



NEW ENGLAND  
ORTHOPEDIC SURGEONS

300 Birnie Avenue • Springfield, MA 01107-1107  
(413) 785-4666 • www.neortho.com

PT NUMBER \_\_\_\_\_

DATE \_\_\_\_\_

**PATIENT REGISTRATION**

LAST NAME: \_\_\_\_\_ FIRST: \_\_\_\_\_ M.I. \_\_\_\_\_

\*\*IF PATIENT IS A MINOR, RESPONSIBLE PARTY IS: \_\_\_\_\_

D.O.B.: \_\_\_\_/\_\_\_\_/\_\_\_\_ SEX (M/F): \_\_\_\_ SSN: \_\_\_\_\_ \*RACE: \_\_\_\_\_ ETHNICITY: \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL: \_\_\_\_\_ WORK: \_\_\_\_\_ EMAIL: \_\_\_\_\_

NAME OF EMPLOYER/SCHOOL: \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

**INSURANCE INFORMATION**

**PRIMARY INSURANCE:** (NAME) \_\_\_\_\_ ID#: \_\_\_\_\_

\*\*SUBSCRIBER: Y  / N  **IF NO — PLEASE PROVIDE INFORMATION BELOW:**

NAME OF POLICY HOLDER: \_\_\_\_\_ D.O.B.: \_\_\_\_/\_\_\_\_/\_\_\_\_ SEX (M/F): \_\_\_\_\_

ADDRESS: \_\_\_\_\_

SSN: \_\_\_\_\_ RELATIONSHIP TO POLICY HOLDER: \_\_\_\_\_

**SECONDARY INSURANCE:** (NAME) \_\_\_\_\_ ID#: \_\_\_\_\_

\*\*SUBSCRIBER: Y  / N  **IF NO — PLEASE PROVIDE INFORMATION BELOW:**

NAME OF POLICY HOLDER: \_\_\_\_\_ D.O.B.: \_\_\_\_/\_\_\_\_/\_\_\_\_ SEX (M/F): \_\_\_\_\_

ADDRESS: \_\_\_\_\_

SSN: \_\_\_\_\_ RELATIONSHIP TO POLICY HOLDER: \_\_\_\_\_

**IS THIS RELATED TO:**    **WORKERS' COMP?** Y  / N     **AUTO?** Y  / N

**IF ACCIDENT RELATED – PLEASE PROVIDE INFORMATION BELOW**

WORKERS' COMP    AUTO   —   INJURY TO WHAT BODY PART? \_\_\_\_\_

DATE OF INJURY: \_\_\_\_/\_\_\_\_/\_\_\_\_    WORKERS' COMP/AUTO CLAIM NUMBER: \_\_\_\_\_

ADJUSTER: \_\_\_\_\_ PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

WORKERS COMP /AUTO/OTHER INSURANCE CARRIER: \_\_\_\_\_

BILLING ADDRESS: \_\_\_\_\_ CITY, STATE, ZIP \_\_\_\_\_

**ATTORNEY INFORMATION**

NAME OF ATTORNEY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE #: \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

## AUTHORIZATIONS

I give permission to NEOS to disclose my Protected Health Information to the following individual(s).  
I hereby understand this listing remains in effect unless revoked by me in writing.

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_  
(other than patient)

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_  
(other than patient)

I give permission to New England Orthopedic Surgeons to leave information and instructions on my answering machine and cell phone voicemail. I hereby give permission for disclosure, during my examination only, of my Protected Health Information to any individual I allow to accompany me into the examination room. I also understand by providing my email I am allowing transmittal of my Protected Health Information.

I acknowledge that I have received a copy of New England Orthopedic Surgeons Notice of Privacy Practices. I hereby authorize New England Orthopedic Surgeons to release information acquired in the course of my examination and/or treatment to my primary care physician, a consulting physician, and my health insurance carrier as part of the normal process in the delivery of healthcare.

### AUTHORIZATION TO PAY BENEFITS DIRECTLY TO PHYSICIAN

I hereby authorize payment directly to New England Orthopedic Surgeons for all medical/surgical benefits, otherwise payable under the terms of my insurance policy. I agree to allow New England Orthopedic Surgeons submit claim and required treatment information to my insurance company or other third party payment program for my care.

### STATEMENT OF FINANCIAL RESPONSIBILITY

I am responsible for any deductibles or co-payments designated by my insurance. I am responsible for any non-covered services, including durable medical equipment, as well as obtaining and maintaining a current referral and/or prior authorization. I fully understand that I am responsible to pay for services rendered, including reasonable attorney's fees and cost of collection in the event of default. Failure to meet your financial obligations can result in further collection actions.

**I HAVE VERIFIED THE ACCURACY OF ALL INSURANCE AND DEMOGRAPHIC INFORMATION WHICH I PROVIDED AT REGISTRATION. I AGREE THAT ALL OF THE ABOVE AUTHORIZATIONS ARE VALID INDEFINITELY UNLESS OTHERWISE STATED.**

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**If the signature above is not the patient's, please state your relationship to the patient:**

RELATIONSHIP: \_\_\_\_\_ DATE: \_\_\_\_\_