Samotin Orthopaedics

Patient Name-First, Last, Middle Initial					
Address		Apt#	City	State	Zip Code
Home Phone ( )	Cell Phone ( )	Social Security Number	Date of Birth	Age	Sex M / F
NORTHERN ADDRESS		**Apt#**	**City**	**State**	**Zip Code**

In Case of Emergency, Whom May We Contact?	Phone Number ( )	Relationship
Name of Family Physician/Primary Care Doctor		Phone Number ( )
Is this an accident or injury? N Y		

Whom May We Thank For Referring You? (Circle all that apply)

Internet — Health and Wellness Magazine — Attorney:_____

Physicians Medical Guide — Friend:_____ — Other:_____

Yellow Pages — Dr. _____ _____

IF PATIENT IS A MINOR, PLEASE FILL OUT THE INFORMATION BELOW

Mother		Date of Birth		Social Security Number	
Address	(if different from patient's address)	Apt#	City	State	Zip Code
Father		Date of Birth		Social Security Number	
Address	(if different from patient's address)	Apt#	City	State	Zip Code

PLEASE	CIRCLE	AUTHORIZATIONS
YES	NO	**LIFETIME INSURANCE AUTHORIZATION** - I hereby authorize Myles Rubin Samotin to release to my insurance co., no fault carrier, and/or workman's compensation carrier, any information including my complete health record needed to determine benefits for services provided by Myles Rubin Samotin or their designee(s).
YES	NO	**ASSIGNMENT OF BENEFITS**- I hereby assign the authorized benefits and direct that payment under any policy or health benefits plan to be made directly to Myles Rubin Samotin for any services rendered to me by Myles Rubin Samotin or their designee(s).
YES	NO	**MEDICARE PATIENTS**- I request that payment of authorized Medicare benefits be made on my behalf to Myles Rubin Samotin for any services furnished to me by Myles Rubin Samotin or their designee(s). I authorize any holder of of medical information about me to release to the Centers for Medicare information needed to determine these benefits.
YES	NO	**NOTICE OF PRIVACY PRACTICES**-I acknowledge that I have read and understood the Notice of Privacy Practices. I understand that copy of the notice will be provided to me upon my request.

PATIENT FINANCIAL POLICY

*Payment for the office services are due at the time of service, unless we participate with your health insurance plan, then we will only require you to pay the co-pay/co-insurance at the time of service. We will accept Visa, MC, Discover, cash, or check.

*All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered" or you do not have authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services, however, you remain responsible for charges for any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

*Past due accounts are subject to collection proceedings. All fees including, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due this office. This contract is entered into the and governed by the State of Florida, County of Collier, Lee, and Charlotte. There is a service fee of $30.00 for all returned checks.

CANCELLATION POLICY-THERE IS A $75.00 FEE FOR ANY CANCELLED OR MISSED APPOINTMENTS WITHIN 24 HOURS OF THE SCHEDULED APPOINTMENT TIME.

Signature of Patient/or Parent/Guardian:_____Date:_____