**Catonsville Orthopaedic Surgery**
**410.788.4250**

**Please Print**

PATIENT (This section refers to the patient only)

Name: _____ Birthday: ____-____-____ Age: _____ Sex: ☐ Male ☐ Female

Address: _____ City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

SS Number: _____ Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Employer Name and Address: _____

Your Email address: (PRINT IN UPPER CASE LETTERS)_____

Emergency Contact Name and Phone Number: _____

BILLING (Please complete if person responsible for bill is other than patient above)

Name of Policy Holder: _____ Birthday of Policy Holder: ____- ____- ____

Address, City, State, Zip (If different than patient address):

_____

Relationship to Patient: ☐Spouse ☐Mother ☐Father ☐Other:_____

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*In order to submit a claim for payment to us for services covered under your policy, we must have your authorization to release medical information to your insurance carrier.*

**POLICY CONCERNING PAYMENT OF MEDICAL BILLS**

Our policy is that payment is to be made at the time services rendered. Whether or not your insurance company pays in full, a portion, or no portion of your medical bills is a matter between you and your insurance carrier. Unless other arrangements have been made, any unpaid balances are due within 30 days of treatment. Payment is accepted in the form of cash, credit card, check or money order. Failure to pay in full will result in collection proceeding.

INSURANCE AUTHORIZATION I request that payment of authorization benefits be made to the above named doctor(s) on my behalf, for services provided to me. I authorize any holder of medical and other information about me to release to Medicare and its agents, any insurance company, and other third party payer, state medical assistance agency, or any other governmental or private payer responsible for paying such benefits, any information needed to determine these benefits or benefits for related services. I agree to pay for all charges not covered by a third party payer. I authorize a copy of this authorization to be used in place of the original. I agree to promptly pay all charges when billed for medical services rendered and I accept legal responsibility for any and all charges for the patient named above. I will be responsible for all costs incurred, legal and otherwise, including reasonable attorney's fees, in collection of this account, including monthly late fees on any overdue balance.

**Signed**_____ **Date**_____

**Patient or person authorized to consent for patient**