NORTH COUNTY ORTHOPEDIC MEDICAL GROUP

SIDNEY H. LEVINE M.D.

CONFIDENTIAL INFORMATION

DATE_____

ACCT. _____

FINANCIAL CLASS_____

1. PATIENT INFORMATION

MS.
MRS.
MR.

_____ _____ _____ _____
LAST NAME FIRST NAME MIDDLE INITIAL PHONE NUMBER

_____
STREET ADDRESS APT # CITY STATE ZIP

2. BIRTH DATE _____/_____/_____ EMAIL _____
MO. DAY YEAR

3. SOCIAL SECURITY # _____ DRIVERS LICENSE # _____EXP. DATE _____

4. PERSON RESPONSIBLE FOR PAYMENT ACCOUNT

_____
LAST NAME FIRST NAME / INITIAL PHONE NO.

_____
STREET ADDRESS APT # CITY STATE ZIP

5. EMPLOYMENT INFORMATION AT TIME OF INJURY

Patient Employed by _____Phone _____

Business Address_____

6. ATTORNEY INFORMATION _____
NAME ADDRESS PHONE

7. INTERPRETER INFORMATION _____
NAME ADDRESS PHONE

8. INSURANCE INFORMATION

Patient/Ins. Co._____Group/Member # _____

WCAB# _____Claim # _____ DOI _____

9. GENERAL INFORMATION

Allergies: _____

Nearest Relative Not Living with You Name_____

Address _____Phone _____

Former Physician _____City _____ State _____

Referred by _____Phone _____

AGREEMENT

In order to prevent any misunderstanding about the payment of medical bills, we wish to point out that: **(1) All medical services furnished are charged directly to the patients. (2) Patients are personally responsible for payment of bills. (3) Patients are expected to keep their accounts current while waiting for their insurance company to make payment.** Your insurance coverage is a contract between you and your insurance company to help you meet medical expenses. It is not possible for us to provide service on the basis that the insurer will always pay all charges as coverage varies greatly. For the convenience of our patients who are unable to pay their full account at the time of service, we have arranged to carry their account balances for a monthly service charge of 1.5 percent per month on the unpaid balance (18 percent per year). This charge will be added to all balances over thirty days old. Should your insurer send us a check, we will credit the amount to your account or refund it to you if your bill is already paid. Please feel free to discuss charges at any time. Patient shall be liable for all costs and expenses, including reasonable attorney fees, as may be incurred by North County Orthopedic Medical Group, Inc. in collecting on any delinquent account.
The undersigned hereby consents to this agreement, acknowledging receipt of true copy thereof, employing North County Orthopedic Medical Group., engaged in the practice of medicine, for his/her medical care.

AUTHORIZATION

I HEREBY AUTHORIZE AND REQUEST THE _____INSURANCE TO PAY THE AMOUNT DUE ME IN MY PENDING CLAIM FOR MEDICAL EXPENSE BENEFITS DIRECTLY TO NORTH COUNTY ORTHOPEDIC MEDICAL GROUP. I AM AWARE THE NORTH COUNTY ORTHOPEDIC MEDICAL GROUP DOES NOT ACCEPT MEDI-CAL.

Dated_____ Signature _____