INTAKE FORM
MOVEMENT ORTHOPEDICS, PLLC

PATIENT INFORMATION

Name: _____ Sex: M F DOB: _____

Soc. Sec. #: _____ - _____ - _____ Cell: _____ Home: _____

Email: _____

Preferred Method of Communication: CELL / HOME / EMAIL / MAIL

Street Address: _____ City: _____ State: _____ Zip: _____

Primary Care Physician: _____ Phone: _____

Next of Kin: _____ Relationship: _____ Phone: _____

PHARMACY INFORMATION

Pharmacy Name: _____ Phone: _____

Street Address: _____ City: _____ State: _____ Zip: _____

PRIMARY INSURANCE INFORMATION

Insurance Name: _____ ID / Claim #: _____

Insured OR Guarantor: _____ SELF / SPOUSE / PARENT / OTHER

Social Security #: _____ - _____ - _____ DOB: _____

SECONDARY INSURANCE INFORMATION

Insurance Name: _____ ID / Claim #: _____

Insured OR Guarantor: _____ SELF / SPOUSE / PARENT / OTHER

Social Security #: _____ - _____ - _____ DOB: _____

HIPAA (Privacy Regulations)

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

Name: _____ Relationship: _____

Name: _____ Relationship: _____

***I have received a copy and understand Movement Orthopedics Notice of Privacy Practices.

Signature _____ **Date:** _____

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 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: **MOVEMENT ORTHOPEDICS, PLLC** 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:** _____