

# LABOR ORTHOPEDICS, P.C. REGISTRATION FORM

**Please Complete All Blanks**

## PATIENT INFORMATION

Patient Name Last		First		Middle Initial		Social Security Number	
Patient Address				City	State	Zip Code	Patient Phone Number ( )
Sex	Marital Status	Date of Birth	Age	Patient Employer		Work Phone Number	Ext. ( )

## SPOUSE/GUARDIAN INFORMATION

Spouse or Guardian (Last, First, Middle Initial)		Date of Birth	Relationship to Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Guardian		Social Security Number	
Spouse or Guardian Address			City	State	Zip Code	Spouse/Guardian Phone Number ( )
Spouse or Guardian Employer					Work Phone Number	Ext. ( )

## INSURANCE INFORMATION

Primary Insurance Company Name				Phone ( )		Relationship to Insured <input type="checkbox"/> Self		
Primary Insurance Address			City	State	Zip Code	<input type="checkbox"/> Spouse		
Primary Insured Name		Group Number	Policy #, I.D. #, or Certificate #	Effective Date		<input type="checkbox"/> Child		
Secondary Insurance Company Name					Phone ( )		Relationship to Insured <input type="checkbox"/> Self	
Secondary Insurance Address			City	State	Zip Code	<input type="checkbox"/> Spouse		
Secondary Insured Name		Group Number	Policy #, I.D. #, or Certificate #	Effective Date		<input type="checkbox"/> Child		
						<input type="checkbox"/> Other		

Is this visit related to an accident? YES or NO      Date of injury  
 If "Yes",       Auto       Job Related

Referring Physician Name	Address	City	State	Zip Code	Phone Number
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## EMERGENCY CONTACT INFORMATION

Who may we notify in case of emergency?	Relationship	Phone Number	<input type="checkbox"/> Work	<input type="checkbox"/> Home
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**PLEASE PRESENT INSURANCE CARD(S) TO RECEPTIONIST FOR PHOTOCOPYING**

**WE APPRECIATE PAYMENT AT THE TIME OF SERVICE.**

**FINANCIAL AGREEMENT:** The undersigned severally agrees, whether signing as a patient or otherwise, that in consideration of the services rendered to the patient, payment of the account is guaranteed by the undersigned to the extent authorized by your health plan, if you have one. While any insurance or other protection related to the doctor's account may be hereby assigned to and payable directly to the doctor, the undersigned clearly understands that the obligation to pay copays and deductibles remains with the patient and the undersigned, and while insurance received by the doctor will be applied to the patient's account, any part of the account not so paid by insurance is nevertheless owing and payable.

In case of default of payment, and if this account should be placed in the hands of a Collector or an Attorney for collection, all collection fees, attorney fees, cost and other expenses will be paid by the undersigned. Notice of dishonor, demand and protest is waived. I accept personal responsibility for payment of charges for services rendered to me. I authorize payments of medical insurance benefits to Tabor Orthopedics, P.C. I authorize the release of any medical information necessary to process this claim.

\_\_\_\_\_  
Patient or Legal Guardian Signature

\_\_\_\_\_  
Date

DSI # 9000

Owen B. Tabor, Sr., M.D., F.A.C.S.  
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## Payment Policy

Most people participate in some type of insurance plan that pays a specified amount or percentage of medical services. These plans range from traditional insurance plans and managed care plans to Medicare. This coverage involves an agreement between the insured member and the plan. Most, if not all, plans require a payment by the member in the form of a co-payment, coinsurance, and/or deductible. It is the responsibility of the member to follow these guidelines.

Tabor Orthopedics, a division of MSK Group, is a participating provider in most of these plans. Our office would be pleased to answer any questions regarding plans in which we participate. The member should direct questions regarding coverage and benefits to the insurance company or agent. The insurance card is a source of valuable information. As a patient, you will be required to bring your insurance card(s) to your appointments.

Our office will file a claim with your plan to assist you in obtaining coverage for the medical services you receive. Your responsibility is clear. Once you receive medical treatment or services, you are responsible for all payment for those services. Insurance was designed to be used as a reimbursement for payment and not as a substitute. The patient is ultimately responsible for payment.

## Referral Authorization

Some managed care plans require the patient to obtain a referral authorization from their primary care provider prior to receiving services from a specialist. If your plan requires a referral authorization, services will be provided only if the referral authorization is at our office at the time of your visit. You will have the option to sign a waiver accepting financial responsibility for services not covered due to the lack of the referral authorization. Or, we would be pleased to reschedule the appointment if you prefer.

## Disability Forms

There will be a \$10.00 charge for each form completed. Payment must accompany the form. All forms must be received in our office at least 10 working days in advance of filing date so that they may be properly processed.

## Workers Compensation

Your Workers' Compensation carrier must grant authorization for you to be seen by our physicians. **This authorization must be in our office prior to your initial visit.** If we do not have the required authorization, your visit will be rescheduled until you are able to obtain it. **We can only bill Workers' Compensation if your claim is active and/or the condition our physician is treating has been allowed on your claim.**

## Summary

This document is merely information to the patient. First and foremost, it is the patient's acceptance of medical services that creates the obligation to Tabor Orthopedics, a division of MSK Group, PC

## Agreement

I understand the procedures and responsibility to ensure my claim is processed promptly and accurately for payment within sixty (60) days. I also understand that I am responsible for any denials, copayments and deductibles. Failure to pay within this time period could have negative implications for the patient including referral to a collection agency which would include additional fees charged to the patient and, if necessary, litigation. If such action is necessary, patient is responsible for all attorney's fees, collection fees and court costs where applicable by law.

Patient /Patient Representative Signature \_\_\_\_\_

Date \_\_\_\_\_



**NOTICE OF PRIVACY PRACTICES  
ACKNOWLEDGEMENT RECEIPT**

I, \_\_\_\_\_, do hereby acknowledge  
*Patient Name*

receipt of *Tabor Orthopedics* Notice of Privacy Practices on \_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Patient Signature*



**CONSENT FOR RELEASE OF INFORMATION  
TO CAREGIVER**

I, \_\_\_\_\_, consent for Tabor Orthopedics to disclose any of my protected health information (PHI) concerning my medical treatment or care including but not limited to laboratory and other test results, x-rays, appointments, medications, diagnoses and prognoses, post operative care to the following caregivers:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

I understand that it is my responsibility to notify Tabor Orthopedics of any changes in the above information. If changes do occur, I understand that I must file **in writing** another Consent for Release of Information to Caregiver.

I understand that I may revoke this consent at any time by submitting a written revocation except to the extent that action has been taken by Tabor Orthopedics in reliance on my consent.

**This consent for Release of Information to Caregiver will remain in full force and effect unless changed or revoked by me in writing.**

\_\_\_\_\_  
(Signature of Patient/Patient Representative) (Date)

**Only to be completed if signed by Patient Representative:**

Printed Name of Patient's Representative \_\_\_\_\_

Description of Representative's Authority to Act for Patient: \_\_\_\_\_

Relationship to the Patient: \_\_\_\_\_

**PLEASE ANSWER ALL QUESTIONS**

Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

SS#: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**WHAT IS YOUR CHIEF ORTHOPEDIC COMPLAINT FOR EVALUATION TODAY?**

(Example: wrist, foot, ankle, back, etc):  Right  Left  Both \_\_\_\_\_

\_\_\_\_\_

Have you been treated for "this same complaint" by another physician? Yes or No: \_\_\_\_\_

If "Yes", by whom? \_\_\_\_\_ For how long? \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_

Is there a lawyer involved? \_\_\_\_\_ If "Yes", please give his/her name: \_\_\_\_\_

Who is your regular doctor? \_\_\_\_\_

**IS THIS COMPLAINT THE RESULT OF ANY INJURY OR ACCIDENT?** Yes or No: \_\_\_\_\_

If "Yes", please give the date of the accident: \_\_\_\_\_

Where the accident happened: \_\_\_\_\_

How the accident happened: \_\_\_\_\_

\_\_\_\_\_

**WERE YOU INJURED AT WORK?** Yes or No: \_\_\_\_\_

If "Yes", have you reported this to your company? \_\_\_\_\_

**WERE YOU SEEN IN AN EMERGENCY ROOM FOR THIS COMPLAINT?** Yes or No: \_\_\_\_\_

If "Yes", what hospital? \_\_\_\_\_ What date were you seen? \_\_\_\_\_

Were you X-rayed? \_\_\_\_\_ Did you bring X-rays or doctor's report with you? Yes or No: \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

**PAST MEDICAL HISTORY**

Major Operations: \_\_\_\_\_

Medical Problems: \_\_\_\_\_

Are you taking any medications at this time?  No  Yes If "Yes", please list all: \_\_\_\_\_

Drug Allergies?  No  Yes If "Yes", please list all: \_\_\_\_\_

**SOCIAL HISTORY**

Work in the home      Employed (occupation \_\_\_\_\_ )  
 Single       Married       Divorced       Separated       Widowed  
 Children?       No       Yes # \_\_\_\_\_  
 Do you live alone?       No       Yes \_\_\_\_\_  
 Smoke currently?       No       Yes \_\_\_\_\_ packs per day for \_\_\_\_\_ years.  
 Quit smoking?       This year       >1 year       >5 years       >10years  
 Previously smoked \_\_\_\_\_ packs per day for \_\_\_\_\_ years.  
 Drink alcohol?       Daily       1-2 x/week       1-2 x/month       1-2 x/year

**FAMILY HISTORY**

Does anyone in your immediate family have a history of:

Diabetes  No  Yes      Heart Disease  No  Yes      Cancer  No  Yes

If "Yes", please explain briefly: \_\_\_\_\_

**SYSTEM REVIEW**

**HAVE YOU HAD...?**

**HEENT**

Nose Bleeds  No  Yes  
 Hearing Problems  No  Yes  
 Eye Problems  No  Yes  
 Difficulty Swallowing  No  Yes

**GI**

Ulcers  No  Yes  
 Liver or Bowel Disease  No  Yes  
 Bleeding  No  Yes

**GU**

Recurring Infections  No  Yes  
 Kidney Stones  No  Yes  
 Abnormal Menstrual Bleeding  No  Yes

**CV**

High Blood Pressure  No  Yes  
 Heart Attack  No  Yes  
 Stroke  No  Yes  
 Irregular Heart Beat  No  Yes  
 Chest Pain  No  Yes  
 Shortness of Breath  No  Yes

**MUSCULOSKELETAL**

Joint pain / Stiffness  No  Yes  
 Muscle Weakness  No  Yes

**SKIN PROBLEMS**

Rashes  No  Yes  
 Ulcers  No  Yes

**PSYCHIATRIC**

Depression  No  Yes  
 Anxiety  No  Yes

**NEUROLOGICAL**

Numbness  No  Yes  
 Tingling  No  Yes  
 Weakness  No  Yes  
 Stroke  No  Yes

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Reviewed By: \_\_\_\_\_ MD

Date: \_\_\_\_\_