

Patient#: _____

PHARMACY INFO

Pharmacy Name: _____	Pharmacy Phone#: _____
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REFERRAL SOURCE

Please check one:				
<input type="checkbox"/> Athletic Trainer	<input type="checkbox"/> Friend	<input type="checkbox"/> Family Member	<input type="checkbox"/> Internet	<input type="checkbox"/> Insurance
<input type="checkbox"/> Self	<input type="checkbox"/> MD Now	<input type="checkbox"/> Med Express	<input type="checkbox"/> Urgent Care	
<input type="checkbox"/> Physician's Name: _____				

Payment Guarantee: The undersigned patient and guarantor, if any, hereby agree to pay all WOI charges to the WOI in accordance with the regular rates and terms of the WOI and agree to pay for any charges not covered by any third party payer. The Medical Practice files insurance as a courtesy to the patient, but the patient is ultimately responsible for payment of the total incurred charges. The undersigned agree that if this account is turned over to a collection agency or attorney, that the undersigned patient and guarantor, if any, shall be obligated to pay the outstanding balance plus all costs of collection including reasonable attorney fees. The undersigned agree that any overpayments collected on this account may be applied directly to any delinquent account for which the undersigned patient is legally responsible. The undersigned patient and guarantor, if any, hereby agree that they are jointly and severally liable to pay the entire balance due and that the WOI is relying upon the undersigned(s) to pay in treating the patient.

Consent to Medical and Surgical Treatment: The undersigned hereby consents to all medical care and services, surgical treatment, examinations, tests and procedures, including but not limited to x-ray examination, laboratory and diagnostic procedures and tests, anesthesia, which a Physician, their employees, nurses, associates or designees may deem advisable to the undersigned patient during this treatment.

Assignment of Insurance Benefits: I hereby authorize payment directly to the Wellington Orthopedic Institute, (hereinafter referred to as "WOI") and assign to them any and all rights and benefits that I or the patient may have under any policy of insurance including medical, automobile, personal injury protection, workers compensation, or any other coverage and further direct any such insurance company to make payment of benefits directly to WOI. I understand that I am financially responsible to WOI for charges not covered by this assignment.

Lifetime Signature Authorization: I hereby authorize WOI to furnish to my insurance company or their representative, or Social Security Administration or the Center for Medicare and Medicaid, or Medigap or its intermediaries or to the billing agent of WOI any information needed for this claim or related claims. I permit a copy of this authorization to be used in place of the original.

Notice of Privacy Practice: I have been provided information by the WOI regarding their privacy practices.

Patient Name: _____

Patient Signature: _____ Date: _____

Responsible Party Signature: _____ Relationship to Patient: _____ Date: _____

If patient is under age 18, I hereby give my permission for _____ to be treated by WOI.