

**Patient Information**

**Patient #:** \_\_\_\_\_ **Account #:** \_\_\_\_\_

Last name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_/\_\_\_\_/\_\_\_\_

Home Phone #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Male \_\_\_\_\_ Female \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

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**Current Employer/School:** \_\_\_\_\_

Address: \_\_\_\_\_

Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer's/School Phone #: \_\_\_\_\_ Occupation: \_\_\_\_\_

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**Name of Parent/Guardian (if under 18):** \_\_\_\_\_

Work Phone: \_\_\_\_\_ Social Security #: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent/Guardian's Employer: \_\_\_\_\_

Address: \_\_\_\_\_

Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Nearest Relative/Friend Not Living With You: \_\_\_\_\_

Relative's/Friend's Phone #: \_\_\_\_\_

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**Referring Physician/Facility:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

Address: \_\_\_\_\_

Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

X \_\_\_\_\_

**Patient's/Parent's/Guardian's Signature**

**Date**

**I have reviewed the above information and the above information remains the same:**

Initial \_\_\_\_\_ Date \_\_\_\_\_ Initial \_\_\_\_\_ Date \_\_\_\_\_ Initial \_\_\_\_\_ Date \_\_\_\_\_

How did you hear about us? Magazine \_\_\_ Radio \_\_\_ Internet \_\_\_ Friend/Family \_\_\_ Other (list) \_\_\_\_\_

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**ATLANTA HAND SPECIALIST/ATLANTA HAND THERAPY**

(770) 333-7888 • (678) 214-6960

# Insurance Information (page 1 of 2)

Patient's Name: \_\_\_\_\_ Patient #: \_\_\_\_\_ Account #: \_\_\_\_\_

Address: \_\_\_\_\_

Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

WE WILL NEED YOUR CURRENT INSURANCE CARD AND YOUR DRIVER'S LICENSE.  
PLEASE GIVE THEM TO THE RECEPTIONIST TO MAKE COPIES.

Do you have Medicare? Yes: \_\_\_ No: \_\_\_ # \_\_\_\_\_ Medicaid? Yes: \_\_\_ No: \_\_\_ # \_\_\_\_\_

Health Insurance Company (1): \_\_\_\_\_ Co-pay Amount: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

I.D. Membership #: \_\_\_\_\_ Group #: \_\_\_\_\_

SUBSCRIBER - Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Authorization/Referral: \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_ Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Health Insurance Company (2): \_\_\_\_\_ Co-pay Amount: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

I.D. Membership #: \_\_\_\_\_ Group #: \_\_\_\_\_

SUBSCRIBER - Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Authorization/Referral: \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_ Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Health Insurance Company (3): \_\_\_\_\_ Co-pay Amount: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

I.D. Membership #: \_\_\_\_\_ Group #: \_\_\_\_\_

SUBSCRIBER - Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Authorization/Referral: \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_ Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Worker's Compensation/Liability Insurance Company: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Address: \_\_\_\_\_ Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Claims Adjuster's Name: \_\_\_\_\_ Claim/File #: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Employer at Time of Injury: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Supervisor's Name: \_\_\_\_\_ Years employed in this position: \_\_\_\_\_

In the event that the bills should be sent to an address other than the worker's compensation insurance company listed above, please complete the next page.

X \_\_\_\_\_  
Signature of patient/parent/guardian/responsible party \_\_\_\_\_ Date \_\_\_\_\_

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Patient Name \_\_\_\_\_ Patient #: \_\_\_\_\_ Account #: \_\_\_\_\_

**Insurance Information continued (pg 2 of 2):**

In the case that the bills should be sent to an address other than the worker's compensation insurance company listed on the previous page, please complete the following:

**Name of Company:** \_\_\_\_\_

**Attention:** \_\_\_\_\_

**Street:** \_\_\_\_\_

**Town:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Phone #:** \_\_\_\_\_ **Fax #:** \_\_\_\_\_

**Referrals (if applicable):** I understand my insurance company will not pay the physician/provider or reimburse for the cost of today's services without a referral and that I am responsible for payment of the office visit charge or any other charge I may incur.

**Co-pays (if applicable):** I understand that co-pay amounts are part of the agreement I have with the insurance company and are due at the time of the visit and that I am responsible for that payment.

**Authorization to pay benefits to the physician/provider:** I hereby authorize payment directly to the physician/provider for surgical and/or medical benefits, if any, otherwise payable to me for services as described, realizing I am responsible to pay non-covered services.

**Authorization to release information:** I hereby authorize the physician/provider to release any information acquired in the course of my treatment necessary to process insurance claims and/or for insurance audit purposes.

**Collection:** Within 90 days after being billed for services performed by the Atlanta Hand Specialist. I promise to pay in full the charges for those services personally, whether or not I have a claim against third parties for the cost of these services. I will also be responsible for any additional charges incurred in the collection of my account.

X \_\_\_\_\_  
Signature of patient/parent/guardian/responsible party Date

**Authorization to release information to your attorney:**

**Complete this section to allow release of information to your attorney if he is representing you for this problem.**

**Attorney's Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Town:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Phone #:** \_\_\_\_\_ **Fax #:** \_\_\_\_\_

**I hereby authorize release of information to the above named attorney:**

X \_\_\_\_\_  
Signature of patient/parent/guardian/responsible party Date

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