaining authorizations for procedures necessary in your treatment, but if you neglect to inform us of your coverage, and your insurance company refuses to pay, it then becomes your responsibility to pay for services rendered. You may have to pay for all unauthorized services or all unauthorized referrals from your primary care physicians.

AUTHORIZATION: I authorize Drs. Ernest A. Eggers, Donald T. McAllister, Norman V. Lewis, Richard A. Sweet, Thomas R. Lehmann, George E. Quill, Jr., Scott D. Kuiper, Ty E. Richardson, Robert A. Goodin, J. Steve Smith, Lori L. Edmonds, ARNP, Melissa D. Taylor, PA-C, Kate S. Hamilton, PA-C, Christina L. Fields, ARNP or Louisville Orthopaedic Surgery Center, PLLC, to release any protected health information necessary to process my health, disability, liability, or workman's compensation insurance.

Furthermore, signing this form gives the Louisville Orthopaedic Surgery Center, PLLC, and its employees permission to notify me at any contact information listed above. I understand that I may not be the primary recipient of the information or message.

PATIENT SIGNATURE: _____ **DATE:** _____

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