Referral Required ❐
Co-Pay ________

# GREGORY L. HUMMEL, M.D., P.C.
## Orthopaedic Surgery

DATE ____________
ACCT # ____________

(PLEASE PRINT)

## PATIENT INFORMATION

Name ______________________________
Last First Middle

Address ______________________________
Street

______________________________
City State Zip Code

Driver's License # ______________ State ______

Home Phone ( ) ______________

Woek Phone ( ) ______________

Cell Phone ( ) ______________

Birth Date ________ Age ______ Sex______

Marital Status: ❐ Single ❐ Married

Spouse's Name ______________________________

Primary Care Physician ______________________
Name

Physician's Address ______________________
Street

______________________________
City State Zip Code

In case of emergency, notify ______________________

Relationship ______________________________
Phone #

Contact's Address ______________________
Street

______________________________
City State Zip Code

Additional Contact:

Friend ______________________________
Name Phone #

Relative______________________________
Name Phone #

Allergies ______________________________

Advserse Reactions ______________________

Present Complaint ______________________

Date Symptoms Started ______________________

Is this due to an accident? ❐ Yes ❐ No

Date of Accident ______________________

Nature of Accident ______________________

## PATIENT INFORMATION (CON'T)

On the job injury? ❐ Yes ❐ No

Date of Inquiry ________Employer Name ____________

Work Comp Carrier ______________________
Name

______________________________
Address Phone #

## EMPLOYMENT INFORMATION

Self ____________ SSN ____________

Employer Name ______________________
Phone #

Spouse ____________SSN ____________

Employer Name ______________________
Phone #

## INSURANCE INFORMATION

**PRIMARY INSURANCE** ______________________

Name of Policy Holder ______________________

Mailing address ______________________

______________________________

Effective date ______________________

Policy/Certificate # __________Group # ________

Policy Holder's employer ______________________

Holder's SSN ________ Holder's birthdate________

Are you covered by Medicare? ❐ Yes ❐ No

If yes, Medicare # ______________________

SECONDARY INSURANCE______________________

Name of Policy Holder ______________________

Address of insurance company ______________

______________________________

Effective date ______________________

Policy/Certificate # __________Group # ________

Policy Holder's employer ______________________

Holder's SSN ________ Holder's birthdate________

**GREGORY L. HUMMEL, M.D., P.C.**
Orthopaedic Surgery

AUTHORIZATION FOR RELEASE OF INFORMATION, ASSIGNMENT OF BENEFITS
AND AGREEMENT OF FINANCIAL RESPONSIBILITY

**Release of Information:** I authorize the release of all medical information, including records which may contain information regarding diagnosis and/or treatment of HIV or AIDS, mental illness or psychiatric treatment, and/or drug and/or alcohol addiction to Gregory L. Hummel, M.D., P.C. which is or may be liable under a contract for all or part of the medical charges, including but not limited to, Medicare, Medicaid or other private or public health or hospital care insurance programs, reviewing agencies, worker's compensation carriers, welfare agencies of patient's employer, which may be needed in order to process any treatment physician claim relating to this treatment.

**Assignment of Benefits:** I hereby assign to Gregory L. Hummel, M.D., P.C., all of my interest and rights to the insurance benefits otherwise payable to me for this treatment arising out of any policy of insurance or self-insured programs covering said treatment and issued by any insurance company or self-insured health plan in my name or in my behalf. I assign payment of physician benefits (including major medical) to the physician or organization furnishing the services, or authorize such physician or organization to submit claim for payment. I understand that I am responsible for satisfying the pre-certification requirements of any policy of insurance or self-insured health plan covering said treatment and that the physician is not responsible for pre-certification. I further understand that I am financially responsible for any penalties imposed by the insurance company or self-insured health plan for lack of pre-certification and/or any charges not covered by this assignment of benefits.

I further request that payment of authorized Medicare and Medigap benefits be made either to me or on my behalf to Gregory L. Hummel, M.D., P.C. for any services furnished me by that physician. I authorize the holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits payable for related services.

______________________________
SIGNATURE OF PATIENT DATE
(Parent, if Minor Patient)

______________________________
SIGNATURE OF INSURED DATE

______________________________
SIGNATURE OF 2ND INSURED DATE

**Financial Responsibility:** In consideration of the physicians supplying or furnishing treatment, I promise to pay the physicians for such treatment supplied and furnished heretofore or to be supplied and furnished said patient. I understand that the acceptance of insurance assignments does not relieve me from any responsibility concerning payment for said services and that I am financially responsible to the physicians for the charges not covered by the policy of the insurance or self-insured health plan. In the event of collection, the cost of collection, including reasonable attorney fees and court costs, shall be included as part of the obligation due Gregory L. Hummel, M.D., P.C.

______________________________
SIGNATURE OF PATIENT DATE
(Parent, if Minor Patient)

______________________________
SIGNATURE OF SPOUSE/ DATE
RESPONSIBLE PARTY

O ce Policy Received: ______________________________
SIGNATURE DATE