David K. Padgett, D.O.

Physical Medicine and Rehabilitation ~ Osteopathic Manipulation ~ Electrodiagnostics ~ Sports Medicine ~ Pain Management

PATIENT INFORMATION SHEET

Welcome to my office. I am committed to provide the best, most comprehensive care possible. Please assist us by providing the following information. **PLEASE PRINT**. *Form: PatInfoSheetPRIME dated 4/3/14*

Date: (circle) New Patient or Update [Office] **Account Number**:

PATIENT NAME: Last _____First_____ Middle Initial ___

Home Address

Street _____ City _____State _____ Zip _____

Home Phone: _____ CELL Phone: _____

If available, I would like to receive appointment reminders via text. [ ] Yes [ ] No

Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Separated [ ] Widowed [ ] Under 18 (minor)

Social Security # (SSN) _____ Date of birth _____ Gender: [ ]Male [ ]Female

Email address: _____

Employment: [ ] Retired [ ] Disabled [ ] Student [ ] Self Employed [ ] Employed by company

Employer Name: _____ Occupation _____

Phone with extension: _____

Address:

Street _____ City _____State _____ Zip _____

In case of emergency, please notify: Name and relationship _____ _____

Best contact number with extension (if any): _____ _____

Worker's Compensation (WC): If this a worker's compensation claim we need: Claim #: _____

Date of Injury _____ Employer at time of injury _____

Adjuster Name _____ Attorney Name (if any) _____

Adjuster Office Phone with extension: _____ **FAX** _____

Insurance Information: [ ] WC Carrier [ ] Commercial (ex. Blue Shield) [ ] NONE (Cash Pay)

Please show insurance card (s) to the front desk in order to insure insurance is accepted and to be photocopied.

PRIMARY INSURANCE	SECONDARY INSURANCE
Name of ins._____	Name:_____
Policy #_____	Policy:_____
Group#_____	Group:_____
St. Address_____	St Addr:_____
City/State/Zip: _____	City/State/Zip: _____
Ins. Phone # _____	Ins. Phone: _ _____
Name of Policy Holder: _____	Policy Holder: _____
Holder's relation to you: _____	Relation to you: _____
Policy Holder Date of Birth _____	Policy Holder Date of Birth _____
Policy Holder SSN:	Policy Holder SSN:

David K. Padgett, D.O.

PATIENT NAME: Last _____First_____

[Office] **Account Number**:

Pharmacy you prefer to use? Name: _____

Referral Information: Who may we thank for referring you? [ ] Doctor [ ] Case Mgr [ ] Adjuster [ ] Attorney [ ] A Patient of Dr. Padgett's [ ] Physical Therapist [ ] Friend [ ] Other _____

Name _____ City of Office Addr: _____

Who is your primary or family (treating) physician? Name: _____City _____

Insurance Authorization:

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above insurance company(s) and assign directly to David K. Padgett, D.O. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance. I understand that balances over 30 days are subject to late fees, plus monthly finance charges. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. **I also acknowledge that it is my responsibility to advise Dr. Padgett's Office of any change in insurance, mailing address, adjuster, etc.** If I do not, then I understand that I may be held fully responsible for any outstanding balances on my or my dependent's account. I acknowledge that non-payment for services rendered could result in my being discharged as a patient of Dr. Padgett.

Signed by responsible party _____ Date _____/_____/ _____

I authorize Dr. Padgett's billing office to leave detailed messages on my voice mail system should communications be necessary to obtain payment for services and I am not reachable in person. _____Date __/__/__

Confidentiality:

I understand that my records are confidential and will not be released without my written consent. However, certain information may be released without my authorization under the following circumstances:

1. In the event of a medical emergency
2. If there is evidence of child abuse, dependent or elder abuse
3. When a hazard to the public requires disclosure
4. When there is an indication that I will likely harm myself
5. When required by law, in particular for Workers Compensation Cases

Fees for Services

I understand that I am responsible at the time of service for co-payments (if I have one) or payment of services in full (if I am a cash pay patient). If I fail to pay for my co-pay or services at the time of service and must be billed, I acknowledge that I will be charged a late fee in addition to the charge for services rendered.

Fees for Uninsured Services

I understand that I will be charged a fee upon the time of service for any non-essential or uninsured supplementary services. These Supplementary Services include, but are not limited to: completion of form (**non-workers compensation disability** insurance), missed appointment or late cancellation (less than 48 hour notification for non-procedure appointments, less than 72 hours for procedures or special reports (i.e. EMGs, injections, medical evals), less than two weeks for depositions., court appearances, etc.) , telephone consultation (patient or third parties), processing returned checks or denied payments, copy of records (progress notes, labs, test results, medication orders, referral slips), as well as co-payment processing if the co-payment is not paid at the time of service. Fee Schedule available upon request.

Osteopathic Manipulation: Please also be advised that some insurance companies will not pay for osteopathic manipulation (OMT). If Dr. Padgett deems OMT an appropriate treatment for your condition and/or you request OMT, you may be financially responsible for that procedure.

Signed by responsible party _____ Date _____/_____/ ____