

IS THIS INJURY RELATED TO A MOTOR VEHICLE ACCIDENT? YES / NO

IF YES: POLICYHOLDER'S NAME: _____
ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____
POLICY NUMBER: _____ DATE OF ACCIDENT: _____

PRIMARY MEDICAL INSURANCE:

COMPANY NAME: _____
ADDRESS: _____
CITY: _____ ST: _____ ZIP: _____ TELEPHONE: _____
INSURED'S NAME: _____ EMPLOYER: _____
SOCIAL SECURITY NO: _____ DATE OF BIRTH: _____ SEX: M / F
POLICY NUMBER: _____ GROUP NUMBER: _____

SECONDARY MEDICAL INSURANCE:

COMPANY NAME: _____
ADDRESS: _____
CITY: _____ ST: _____ ZIP: _____ TELEPHONE: _____
INSURED'S NAME: _____ EMPLOYER: _____
SOCIAL SECURITY NO: _____ DATE OF BIRTH: _____ SEX: M / F
POLICY NUMBER: _____ GROUP NUMBER: _____

We will file your claim for you. We require that any co-payments be made at the time services are rendered. If you have met your deductible you will be required to pay 20% of your daily charges at the time of service. If you are not medically insured, we request that all charges be paid after each office visit. If this account is assigned to a collection agency, or an attorney for collection and/or suit, Cheyenne Orthopaedics, P.C., shall be entitled to reasonable costs of collection and attorney's fees.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans to: Cheyenne Orthopaedics, P.C. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

PATIENT'S SIGNATURE: _____ DATE: _____

RESPONSIBLE PARTY'S SIGNATURE: _____ DATE: _____

EMPLOYEE'S SIGNATURE: _____