INSTITUTE of SPORTS MEDICINE & ORTHOPAEDICS

STEVEN GORIN D.O.
BOARD CERTIFIED
ORTHOPAEDIC SURGEON
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PATIENT REGISTRATION FORM

Date:_____

Patient Name:_____
Last First MI Date of Birth

Address_____
City, State, Zip_____
Home Phone_____
Cell Phone_____
Work Phone_____
E-Mail_____

☐Single ☐Married ☐Divorced ☐Widowed ☐Male ☐Female

SS#_____
Driver's License #_____

Referred By_____
Primary Care Physician_____
Preferred Pharmacy/#_____
Emergency Contact#_____
Name/Relationship_____

Patient Occupation_____
Patient Employer_____

Primary Insurance Company
Carrier Name_____
Member's Name_____
Member's ID_____
Group #_____
Patient Relation to Subscriber_____

Secondary Insurance
Carrier Name_____
Member's Name_____
Member's ID_____
Group #_____
Patient Relation to Subscriber_____

Responsible Party (if not patient)
Name_____
Address_____
City, State, ZIP_____
Phone_____
SS#_____

A. AUTHORIZATION TO RELEASE INFORMATION/ASSIGNMENT OF MEDICARE BENEFITS
I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claim(s). I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Furthermore, I request that payment under the medical insurance benefits either to myself or to the party who accepts assignment below. Furthermore, I request that payment under the medical insurance program be made to me or to **INSTITUTE OF SPORTS MEDICINE AND ORTHOPAEDICS,** I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the holder of medical information about me to release it to Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claim(s). I understand that this is a lifetime signature authorization.

I request that payment of authorized MEDIGAP benefits be made on my behalf to **INSTITUTE OF SPORTS MEDICINE AND ORTHOPAEDICS,**. for any services furnished me by (physician/supplier). I authorize any holder of medical information to release to **INSTITUTE OF SPORTS MEDICINE AND ORTHOPAEDICS,** any information needed to determine these benefits or the benefits payable for related services.

B. ASSIGNMENT OF INSURANCE BENEFITS/RELEASE OF INFORMATION
I authorize **INSTITUTE OF SPORTS MEDICINE AND ORTHOPAEDICS,** to release to your company or its representatives 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 service by reason of such treatment or service.

C. FINANCIAL RESPONSIBILITY
I understand that I am financially responsible for charges not covered by this authorization and for the guarantees stated above. Also, I understand that it is my responsibility as the insured to pay all copayments and coinsurance at the time of the visit.

D. APPOINTMENT POLICY
I understand that I will be charged a fee for appointments not canceled within 24 hours. This includes canceled appointments, rescheduled appointments, and missed appointments ("no-shows"). Appointments may be canceled via telephone or website. The fee is $50.00 but is subject to change at the discretion of **INSTITUTE OF SPORTS MEDICINE & ORTHOPAEDICS**

Please initial here _____

E. REFERRALS AND AUTHORIZATIONS
I understand that it is my responsibility to obtain all authorizations or referrals necessary for treatment. **INSTITUTE OF SPORTS MEDICINE & ORTHOPAEDICS** does not accept faxed authorizations or referrals. If an authorization or referral is not obtained by the time of the visit, the visit will be rescheduled and considered a same-day cancellation, resulting in a fee. (SEE ABOVE)

F. MEDICAL MALPRACTICE
Under Florida law physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. Dr. Steven Gorin has decided to NOT carry medical malpractice insurance. According to Florida statuette 458.320 (5)(g)(1), this is permitted under Florida law subject to certain conditions. Florida law imposes penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law.

Please initial here _____

I, THE PATIENT OR GUARANTOR, CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE. I ACCEPT RESPONSIBILITY FOR THE MEDICAL CHARGES INCURRED BY THE PATIENT AND AGREE TO PAY ALL BILLS AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE. I AUTHORIZE PHYSICIAN AND PRACTICE TO RELEASE ANY INFORMATION TO PROCESS INSURANCE CLAIMS. I ALSO AUTHORIZE MY INSURANCE CLAIMS TO BE PAID DIRECTLY TO THE PRACTICE OR ITS REPRESENTATIVE.

PATIENT or GUARANTOR SIGNATURE _____ *DATE* _____