NEXT STEP ORTHOPAEDICS, INC.

LIFETIME
PATIENT INFORMATION SHEET & ASSIGNMENT OF BENEFITS
AUTHORITY FOR RELEASE OF INFORMATION

PATIENT ____ *SEX: M – F D.O.B.* _____/_____/_____
. *LAST NAME* *FIRST NAME*

SS# ______________________________ *DRIVERS LICENSE#* ___________________________ *MARITAL STATUS* ____________

HOME STREET ADDRESS ____ *APT#* ___________ *COUNTY* ________________

CITY __________________________________ *STATE* __________________________ *ZIP CODE* _____________________

HOME PHONE _______________________ *WORK PHONE* _________________________ *CELL PHONE* _________________

GUARANTOR ____ *D.O.B* ____/_____/_____ *SS#* ___________________
LAST NAME *FIRST NAME*

EMAIL ADDRESS ____

EMPLOYER NAME & ADDRESS (IF APPLICABLE) ____

EMERGENCY CONTACT ____ *RELATION* _________________________
NAME & PHONE NUMBER

*REFERRING DOCTOR*_____________________________ *HOW DID YOU HEAR ABOUT US?* __________________________

INSURANCE INFORMATION

PRIMARY INS _______________________________ *ID#* _________________________ *PHONE#* ______________________

SUBSCRIBER _______________________________ *DOB* _______________________ *RELATION*______________________

SECOND INS _______________________________ *ID#* ________________________ *PHONE#* _______________________

SUBSCRIBER _______________________________ *DOB* _______________________ *RELATION* ______________________

THIRD INS ________________________________ *ID#* _________________________ *PHONE#* _______________________

SUBSCRIBER ______________________________ *DOB* ________________________ *RELATION* ______________________

HOW DO YOU INTEND TO PAY YOUR PORTION? CASH _____ CHECK _____ CREDIT _______

MEDICAL HISTORY

(PLEASE CIRCLE ALL THAT APPLY)

I HAVE BEEN OR AM CURRENTLY BEING TREATED FOR ONE OR MORE OF THE FOLLOWING:

ANEMIA ARTHRITIS ASTHMA BRONCHITIS BLADDER PROBLEMS BLEEDING/CLOTTING PROBLEMS CONGESTIVE HEART FAILURE STROKE

CHRONIC OBSTRUCTIVE PULMONARY DISEASE DIABETES DVT EMPHYSEMIA GLAUCOMA GOUT HEART ATTACK

HEART DISEASE HIGH BLOOD PRESSURE IRREGULAR HEARTBEAT JAUNDICE KIDNEY DISEASE KIDNEY FAILURE LIVER DISEASE PHLEBITIS

LIME/TICK BITE MITRAL VALVE PROLAPSE OSTEOARTHRITIS OSTEOPOROSIS SEIZURES THYROID DISORDER

CURRENT MEDICATIONS ____

SURGERIES ____

ALLERGIES ____

ARE THERE ANY OTHER MEDICAL PROBLEMS THAT YOU MAY FEEL WOULD INTERFERE WITH SERVICES FROM NEXT STEP ORTHOPAEDICS, INC.? _____ *YES* _____ *NO*

IF YES, PLEASE EXPLAIN: ____

IS YOUR VISIT TODAY RELATED TO A WORKMAN'S COMPENSATION CLAIM? _____ *YES* _____ *NO*

IS YOUR VISIT TODAY RELATED TO A MOTOR VEHICLE ACCIDENT? _____ *YES* _____ *NO*

IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE PROVIDE DATE OF INJURY ______________________

IMPORTANT NOTICE

I HAVE AUTHORIZED TREATMENT FROM NEXT STEP ORTHOPAEDICS, INC. AND I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE, MEDICAID, OR PRIVATE INSURANCE BENEFITS BE MADE TO NEXT STEP ORTHOPAEDICS, INC. FOR ANY COVERED SERVICES FURNISHED BY NEXT STEP ORTHOPAEDICS, INC. I AGREE TO PAY TO NEXT STEP ORTHOAPEDICS, INC ANY COPAY, DEDUCTIBLE OR COINSURANCE ON MY CLAIM. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO BE RELEASED TO THE CENTERS OF MEDICARE & MEDICAID SERVICES (CMS) AND ITS. AGENTS. CHAMPUS / TRICARE, OR TO ANY PRIVATE INSURANCE COMPANY ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. I FURTHER UNDERSTAND THAT AFTER ALL EFFORTS ARE MADE TO RECOVER PAYMENT, FURTHER LEGAL ACTION MAY BE TAKEN AGAINST ME. I FURTHER CERTIFY THAT ALL INFORMATION PROVIDED IS TRUE AND FACT TO THE BEST OF MY KNOWLEDGE AND I AM RESPONSIBLE FOR NOTIFYING NEXT STEP ORTHOPAEDICS, INC OF ANY CHANGES IN MY RESIDENCE, INSURANCE OR HEALTH INFORMATION. I HAVE AUTHORIZED NEXT STEP ORTHOPAEDICS, INC. TO BILL ANY INSURANCE INFO PROVIDED AS I MAY OR MAY NOT BE ABLE TO PROVIDE COPIES OF INSURANCE CARDS AT THE TIME.

I HAVE RECEIVED A COPY OF THE FINANCIAL POLICY, THE NOTICE OF PRIVACY PRACTICES AND MEDICARE SUPPLIER STANDARDS (FOR MEDICARE PATIENTS ONLY).

PATIENT'S SIGNATURE ______________________________________DATE ______________________

GUARDIAN'S SIGNATURE ______________________________________DATE ______________________
PATIENT IS UNDER THE LEGAL AGE OF 18 OR UNABLE TO SIGN

REP. SIGNATURE ___________________________________ TITLE ______________ DATE ____________
REPRESENTATIVE NAME