Sebastopol Orthopaedics
& Sports Medicine

Dr. Michael Bollinger, MD
Dr. Bruce Bragonier, MD

PATIENT INFORMATION

Please print legibly

Date of Visit_____

Name Last, First, Middle_____ Gender □ M □ F

Address_____ City_____State_____Zip_____

E-mail_____Home _____Cell_____

Preferred method of contact - check all that apply: □ Home Phone □ Cell Phone □ e-mail

Date of Birth_____ SS#_____ Drivers License_____

Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed □ Other:_____

I hereby consent to the release of protected health information to the following individuals. I understand this authorization will be in effect until I personally revoke it:

Name	Relationship
_____	_____
_____	_____

Insurance Information:

Do you have Insurance? □ Yes □ No If yes, please provide your insurance information below. If no, please be prepared to pay cash or use a credit card for your visit today and each subsequent visit. Thank you!

PLEASE PROVIDE THE FRONT DESK WITH A COPY OF YOUR INSURANCE CARD(S) AND CURRENT PHOTO ID.
IF YOU DO NOT HAVE THEM, YOUR APPOINTMENT WILL NEED TO BE RESCHEDULED.

Primary Insurance Carrier_____**Secondary Carrier**_____

Preferred Language_____ Race_____ Ethnicity_____

Occupation_____ Employer_____ Phone_____

If Minor, Name of Parent/s_____

Emergency Contact Name_____Relationship_____

Emergency Contact Phone (Home#)_____ (Cell #)_____

Referring Physician_____ Phone_____

Primary Care Physician_____ Phone_____

Are you currently in a Skilled Nursing Facility? □ No □ Yes Name of facility:_____

Is your visit due to an injury at work? □ Yes □ No If yes, date of injury:_____

Have you retained an attorney? If so, name and phone number _____

FEES FOR FORMS: The following forms will each require a $15.00 charge for our staff to complete: EDD Forms (CA State Disability), Union Paperwork, Aflack insurance forms, Medical verification report for child support, PG&E forms, other miscellaneous Medical forms and letters written by the doctor (for medical insurance qualification, travel cancellation, etc). There is also a $5.00 charge for all requests for DMV Disabled Person Placard forms.

BASIC POLICY: Payment for professional fees are due, in full, at the time services are provided in our office. **Co-payments and deductibles are also due at the time of your office visit.**

PATIENTS WITH INSURANCE: We will bill insurance carriers for patients who are covered under our participating health plans. Since your agreement with your insurance carriers is a private matter we do not routinely research why an insurance carrier has not paid or why they pay less than anticipated for your care. We also will bill any participating secondary insurance carriers.

SURGERY FEES: All surgical co-payments and deductibles, as well as payment for any non-covered surgical procedures are due prior to your scheduled surgery. **Please note: Your insurance carrier may require prior authorization for office visits and/or surgery.**

AUTHORIZATIONS:

I, _____HEREBY AUTHORIZE PAYMENT OF MEDICAL AND/OR SURGICAL BENEFITS TO MICHAEL T. BOLLINGER, MD AND/OR BRUCE R. BRAGONIER. THIS AGREEMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. I FURTHER AGREE TO BE FINANCIALLY RESPONSIBLE FOR PAYING ALL CHARGES NOT PAID BY MY INSURANCE COMPANY. I HEREBY AUTHORIZE THE RELEASE OF ALL MEDICAL RECORDS OR INFORMATION NECESSARY TO SECURE THE PAYMENT OF SAID BENEFITS.

I, _____ HEREBY AUTHORIZE THE RELEASE OF MEDICAL RECORDS OR INFORMATION TO MY PRIMARY CARE PHYSICIAN AND/OR A SPECIALIST WHEN NECESSARY FOR FURTHER TREATMENT.

Signature_____Date_____

MEDICARE: (please **only** sign below if your primary insurance carrier is Medicare)

I, _____request that payment of authorized Medicare benefits be made on my behalf to Michael T. Bollinger and/or MD, Bruce R. Bragonier, MD for any services provided me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If Item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier. I also authorize payment of coinsurance benefits be made to Michael T. Bollinger, MD or Bruce R. Bragonier MD.

Signature_____Date_____

MINOR PATIENTS: (please **only** sign below if you are the parent or guardian of said minor)

I, _____hereby authorize medical treatment of my **minor child**. In addition, I authorize payment of medical and/or surgical benefits to Michael T. Bollinger and/or MD, Bruce R. Bragonier. This agreement will remain in effect until revoked by me in writing. I further agree to be financially responsible to pay for any and all charges not paid by my insurance carrier. I hereby authorize the release of all medical records or information to secure the pay/or a specialist when necessary for further treatment.

Signature_____Relationship_____Date_____