Mid-America Orthopedic & Spine Institute, LLC

PATIENT INFORMATION

First Name	Middle	Last	Date of Birth / /	Age	Sex
Street Address		City	State	Zip	
Home Phone	Cell Phone	Work Phone	Marital Status M S W D	Social Security #	
Employer			Date of Accident, Injury, or First Symptom and Where (If Applicable)		
Next of Kin/Emergency Contact Name			Relationship	Phone #	

INDIVIDUAL RESPONSIBLE FOR PAYMENT

First Name	Middle	Last	Social Security #
Street Address	City	State	Zip

Please furnish your cards for copying.

PRIMARY INSURANCE COMPANY

Name		Policy ID #	Group #
Street Address	City	State	Zip
Name of Policy Holder		Birth Date / /	Relationship to Insured

SECONDAY INSURANCE COMPANY

Name	Policy ID #	Group #

ASSIGNMENT OF BENEFITS

I understand that I am responsible for payment in full of all charges. I authorize payment of benefits from my Primary and Secondary insurance be paid directly to **Dr. John Bailey**. I also authorize **Dr. Bailey** to release to my insurance companies any and all medical information necessary for the processing of insurance claims.

I request that payment of authorized Medicare and insurance benefits be made on my behalf to **Dr. Bailey** for any services furnished me by the physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance coverage is indicated in Item 9 of the HCFA-1500 claim form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and deductible are based on the charge determination of the Medicare or insurance carrier.

Signature______________________________ Date______________________________

If you have a **Secondary** policy or MEDIGAP policy to which your Medicare carrier automatically "cross over", we are required to keep a separate signature on file.

I request and authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorized any holder of medical information to release to the above MEDIGAP carrier any information need to determine these benefits or the benefits payable for related services.

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Signature as it appears on Secondary/Medigap Card Date