KEY WEST ORTHOPEDICS, P.A.
3428 N. Roosevelt Blvd.
Key West, Florida 33040
Phone (305) 295-9797
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Robert Catana, D.O.
David C. Perry, M.D.

20__ Patient Registration Form

Patient's Name

First *Last* *Suffix* *Middle Initial* *Nick Name*

Primary Language:
☐ *English* ☐ *Spanish* ☐ *Other:*_____

Local Address

City *State* *Zip*

Other Address

City *State* *Zip*

Work Telephone *Home Telephone* *Cell Phone* *Beeper*

- - ***Social Security Number***

Sex:
☐ Male ☐ Female

Home Email: _____
Work Email: _____

/ / ***Date of Birth***

Age

Marital Status:
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Employment Status:
☐ Full Time ☐ Part Time ☐ Retired
☐ Unemployed ☐ Disabled

Student Status:
☐ Full Time ☐ Part Time ☐ Not Applicable

Employer's Name *Occupation*

Address

City *State* *Zip*

Emergency Contact *Telephone* *Relationship to Patient*

Patient's Signature or Guardian's Signature ***Date***

Patient's Insurance Information

Primary Insurance:

Insurance Company Name

Policy Number *Group Plan Number*

Are you the Policy Holder/Insured?

☐ Yes ☐ No

IF YOU ARE NOT THE POLICY HOLDER, PLEASE COMPLETE THE SECTION BELOW

Name of the Policy Holder/Insured:

First *Last* *Middle Initial*

Relationship to you: - -
Social Security Number of Insured

Policy Holder's Address

City *State* *Zip*

/ /
Phone Number *Date of Birth*

Secondary Insurance:

Insurance Company Name

Policy Number *Group Plan Number*

Are you the Policy Holder/Insured?

☐ Yes ☐ No

IF YOU ARE NOT THE POLICY HOLDER, PLEASE COMPLETE THE SECTION BELOW

Name of the Policy Holder/Insured:

First *Last* *Middle Initial*

Relationship to you: - -
Social Security Number of Insured

Policy Holder's Address

City *State* *Zip*

/ /
Phone Number *Date of Birth*

INSURANCE AND MEDIGAP BENEFICIARY SIGNATURE AUTHORIZATION

I request that payment of authorized Insurance or Medigap benefits be made on my behalf to Key West Orthopedics, PA for services rendered me. I authorized any holder of medical information about me to release any information needed to determine those benefits or the benefits payable for related services.

THIS AUTHORIZATION TO RELEASE MEDICAL INFORMATION WILL ALSO INCLUDE SPECIFIC RELEASE OF HIV/AIDS TESTS, SUBSTANCE ABUSE AND/OR PSYCHIATRIC CARE.

RELEASE AND ASSIGNMENT

To _____
Insurance Company

I hereby authorized Key West Orthopedics, PA, to release to your company or its representative, any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Medical or Surgical Care.
I also authorize and request your company to pay directly to the above named doctor the amount due me in my pending claim for Medical or Surgical treatment or services by reason of such treatment or services rendered.
I understand I am responsible for charges not covered by the authorization.

Patient's Name	**Patient or Guardian's Signature**
Date	**Date**

Financial Policy

Thank you for choosing Key West Orthopedics as your health care provider. It is our goal to meet patient needs and address patient concerns effectively.

An area of primary concern for all patients are financial policies of the practice, especially those pertaining to insurance billing and patient payment requirements, In an effort to keep patients informed about such policies, we ask that all patients read and sign a copy of our Financial Policy prior to receiving treatment. As in all aspects of healthcare today, the greater role the patient assumes in the healthcare process, the higher the degree of satisfaction achieved. For that reason, we expect our patients to take an active role in their healthcare management, including the area of finances

PAYMENT is expected at the time services are rendered. This includes all deductibles, co-insurance and co-payments. Patients who have an insurance carrier with whom the practice has a valid control will be responsible for all fees as outlined in the patients' contract agreement.

DEPOSITS are collected on all first time self pay patients and all procedures over $250. The deposit is to be paid prior to the appointment or on the actual date of the procedure.

INSURANCE claims are filed for all primary, secondary and tertiary carriers as a courtesy to our patients. We will make every effort to collect from the insurance carrier. In the event your carrier does not pay the claim, you will be responsible for the bill.

STATEMENT AND BILLING CORRESPONDENCE are sent to update the patient as to the status of the account and whether your insurance company has fulfilled their obligation to you, the policy owner. It is the patient's responsibility to update the office of any change in address, phone number or insurance carrier information. Without current information we cannot effectively do our job.

RETURNED CHECKS will result in a $25 service charge. The check amount plus the service fee must be paid in cash within 10 days of notification. Failure to pay in full within 10 days will result in collection through the State Attorney's Office.

DELINQUENT ACCOUNTS are placed for collections 90 days from the date service was rendered. In the case of an insurance carrier the account will be placed for collection 90 days after the carrier has paid on the claim. Patients having financial difficulties are encouraged to discuss them frankly with our financial counselor before the account becomes delinquent.

MOTOR VEHICLE ACCIDENT CLAIMS are not filed for second or third party payors. These claims cannot be filed until the claim has been called in to your carrier and a claim number is obtained.

WORKERS COMPENSATION CLAIMS are filed only if verification can be completed. The patient is responsible for providing all necessary Information.
I have read the Financial Policy of Key West Orthopedics. I understand and agree to adhere to the Policies, as outlined.

Patient Signature: _____

Date: _____