BRISTOL ORTHOPAEDICS
SPORTS MEDICINE & ARTHRITIS CENTER

641 Clark Avenue
Bristol, CT 06010
Tel 860-582-6603
Fax 860-585-9245

MICHAEL E. CUCKA M.D.
SCOTT W. ORGAN M.D.

Last Name: _____ First Name: _____ Date: _____

Home Address: _____ City _____ State _____ Zip _____

Date of Birth: _____ Age: _____ ☐ Male ☐ Female

Social Security #: _____ Home Phone #: _____

Patient Work Phone #: _____ Patient Cell Phone #: _____

Employer: _____ Occupation: _____

Responsible Party Name: _____ Relation to patient: _____

Address: _____ Phone #: _____

Mother Name _____ Father Name _____

Mom Work #: _____ / Cell: _____ Dad Work #: _____ / Cell: _____

Primary Care Physician: _____ City/Phone: _____

Emergency Contact Person: _____ Relation: _____

Phone #: _____ Work Phone #: _____ Cell Phone #: _____

PRIMARY INSURANCE _____ ID# _____

Policy Holder Name: _____ D.O.B.: _____

Employer: _____

Relationship to Patient: _____

SECONDARY INSURANCE _____ ID# _____

Policy Holder Name: _____ D.O.B.: _____

Employer: _____

Relationship to Patient: _____

MOTOR VEHICLE INSURANCE *(if applicable)* _____

WORKMAN'S INSURANCE _____

Employer: _____

Claim #: _____ Contact Person: _____

Do you have a living will/advanced directive, a conservator or attorney in fact or are you making an anatomical gift? _____

REVIEW AND SIGN REVERSE SIDE ➠

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS/PERMISSION TO TREAT

Patient Name: _____
(please print)

Dear Patient/Guarantor:

Bristol Orthopaedics would like to be of service to you in billing your health plan. We will make every effort to communicate with your health plan so as to maximize services and benefits for you. Your signature below will authorize us to communicate effectively with your health plan and verify coverage.

ASSIGNMENT OF BENEFITS: "I authorize Bristol Orthopaedics to release to my health plan and/or its agents information necessary to verify benefits, authorize services and process medical claims. Such information may include, but is not limited to, identification information, necessary medical information, services and charges. I authorize my health plan to pay benefits directly to Bristol Orthopaedics. I understand that I am responsible for payments of charges for services not covered by my health plan, or not covered under the terms of any agreement between my health plan and Bristol Orthopaedics, including by not limited to co-payments and deductibles, as well as charges which are considered by my health plan to be beyond usual, customary and reasonable."

NON ASSIGNMENT OF BENEFITS OR SELF PAY: "I understand that if my health plan does not consider Bristol Orthopaedics a participating provider, charges incurred will be paid by me. I further agree to accept full financial responsibility for payments of charges rendered to the above named patient.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION: "I authorize Bristol Orthopaedics to release medical information or any information pertaining to the examination, treatment, history and medical charges to my health plan and/or their acting intermediaries and/or agents for the purpose of processing insurance claims. This release may include electronic release, reviewing and/or photocopying pertinent documents for the purpose of payment by my health plan. I further authorize Bristol Orthopaedics to release pertinent medical information to other health agencies and institutions involved in my continuing care." This consent is subject to revocation at anytime except to the extent that action has been taken in reliance on it, withdrawal of consent shall be addressed in writing to the Office Manager.

CONSENT TO BASIC TREATMENT AND DIAGNOSTIC PROCEDURES: "This is to certify that I, the undersigned, consent to the administration of treatment to the above named patient at the office of Bristol Orthopaedics. I consent to any x-ray, laboratory or other medical procedures or examinations and any other services rendered to me under the general and specific instruction of my physician. I understand that, except in emergency, all special procedures, blood or bleed plasma transfusions, use of anesthetics or conscious sedation will be discussed with me by my physician and that an additional specific consent form may be required."

_____
SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE

_____ _____
IF GUARANTOR, RELATIONSHIP TO PATIENT DATE