

# Louisville Bone & Joint Specialists, PSC

## Patient Demographic Information

**Patient Name** \_\_\_\_\_ **Patient Account # (office use only)** \_\_\_\_\_

**Patient Date of Birth** \_\_\_\_\_ **Age** \_\_\_\_\_ **Patient Social Security Number** \_\_\_\_\_

**Patient Address** \_\_\_\_\_  
Street Address City State Zip Code

**Home Phone** \_\_\_\_\_ **Cell or Alternate Phone** \_\_\_\_\_ **Employer Phone** \_\_\_\_\_

Please Include Area Code

**Patient Employer** \_\_\_\_\_

---

**This section must be completed for all patients:**

**Emergency Contact** \_\_\_\_\_ **Relation to Patient** \_\_\_\_\_

**Emergency Contact Primary Phone** \_\_\_\_\_ **Alternate Phone** \_\_\_\_\_

---

### INSURANCE/RESPONSIBLE PARTY INFORMATION

Please list your primary health insurance here. If you are filing a workers' comp, motor vehicle, or other third party insurance also complete the section below.

**Primary Insurance** \_\_\_\_\_ **Subscriber** \_\_\_\_\_

**Address of Insurance** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Phone** \_\_\_\_\_ **Subscriber Social Security #** \_\_\_\_\_ **Subscriber Date of Birth** \_\_\_\_\_

**Subscriber Relation to Patient**  Parent  Spouse/Other **Subscriber Employer** \_\_\_\_\_

**Other or Secondary Insurance** \_\_\_\_\_ **Subscriber** \_\_\_\_\_

**Address of Insurance** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Phone** \_\_\_\_\_ **Subscriber Social Security #** \_\_\_\_\_ **Subscriber Date of Birth** \_\_\_\_\_

**Subscriber Relation to Patient**  Parent  Spouse/Other **Subscriber Employer** \_\_\_\_\_

**Accident Related To:**  Car Accident  Workers' Comp  Other  No Accident

**Accident Date** \_\_\_\_\_ **State Accident Occurred (for car accident only)** \_\_\_\_\_

**If workers' comp or car accident, please list the adjuster in charge of your claim:**

**Adjuster Name and Phone Number** \_\_\_\_\_

**Claim Number** \_\_\_\_\_

---

I hereby give authorization for payments to go directly to Louisville Bone & Joint Specialists PSC for benefits as determined by my health insurance carrier for the expenses of indicated services. I understand any charges not covered by my insurance are my responsibility.

I further understand there are many insurance plans which Louisville Bone & Joint Specialists, PSC does not participate with. I understand it is my responsibility to ascertain the participation of this office with my plan. I understand that if I am filing a workers' comp, car accident, or other third party claim it is my responsibility to provide the appropriate claim information to Louisville Bone & Joint Specialists, PSC. I understand that I will be responsible for any balance on my account should the physicians of Louisville Bone & Joint Specialists, PSC not participate with my insurance plan or if I fail to provide the appropriate claim information.

Co-payments are due at the time of service and are considered part of your insurance contract. Deductibles and any remaining balances on accounts are expected to be paid in a timely manner. If you need to make financial arrangements, our billing office personnel will be happy to assist you.

My signature below indicates my understanding of the financial policies of Louisville Bone & Joint Specialists, PSC and indicates that I intend to abide by the policies. All information provided is true and accurate to the best of my knowledge.

**INSURANCE PLANS WE DO NOT TAKE: Aetna, AIK Work Comp, Great West Life, Indiana Medicaid, Multiplan, Passport/Passport Advantage, Tricare Prime, US Department of Labor Workers' Comp, any case (auto, workers' comp, third party liability) if an attorney is involved.**

I acknowledge that I have received a Privacy Notice from Louisville Bone & Joint Specialists, PSC.

\_\_\_\_\_  
Patient/Personal Representative/or Parent if Minor Date

If personal representative's signature appears above, please describe personal representative's relationship to patient:

\_\_\_\_\_