American Orthopaedics and Sports Medicine

William C. Holland, M.D.

Adult and Children's General Orthopaedics • Surgery of the Knee and Shoulder • Surgery of the Hand • Joint Replacement and Reconstruction
Sports Medicine • Arthroscopic Surgery • Surgery of the Foot and Ankle • Spinal Disorders • Surgery of the Spine • Trauma

American Board of Orthopaedic Surgery • American Academy of Orthopaedic Surgeons • Qualified Medical Examiners

Name: _____ today's Date: _____

Sex ☐M ☐F **Birth Date:** _____ Age: _____ SS# _____-_____-_____

Address: _____ City/State _____ Zip_____

Home# _____ Cell# _____ Work#_____

Email: _____ Occupation_____

Ethnicity: _____ Race: _____ Preferred Language: _____

Primary Care Doctor: _____ Address: _____ Phone: _____

Name of your insurance plan: _____

Responsible Party information: (Please fill out the information completely)

Name: _____ **Date of Birth:** _____

Address: _____ City/State _____ Zip_____

Home# _____ Cell:_____ Work #_____ Email: _____

Relationship to patient: ☐ Spouse ☐ Parent ☐ Self SS#_____-_____-_____

Primary Insured: (Please fill out the information completely)

Name: _____ **Date of Birth:** _____

Address: _____ City/State _____ Zip_____

Home# _____ Cell#_____ Work #_____ Email: _____

Relationship to patient: ☐ Spouse ☐ Parent ☐ Self SS#_____-_____-_____

Insured patients: POS: For POS (Point of Service) plans we are not contracted with the HMO benefit level of your POS plan. We will bill your insurance company under the POS benefit. This may result in a deductible and/or higher cost share being applied. Should your insurance company deny payment, you will be financially responsible. For, and in consideration of the care and treatment provided to the patient, I promise to pay at time of treatment, American Orthopaedics & Sports Medicine, or agents, all charges for services rendered to or on behalf of the patient, I further assign my benefits to America Orthopaedics & Sports Medicine under my medical insurance plan. I understand that American Orthopaedics & Sports Medicine does not bill third parties in the case of auto accidents or personal injuries and does not accept liens. I understand that I am financially responsible for any outstanding balance not paid by my insurance company or for any benefits paid directly to me. HIPAA: I have read and understand the HIPAA Protected Health Information Privacy Notice 3.S.1A. I understand that upon request a copy of the complete notice will be provided to me.

I hereby consent to and authorize the administration of all treatment that may be considered advisable or necessary in the judgment of the physician, and I hereby authorize American Orthopaedics & Sports Medicine or contracted agents to release as determined appropriate for any lawful use without limitation, any medical information regarding the patient's history, condition, or treatment. I understand that I am entitled upon demand to a copy of this authorization. I agree to pay the doctor's usual fees for any legal testimony or work requested by myself, my attorney or agent, or any other entity which arises from any legal action to which I am a party.

Signature: _____ Date: _____ Relationship to patient_____

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