INTAKE FORM

METROPOLITAN ORTHOPAEDIC ASSOCIATES

PATIENT INFORMATION

Name - First:	Last:
Date of Birth:	Soc. Sec. #:
Email:	
May we send appointment information by email or phone / text?	☐ Yes ☐ No
Phone #:	Alternate Phone #:
Address:	
City:	State: Zip Code:
Next of Kin:	Phone #:
Primary Physician:	

HIPAA (privacy regulations)

May we leave a message at your phone numbers?	☐ Yes ☐ No

Who can information be released to regarding your treatment and/or billing questions?

1. Name: Relationship:
2. Name: Relationship:

PAYMENT INFORMATION

Your insurance company will be billed for covered services. Any unpaid balance will be the responsibility of the patient or responsible party. The balance of the account will be due and payable if the insurance company has not paid within 60 days. Please make every effort to keep patient information and insurance information up to date to ensure accurate billing of services. Please talk to us about payment plans if you are unable to pay within 60 days.

AUTHORIZATION

I understand that I am financially responsible for all charges arising from treatment of the above named patient. I hereby authorize payment directly to: METROPOLITAN ORTHOPAEDIC ASSOCIATES, P.C. of the surgical and/or medical benefits payable to me for their services as described but not to exceed reasonable and customary charges for those services. I authorize any holder of medical or other information about me to release such information as necessary to process these claims or related medical claims. I permit a copy of this authorization to be used in place of the original.

SIGNATURE:	DATE: