Louisville Bone & Joint Specialists, PSC
Patient Demographic Information

Patient Name ____ Patient Account # (office use only)__________________

Patient Date of Birth ____________________ Age ________ Patient Social Security Number______________________

Patient Address ____Home Phone ___________________
Street Address City State Zip Code Area Code

Cell or Alternate Phone ________________________ Employer Phone ________________________________

Patient Employer ____

This section must be completed for all patients:

Emergency Contact _________________________________ Relation to Patient ________________________

Emergency Contact Primary Phone _____________________ Other Phone ___________________________

INSURANCE/RESPONSIBLE PARTY INFORMATION

Please list your primary health insurance here. If you are filing a workers' comp, motor vehicle, or other third party insurance also complete the section below.

Primary Insurance __________________________________ Subscriber ____________________________________

Subscriber Social Security #___________________ Subscriber Date of Birth ___________________

Subscriber Address: ____

Subscriber Relation to Patient ☐ Parent ☐ Spouse/Other Subscriber Employer ____________________________

Other or Secondary Insurance__________________________ Subscriber______________________________________

Subscriber Social Security #___________________ Subscriber Date of Birth _______________

Subscriber Address: ____

Subscriber Relation to Patient ☐ Parent ☐ Spouse/Other Subscriber Employer _____________________________

Accident Related To: ☐ Car Accident ☐ Workers' Comp ☐ Other ☐ No Accident

Accident Date________________________ State Accident Occurred (for car accident only)_______________

If workers' comp or car accident, please list the adjuster in charge of your claim:

Adjuster Name and Phone Number ____

Claim Number ______________________________________

May we leave messages on your answering machine or voice mail? ☐ Yes ☐ No

May we send E-mail messages to you? ☐ Yes ☐ No E-mail Address: ______________________________________

PLEASE LIST ANYONE WITH WHOM WE ARE AUTHORIZED TO DISCUSS YOUR MEDICAL OR APPOINTMENT INFORMATION:
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I hereby give authorization for payments to go directly to Louisville Bone & Joint Specialists PSC for benefits as determined by my health insurance carrier for the expenses of indicated services. I understand any charges not covered by my insurance are my responsibility.

I further understand there are many insurance plans which Louisville Bone & Joint Specialists, PSC does not participate with. I understand it is my responsibility to ascertain the participation of this office with my plan. I understand that if I am filing a workers' comp, car accident, or other third party claim it is my responsibility to provide the appropriate claim information to Louisville Bone & Joint Specialists, PSC. I understand that I will be responsible for any balance on my account should the physicians of Louisville Bone & Joint Specialists, PSC not participate with my insurance plan or if I fail to provide the appropriate claim information.

Co-payments are due at the time of service and are considered part of your insurance contract. Deductibles and any remaining balances on accounts are expected to be paid in a timely manner. If you need to make financial arrangements, our billing office personnel will be happy to assist you.

My signature below indicates my understanding of the financial policies of Louisville Bone & Joint Specialists, PSC and indicates that I intend to abide by the policies. All information provided is true and accurate to the best of my knowledge.

INSURANCE PLANS WE DO NOT TAKE: AIK Work Comp, Indiana Medicaid, Passport/Passport Advantage, Tricare Prime, US Department of Labor Workers' Comp, any case (auto, workers' comp, third party liability) if an attorney is involved.

I acknowledge that I have received a Privacy Notice from Louisville Bone & Joint Specialists, PSC.

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Patient/Personal Representative/or Parent if Minor Date

If personal representative's signature appears above, please describe personal representative's relationship to patient:

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