John Vitolo, M.D., F.A.A.O.S.
Board Certified Orthopedic Surgeon

Today's date:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Home phone no.: ( )	Work phone no.: ( )	Cell phone no.: ( )	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Drivers License:

City:	State:	ZIP Code:

❑ Employed ❑ Part Time Student ❑ Full Time Student	Employer/School:	Responsible Party's name:

Primary Care Doctor's name:	Primary Care Doctor's address:	Primary Care Doctor's phone no.: ( )

Referred to by (please check one box): ❑ Doctor ❑ Insurance Plan ❑ Hospital ❑ Close to home/work
❑ Family ❑ Friend ❑ Website ❑ Yellow Pages ❑ Other: ____________________

Who may we thank for referring you (name, address, phone no.)?

INSURANCE INFORMATION

(You must have your insurance card.)

PRIMARY Insurance Company's Name:	Street address:

City:	State:	ZIP Code:

I.D. no.:	Group no.:	Co-payment: $

Insured name (name of the person holding the insurance):	Birth date: / /	Social Security no.:

Relationship to patient:	Insured's Employer's name (place of work for insured party):

SECONDARY Insurance Company's Name:	Street address:

City:	State:	ZIP Code:

I.D. no.:	Group no.:

Insured name (name of the person holding the insurance):	Birth date: / /	Social Security no.:

Relationship to patient:	Insured's Employer's name (place of work for insured party):

PAYMENT POLICY, FINANCIAL AGREEMENT AND PRE-AUTHORIZATION POLICY

- Payment for services and supplies are due at the time services are rendered. (Unless prior payment arrangements have been approved in advance)
- We accept cash, checks, MasterCard, Visa, and American Express. (Returned checks are subject to additional service charges)
- When we are a participating provider with your insurance company, your referral form, co-pay, coinsurance or deductible is due at the time of service.
- Any unpaid balance on your account will incur a 7% finance charge after 60 days.
- Should the patient fail to make payment or the account is placed for collection, the patient will be responsible for collection costs, attorney fees, and a monthly interest charge of 7%.
- The patient will be responsible for any denied services or services not covered by insurance.
- In the case of a motor vehicle accident, a claim may be filed with the motor vehicle carrier. If the account is not paid within 60 days, it will be the patient's responsibility to settle the account with Skyview Orthopedic Associates.
- Surgical procedures may require a deposit, including deductible and or co-pay. Remaining balances are to be paid within one month of settlement with your insurance company. We will pre-approve the surgical procedure with individual insurance carriers to determine benefits. However, it is ultimately the patient's responsibility to pre approve all procedures, and to be aware of your insurance guidelines.
- Pre-certification is not a guarantee of eligibility or benefits. Your claim will be considered for payment after it has been received and reviewed by your insurance company.
- Most insurance plans require pre-authorization for diagnostic services such as MRI's and CAT scans etc. The office requires 48-72 hours to initiate such services. Please do not obtain such tests without proper authorization or you will be responsible for the charges incurred.
- I understand that there are fees associated with the release of my medical records and filling out forms associated with disability, workman's comp, MVA, and or school.

I am in agreement with the Payment Policy, Financial Agreement and Pre-Authorization policy stated above.
I agree and certify that a photocopy of this document will be accepted as the original.

I hereby authorize the release of any medical information necessary to process the direct payment of medical benefits to the named provider.

My medical records are the property of Skyview Orthopedic Associates and requires signed permission from me (18 yrs and older) prior to its release to anyone other than Skyview Orthopedic Associates or to another treating physician or specialist.

My signature indicates that I have read, understand and agree with the above statements.

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Patient's name

_______________________________ _______________________________ _______________

Patient/Guardian signature *Relationship* *Date*