Arch Health Partners

Orthopedic Surgery
ASSOCIATES OF NORTH COUNTY

Reason for Visit

Orthopedic treatment is often a result of an accident or injury, your insurance company may require the details of your visit before processing your claim(s) for payment; this information is often used to determine financial liability. Most insurance companies will not pay claims without this information.

NAME (PLEASE PRINT): _____

If you are here for a reason OTHER THAN AN ACCIDENT, please complete this section

My visit is due to _____ Date first noticed: _____

Place occurred (home, work, school, etc) _____

Please describe how this may have occurred: _____

_____

_____

If you are here DUE TO AN ACCIDENT; please complete this section

My visit is due to an accident: Yes ☐ Date of accident: _____

Location of accident (home, work, school, care, etc) _____

Please describe how the accident occurred: _____

_____

_____

Name of Medical Insurance Company: _____

Is there any other insurance company or entity that may be financially responsible for payment of this claim, such as an automobile insurance, homeowners insurance, student insurance, etc.? If so, please explain and provide any additional information so we can determine who the appropriate entity is to be billed for your services.

Note: Although you may advise us that another entity is responsible for payment of the claims, *our office does not file third party billing*; and if it is determined that a third party is responsible, we will provide you with the necessary paperwork to submit your claims. In the meantime, you are financially responsible for any outstanding bills due Arch Health Partners Orthopedic Surgery Associates and payment will be expected upon receipt of the first itemized statement.

My signature below indicates that I have read the above and understand I am financially responsible for all medical care rendered, pending any liability disputes.

Signature: _____ **Date**: _____