



2908 E 26th St
Sioux Falls, SD 57103
(605) 336-2638 • (800) 477-5899
FAX (605) 334-3500

GREGORY F. **ALVINE, MD**
ERIK **PETERSON, MD**
JEFFREY S. **KALO, DO**
SCOTT **MCPHERSON, MD**
TRAVIS **LIDDELL, MD**
TRAVIS **VENNER, DPM**
DAVID **WATTS, MD**

Thank you for choosing CORE Orthopedics!

You can help make our registration process faster and more efficient by completing the enclosed forms and returning them to us in the postage paid envelope provided.

Please carefully fill out the insurance portion on the back of this form.

- Please be sure to sign on the line beside the highlighted **X** area on the form.
- We do file insurance automatically as a courtesy to you.
- We request that you bring your insurance card(s), and photo I.D. with you so that we can make a copy of them for our records.
- If you need a referral for insurance or Medicaid, please bring that card with you.
- If you are requesting worker's compensation, motor vehicle accident, and/or public liability, it is your responsibility to have the billing and/or insurance information completed on the form and should accompany you to your appointment.
- Co-payment is due at time of service.

X-rays, CT scans, Bone scans, MRI's etc

- Please remember to bring all films and/or reports with you to your appointment.

Medical records

- Please either hand carry or forward (to our office) any outside medical records pertaining to the orthopedic problem(s) you are going to be seen for.

Medications

- Please remember to bring a list of all medications with you to your appointment.

Thank you! We look forward to meeting you.

Appointment Date _____ Time _____

Doctor _____



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Appt Date _____ Time _____
 Chart _____
 Account _____

PATIENT INFORMATION

First Name _____ M.I. _____ Last Name _____
 Maiden Name (if applicable) _____ Social Security # _____
 DOB _____ Gender _____ Age _____
 Address _____ City _____ State _____ Zip _____
 Cell Phone _____ Home Phone _____
 Email _____
 Parent/Guardian Name (if under 18) _____ Phone _____
 Employer _____ Work Phone _____
 Address _____ City _____ State _____ Zip _____
 Spouse Name (if applicable) _____ DOB _____
 Employer _____ Work/Cell Phone _____
 Address _____ City _____ State _____ Zip _____
 Family Doctor _____ Referring Physician _____
 How did you hear about us? _____
 Why are you seeing the doctor today? _____

 Current problem is the result of a: motor vehicle accident work-related injury liability other _____
 Date of Injury _____ State in which injury occurred _____
 Authorization to pay CORE Orthopedics _____

EMERGENCY CONTACT INFORMATION (must be someone who does not live with you)

First Name _____ Last Name _____
 Work Phone _____ Home/Cell Phone _____
 Email _____
 Address _____ City _____ State _____ Zip _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received the Notice of Privacy Practices from CORE Orthopedics.
X _____ Date _____
 In lieu of patient signature, I, _____, a staff member at CORE Orthopedics, state
 that _____ has been given our current Notice of Privacy Practices.
X _____ Date _____

INSURANCE INFORMATION Medicare # _____ Medicaid # _____ State _____ **Primary Insurance**

Company Name _____

Address _____ City _____ State _____ Zip _____

Policyholder Name _____

Policyholder Social Security # _____ DOB _____

Patient relationship to policyholder: self spouse child other _____

Policy Number of Insured _____

Group Name _____ Group # _____

Does your insurance company require pre-authorization? yes no **Secondary Insurance**

Company Name _____

Address _____ City _____ State _____ Zip _____

Policyholder Name _____

Policyholder Social Security # _____ DOB _____

Patient relationship to policyholder: self spouse child other _____

Policy Number of Insured _____

Group Name _____ Group # _____

Does your insurance company require pre-authorization? yes no**FINANCIAL AGREEMENT**

I understand that I am financially responsible for all charges not covered by insurance. In the event that there is a balance unpaid by insurance, I guarantee the balance to be paid by:

 cash check credit/debit card Card # _____ Exp. Date _____

I understand that any balance is considered delinquent after 90 days:

 _____ Date _____**PRE-AUTHORIZATION**

Our office will pre-authorize surgeries, however, pre-authorization does not guarantee payment. Questions regarding payment or benefits should be directed to your insurance carrier.

If your insurance company requires that you go to a specific hospital or facility in order to receive benefits for surgery, tests, or therapy, it is your responsibility to let us know.

Guidelines when calling your insurance company:

- Is pre-authorization required?
- Is a second opinion required?
- Are you in a waiting period for pre-existing conditions?

 _____ Date _____



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Financial Policy

The physicians and staff of CORE Orthopedics & Sports Medicine value the trust that you place in us to provide your care. Your clear understanding of our financial policy is an important part of our professional relationship. Please make sure to ask if you have any questions about our fees, our policies or your responsibilities.

Prior to your appointment you will be required to complete our Patient Information Forms. This needs to be completed before you see the physician and bi-annually thereafter.

INSURANCE

- New federal guidelines require us to ask for a **photo ID** and your **insurance card** at each visit.
- It is the patient's responsibility to provide current insurance information to the billing office.
- It is your responsibility to call your insurance company to make sure we are in your network.
- **Work Comp:** Billing information from your employer is required before you see your physician.
- **Medicaid:** Referral cards need to be provided before you see your physician.
- Your insurance policy is a contract between you and your insurance carrier. We file insurance as a courtesy to you and will help you in any way but we will not be involved in disputes between you and your insurance carrier. This includes but is not limited to: deductibles, co-pays, non-covered charges and "usual and customary" charges. You are ultimately responsible for the timely payment of your account.
- **Co-payments** are due at check-in.

PAYMENT ARRANGEMENTS

- Full balance is due at the time of service, however if you are unable to pay the full balance, payment arrangements can be made prior to your visit. Our billing office is available Monday–Friday, 8am–5pm. They may be reached at 800-477-2899 or directly at 605-221-0869.
- We accept cash, checks, and all major credit cards.
- **Unpaid balances** are subject to finance charge after 90 days and outstanding balances will be collected at check-in time.
- **Self Pay:** We offer a 30% discount to our patients who do not have insurance. We require that you pay one half of estimated charges before you see the physician and one half of estimated surgery charges before any surgical procedure is scheduled.

ADDITIONAL INFORMATION AND/OR FEE

- \$30 charge for insufficient funds check
- \$25 for completing disability forms
- \$25 for medical records that are not sent to referring or consulting physicians.
- Parents or guardians of minors are responsible for full payment and will receive billing statements for the minors. It is preferred that minors be accompanied by a parent or guardian but in the event that that is not possible, unaccompanied minors will not be treated without a signed release from a parent or guardian.
- Many times you are referred to outside facilities for tests, surgery and second opinions. You are responsible for obtaining pre-certification from your insurance company for any outside referrals.

I have read and agree with CORE Orthopedics & Sports Medicine's Financial Policy.

Patient Name (please print) _____

Patient/Responsible Party Signature _____ Date _____