Norris, Blessinger & Woebkenberg
Orthopaedics & Spine
1900 Saint Charles Street • Jasper, IN 47546 • 812-634-1211

PATIENT REGISTRATION FORM
(Complete Front & Back)

PATIENT NAME ____
(Last) (First) (Middle Init.)

STREET OR BOX NO. ____

CITY ______________________STATE___________ZIP CODE________________

HOME PHONE_____________WORK #__________CELL #__________EMAIL________________

MARITAL STATUS (Circle one): Married Divorced Single Widowed RACE/ETHNICITY (circle one): Caucasian African American Latino

SOC. SEC. # _____________BIRTH DATE__________ AGE______ MALE / FEMALE (Circle one)

FAMILY PHYSICIAN AND ADDRESS ____

WERE YOU SEEN BY A PHYSICIAN FOR THIS PROBLEM AND REFERRED? ___YES ___NO BY WHOM: ______________

PATIENT EMPLOYER AND ADDRESS____

DATE OF INJURY__________DATE OF SYMPTOMS__________ AUTO ACCIDENT? YES______ NO______

APPROVED WORKMEN'S COMPENSATION INJURY? YES____ NO____ COVERED BY SCHOOL INSURANCE? YES______ NO______

SPOUSE OR PARENT INFORMATION (If parent information, fill both name sections completely.)

______________________________ (Last) First) (MI)	______________________________ (Last) (First) (MI)
STREET OR BOX NO.____________________	STREET OR BOX #:____________________
CITY______________STATE______ZIP__________	CITY______________STATE______ZIP__________
HOME PHONE__________BUS PHONE__________	HOME PHONE__________BUS PHONE:__________
SOC. SEC. #__________BIRTH DATE__________	SOC. SEC. #__________BIRTH DATE__________
EMPLOYER____________________	EMPLOYER____________________
ADDRESS:____________________	ADDRESS: ____________________
PRIMARY INSURANCE:	**SECONDARY INSURANCE**:
NAME OF INS.____________________	NAME OF INS.____________________

TREATMENT AND FINANCIAL AGREEMENT: I hereby consent to treatment by Dr. Norris, Dr. Blessinger, Dr. Woebkenberg, Will Walker, NP, Kelsey Vonderheide, PA-C, or Jarred Lampert, PA-C to include x-rays, injections, casts, and such other office procedures as they deem necessary. I accept full responsibility for any charges incurred for services rendered to me. I agree to make payment at the time of my service(s) and allow the insurance to reimburse me for that amount. The office staff will file my claim with my primary insurance carrier if all information is provided by me. HOWEVER, PAYMENT IS STILL DUE AT THE TIME OF SERVICE. Exceptions to this are: Blue Cross/Anthem, Encore, Sagamore, Patoka Valley, Medicare, and Worker's Compensation. I understand that Dr. Norris is not a Medicaid provider. I also understand our providers are not mediators between my insurance company(ies) and me and that it is my responsibility to contact the insurance company for payment on my account. I UNDERSTAND THE ABOVE AND CONSENT TO TREATMENT AT THIS TIME.

SIGNATURE ______________________________ DATE______________________
(Patient/Responsible Party)

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RELEASE OF INFORMATION

I AUTHORIZE any physician, medical practitioner, hospital, clinic, or other medically related facility, peer review organization, insurance or reinsuring company, the Healthcare Financing Administration, the Medical Information Bureau, Inc., consumer reporting agency, or third party administrator having information available as to diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment of me or my dependents to give to the group policyholder, my employer, third party administrator, my third party carrier, or its legal representative, any and all such information.

I UNDERSTAND the information obtained by this authorization will be used to determine eligibility for insurance and eligibility for benefits under my insurance coverage. Any information will not be released except to persons or organizations performing business or legal services in connection with the claim or claims submitted by Dr. Norris, Dr. Blessinger, Dr. Woebkenberg, Will Walker, NP, Kelsey Vonderheide, PA-C, or Jarred Lampert, PA-C, or as may be otherwise lawfully required, or as I may further authorize. I AGREE that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

I AUTHORIZE payment of medical benefits to be made to NORRIS, BLESSINGER & WOEBKENBERG ORTHOPAEDICS & SPINE on any claim submitted for any services furnished me by either Dr. Norris, Dr. Blessinger, Dr. Woebkenberg, Will Walker, NP, Kelsey Vonderheide, PA-C, or Jarred Lampert, PA-C.

I have received a copy of the Privacy Practices of Norris, Blessinger & Woebkenberg Orthopaedics & Spine.

SIGNED____________________________________ DATE ____________________________________

COST OF COLLECTIONS

In the event any unpaid balance is assigned for collections with any third party and/or an attorney to obtain judgment or otherwise satisfy payment of this account, I am obligated to pay the costs incurred directly or indirectly by Dr. Norris, Dr. Blessinger, Dr. Woebkenberg, Will Walker, NP, Kelsey Vonderheide, PA-C, or Jarred Lampert, PA-C to collect amounts owed such as 33 1/3% collection costs, court costs, attorney's fees, interest, late fees, sheriff's fees, and the like. In the event of a returned check, there will be a fee assessed of $22.

SIGNED ______________________________________ DATE ___________________________________