

Fair Oaks Orthopaedic Associates, Inc.

Brent R. Ain, MD
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Patient Name (Last, First, MI)						
Home Address			City	State	Zip	Phone #
SSN	DOB	Sex	Age	Marital Status	Email	
Employer		Occupation			Work #	
Referring Physician		Primary Care Physician			Cell #	
Emergency Contact Information						
Name			Phone#		Relationship	
Address			City	State	Zip	
Primary Insurance Information						
Insurance Company						
Insurance Company Address					Phone#	
Subscriber's Name			DOB	SSN	Relationship	
ID#			Group#		Effective Date	
Secondary Insurance Information						
Insurance Company						
Insurance Company Address					Phone#	
Subscriber's Name			DOB	SSN	Relationship	
ID#			Group#		Effective Date	

PATIENT AUTHORIZATION

- I, _____ hereby authorize Fair Oaks Orthopaedic Associates, Inc., to apply for benefits on my behalf to my primary and/or secondary health insurance carrier(s) for covered services rendered by Fair Oaks Orthopaedic Associates, Inc. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information, for this or any related claim, the above named billing agent and/or other insurance carrier. I permit a copy of this authorization to be used in place of the original.
- I understand that I am ultimately responsible for my bill and that Fair Oaks Orthopaedic Associates, Inc. has no control or authority over my insurance company. In the event of insurance claim denial or payment delay, I will be responsible for payment of all charges incurred. If my account is turned over to a collection agency I will be responsible for the balance due, plus any collection and court costs incurred.
- Cancellation policy: There is a \$50 fee for appointments not cancelled at least 24 hours in advance. This fee is not billable to your health insurance and is your responsibility.

 Patient/Guarantor Signature

 Date