Southern California
Bone & Joint Clinic

12021 Jacaranda Ave, Suite 202, Hesperia, CA 92345
Tel: (760) 956-5200 Fax: (760) 669-0793

How did you hear about us?
- ☐ Doctor
- ☐ Friend _______________
- ☐ School/Athletic Trainer
- ☐ Advertisement (pls circle)
  - Billboard
  - Newspaper Ad
  - Radio
- ☐ Other:_______________

PATIENT INFORMATION:

Patient Name: ____Age: ________________ Sex: ___________________

Date of Birth: ___________________________ Place of Birth: __________________________ Ethnicity: ________________________

Maiden Name: __________________________ Marital Status: _______ Name of Spouse: ___________________________________

Street Address: ____City: _____________________State: _______Zip:________

Phone: (Home)_________________________ (Cell)_____________________ Email:____
Preferred phone no. to use: ☐ home ☐ Cell ☐ Text Message Preferred language: ☐ English ☐ Spanish

Previous Patient: Yes: ___No: ___SS#: __________________________ Drivers License#/State: _______________________________

Employer: ____Employer Phone Number: ____________________________

Employer Address: ____ City __________________ State ________Zip Code: __________

Occupation: ____ Length of employment: ________________________

Is patient a student? Yes____No____ Full Time____Part Time____School Name: ____

Nearest Relative or Friend (Not residing with you):______________________________Relationship:___________________________

Address: ____ Phone #: ___________________________________

Emergency contact: Name: ____Relationship:__________________________________

Address:____

Day Phone Number:_______________________________Night Phone Number:(or cell #)____________________________________

RESPONSIBLE PARTY:

Name of Responsible Party: ________________________________Relationship:_______________ Birth date: _________________

Phone:________________________________ Address:____

SS#:____ Drivers License#:____

Employer: ______________________________ Occupation: ___________________________Work Phone: _____________________

EmployerAddress:____

INSURANCE INFORMATION:

Primary Insurance Name:_____________ ____

Insured’s Name: (If other than patient) ______________________________________ SS #:____________________________________

Secondary Insurance Name: ____

Insured’s Name: (If other than patient) ______________________________________ SS #:__________________________

TURN

OVER

PLEASE READ AND SIGN:

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS:

I hereby instruct and direct my insurance company to pay by check made out and mailed to:

Southern California Bone And Joint Clinic
12277 Apple Valley Road, Box #288
Apple Valley, CA 92308

If my current policy prohibits direct payment to the provider, I hereby also instruct and direct my insurance company to make out the check to me and mail it to the above address for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

This is a direct assignment of my rights and benefits under this policy.

This payment will not exceed my indebtedness to Southern California Bone And Joint Clinic, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

Please check each box:

- ☐ I hereby authorize Southern California Bone And Joint Clinic to release information to insurance companies, adjusters or attorneys involved in my case, concerning my illness and treatment for the purpose of processing claims and securing payment of benefits. I have received a copy and reviewed Southern California Bone And Joint Clinic's Notice of Privacy Practices (NPP) and understand it provides more detailed information about how Southern California Bone And Joint Clinic may use and disclose my protected health information (PHI).
- ☐ I authorize the use of this signature on all insurance submissions. A photocopy of the Assignment of Benefits shall be considered as effective and valid as the original.
- ☐ I authorize Southern California Bone And Joint Clinic to deposit checks made in my name. (Insurance reimbursements for services rendered.)
- ☐ I authorize Southern California Bone And Joint Clinic to initiate a complaint to the Insurance Commissioner for legitimate reasons on my behalf.
- ☐ I understand that I am financially responsible for any and all charges for services rendered which may not be covered by my insurance.

For Medicare Patients:

Southern California Bone And Joint Clinic agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient's Name:____ Signature: ____________________________ Date:__________________

Name and Signature of Policyholder: (If other than patient) ____ Witness: _________________________