OrthoSports Associates, L.L.C.

Have you seen our doctors in the past?

___ Yes ___ No

Date ________________________________

When?________________________________

Patient Information Sheet

PATIENT INFORMATION (PLEASE PRINT)

NAME	SEX	MARITAL STATUS	SOCIAL SECURITY NO.	AGE	BIRTHDATE
ADDRESS		CITY	STATE	ZIP	HOME PHONE NO.
EMPLOYER/SCHOOL AND ADDRESS		CITY,STATE, ZIP	OCCUPATION		CELL PHONE NO
SPOUSE'S NAME	ADDRESS IF DIFFERENT FROM ABOVE				
SPOUSE'S BIRTHDATE & S.S.#	SPOUSE'S EMPLOYER & PHONE		OCCUPATION		
CONTACT OUTSIDE OF HOME & RELATIONSHIP	ADDRESS	CITY	STATE	CONTACT PHONE	

COMPLETE THIS SECTION IF PATIENT IS A MINOR OR STUDENT

FATHER'S NAME	ADDRESS	CITY	STATE	ZIP	HOME PHONE
FATHER'S BIRTHDATE & S.S. #	FATHER'S EMPLOYER	OCCUPATION			BUSINESS PHONE
MOTHER'S NAME	ADDRESS	CITY	STATE	ZIP	HOME PHONE
MOTHERS BIRTHDATE & S.S. #	MOTHER'S EMPLOYER	OCCUPATION			BUSINESS PHONE

RESPONSIBLE PARTY AND INSURANCE INFORMATION

PERSON RESPONSIBLE FOR PAYMENT	RELATION TO PATIENT	ADDRESS	CITY	STATE/ZIP	HOME PHONE
1. INSURANCE-CO NAME & ADDRESS		GROUP/POLICY #			EFFECTIVE DATE
POLICY HOLDER/SUBSCRIBER NAME & ADDRESS		BIRTHDATE	SOC. SEC. #	RELATIONSHIP TO PATIENT	
2. INSURANCE-CO NAME & ADDRESS		GROUP/POLICY #			EFFECTIVE DATE
POLICY HOLDER/SUBSCRIBER NAME & ADDRESS		BIRTHDATE	SOC. SEC. #	RELATIONSHIP TO PATIENT	

ACCIDENT OR REASON FOR VISIT INFORMATION	WERE YOU INJURED ON THE JOB? _____YES _____ NO	WAS AN AUTOMOBILE INVOLVED? _____ YES _____ NO	DATE OF INJURY?
WERE XRAYS TAKEN OF INJURY/PROBLEM?	WHERE?	DATE XRAYS TAKEN	

HOW AND WHERE WAS INJURY SUSTAINED?

WHAT INJURIES WERE SUSTAINED?

I HEREBY ASSIGN TO AND AUTHORIZE PAYMENT TO ORTHOSPORTS ASSOCIATES, LLC. TO REALEASE ANY INFORMATION ACQUIRED IN MY EXAMINATION OR TREATMENT TO ANY INSUROR, GOVERNMENT AGENCY PROVIDING BENEFITS, OR TO ANYONE FOR CHARGES.

X SIGNED ________________________________ DATE __________

I HEREBY ASSIGN TO AND AUTHORIZE PAYMENT DIRECTLY TO ORTHOSPORTS ASSOCIATES, LLC OF ALL BENEFITS PAYABLE UNDER THE TERMS OF ANY APPLICABLE INSURANCE POLICY. I REALIZE THE INSURANCE, WORKMEN'S COMPENSATION, AND/OR LIABILITY INSURANCE MAY NOT PAY THE ENTIRE BILL. I UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR CHARGES NOT COVERED BY INSURANCE. I UNDERSTAND THAT ANY INSURANCE CLAIMS WILL BE FILED AS A COURTESY. I AGREE TO ASSIST WITH THE FILING OF INSURANCE CLAIMS AS REQUESTED AND UNDERSTAND THAT MY FAILURE TO ASSIST MAY RESULT IN THE DENIAL OF CLAIMS. FURTHER, I FULLY UNDERSTAND AND AGREE THAT I AM RESPONSIBLE FOR ANY AND ALL CHARGES ASSOCIATED WITH MY ACCOUNT. IF MY ACCOUNT IS NOT PAID IN FULL WHEN DUE, AND THE PRACTICE SHOULD RETAIN AN ATTORNEY OR COLLECTION AGENCY, I AM RESPONSIBLE TO PAY, IN ADDITION TO ALL CHARGES ASSOCIATED WITH MY ACCOUNT: (1) ANY COLLECTION AGENCY FEE, WHICH WILL NOT EXCEED FORTY PERCENT (40%) OF THE DEBT, PLUS (2) ALL COSTS AND EXPENSES (INCLUDING, BUT NOT LIMITED TO, ATTORNEY'S FEES, COURT COSTS AND COURT RELATED EXPENSES) INCURRED IN CONNECTION WITH EFFORTS TO COLLECT THE DEBT. I HEREBY WAIVE MY EXEMPTION UNDER THE CONSTITUTION AND LAWS OF THE STATE OF ALABAMA. I AUTHORIZE ORTHOSPORTS ASSOCIATES LLC TO RELEASE ANY INFORMATION NECESSARY FOR PAYMENT OF CLAIMS OR AS NECESSARY FOR MY TREATMENT.

X SIGNED ________________________________ DATE __________

NOTICE OF NONDISCRIMINATION: OrthoSports Associates, LLC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. OrthoSports Associates, LLC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.