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

GREGORY F. **ALVINE, MD**
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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 requestion 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 **X**____

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:

X ______________________________ 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-exisiting conditions?

X ______________________________ 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 understating 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 ____________