SCHOFIELD, HAND & BRIGHT ORTHOPAEDICS, PLLC

Patient Information

Today's Date _____

Patients Name_____
(LAST) (FIRST) (MIDDLE)

Local address_____ APT/UNIT_____

City_____ State_____ Zip_____

Billing address_____ APT/UNIT_____

City_ _____ State_____ Zip_____

Home Phone (___)_____ Cell Phone (___)_____ Local Phone (___)_____

Email address:_____

Age_____ Date of Birth _____/_____/_____ Sex_____ Social Security #_____
MO / DAY / YEAR

Marital Status: Single _____Married_____Divorced____Separated_____Widowed____Minor_____

If Minor, Responsible Parties: _____

Address_____Phone (___)_____

Employers Name_____ Business phone (___) _____

Employers Address _____ City_____ State____ Zip_____

Person to Notify In Case of Emergency /Relation_____PHONE (___)_____

PRIMARY INSURANCE CARD HOLDER'S DOB _____ **And SSN** _____

SECONDARY INSURANCE CARD HOLDER'S DOB_____ **And SSN**_____

ALL UNPAID ACCOUNT BALANCES WILL BE CONSIDERED DELINQUENT SIXTY (60) DAYS FROM THE DATE OF THE CHARGE. ANY DELINQUENT ACCOUNT REFERRED TO A COLLECTION AGENCY WILL BE RESPONSIBLE FOR THE COST OF COLLECTION INCURRED BY SCHOFIELD, HAND & BRIGHT ORTHOPAEDICS, INCLUDING REASONABLE ATTORNEY'S FEES.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY INSURANCE AUTHORIZATIONS REQUIRED BY MY INSURANCE POLICY PRIOR TO MY VISIT. I ALSO UNDERSTAND THAT I WILL BE RESPONSIBLE FOR ALL BALANCES DUE IF THERE IS NO AUTHORIZATION RECEIVED BEFORE MY VISIT.

I HEREBY AUTHORIZE MY INSURANCE COMPANY, INCLUDING PRIVATE MEDICAL INSURANCE AND ANY OTHER HEALTH PLAN TO PAY BENEFITS TO WHICH I AM ENTITLED, FOR OFFICE VISITS, AND OFFICE AND/OR SURGICAL PROCEDURES TO BRIAN SCHOFIELD M.D., JOHN HAND M.D., & ADAM BRIGHT MD. I ACKNOWLEDGE AND UNDERSTAND THAT IF MY PROVIDER IS NOT CONTRACTED OR PARTICIPATING WITH MY INSURANCE, MY CLAIM WILL NOT BE SUBMITTED TO MY INSURANCE AND I WILL BE CHARGED THE ALLOWED AMOUNT AND AM RESPONSIBLE FOR REIMBURSING THE PROVIDER DIRECTLY.

I AUTHORIZE MY PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF NON PAYMENT FOR MY VISIT(S). I ALSO AGREE TO THE RELEASE OF ALL OR ANY INFORMATION NECESSARY BY MY PHYSICIAN TO THOSE THAT MAY FIND IT USEFULL IN MY TREATMENT.

DR BRIAN SCHOFIELD, DR JOHN HAND AND DR ADAM BRIGHT ARE INVESTORS IN ADVANCED SURGERY CENTER OF SARASOTA.

PRESCRIPTION RENEWAL POLICY
IT IS OUR POLICY TO RENEW PRESCRIPTIONS ONLY DURING BUSINESS HOURS. MONDAY THROUGH FRIDAY BETWEEN 8:00 AM AND 4:30 PM. PRESCRIPTIONS WILL NOT BE FILLED AFTER HOURS, AT NIGHT, WEEKENDS, OR HOLIDAYS. IF A PRESCRIPTION NEEDS TO BE REFILLED BEFORE YOUR NEXT APPOINTMENT, PLEASE ALLOW 2-3 BUSINESSS DAYS TO RENEW YOUR PRESCRIPTIONS.

PHARMACY NAME_____ **PHARMACY LOCATION** _____

_____**I have read and understand the above policies**

(PATIENT OR GUARDIAN SIGNATURE)