Please bring the following to your appointment along with completed forms:

Insurance cards & photo ID. Please check to see if your insurance company requires a referral from your primary (family) care physician before your appointment. If you have a workman's compensation claim, liability or a motor vehicle accident claim, please call our office a few days before your appointment with information as these claims need to be pre-authorized or your appointment will be rescheduled. All co-pays are expected at time of service. Self-pay patients are also expected to pay on the day of service.

X-Ray, MRI or any other tests related to the complaint you are being seen for. Please make sure reports are included with any films you are bringing. If you anticipate having x-rays in our office, please wear or bring sweat pants or shorts with no zippers or buttons.

A current list of medications.

If you cannot make your appointment, please call at least 24 hours in advance to cancel or reschedule- otherwise a no show fee may be incurred. Thank you for your cooperation to make your appointment a smooth and pleasant one.

Our locations:

Osceola Office:
River Valley Orthopedics & Sports Medicine
320 Lincolnway E
Osceola, IN 46561
574-674-6700

Plymouth:
Patel Family Medicine Center
1904 Lake Ave
Plymouth, IN 46563

Lagrange:
Medical Office Building
2400 Ventura Way
LaGrange, IN 46761
* No x-ray capability at this location, please bring your x-rays with you.

River Valley Orthopedics
& Sports Medicine, P.C.

John M. Graham, D.O.

320 Lincolnway East
Osceola, IN 46561

(574) 674-6700
Fax (574) 674-7171

Patient Registration Form

Date: _____

Last Name: _____ **First Name:** _____ **M.I.** _____

Address: _____**City:**_____**State:**_____**Zip:**_____

Home Phone (_____) _____**Cell/Other (_____)** _____

Male Female Date of birth: _____ **Age:**_____ **Social Security#** _____

Race: _____ **Patient Employer/School:** _____

Marital status: _____ **Name of spouse:** _____ **Spouse SS#:** _____

Referring Physician: _____ **Family physician:**_____

Emergency contact: _____**Relationship:** _____ **Phone #:**_____

Are you a nursing home resident? No Yes If yes, where are you staying? _____

Are you a Medicare patient enrolled in Hospice? No Yes

If patient is a minor, Please list both parents names, social security numbers and address (if different from patient):

Mother: _____ **SS#**_____**Address**_____

Father: _____**SS#**_____ **Address**_____

****Anyone under the age of 18 will require either verbal or written consent by a responsible adult prior to treatment.****

PRIMARY INSURANCE COMPANY: _____

Name of policyholder: _____**Social Security#:**_____ **Date of birth:**_____

Relationship to patient _____**Home phone:**_____ **Work Phone:** _____

Address:_____ **City:** _____**State:**_____**Zip:**_____

Employer_____

SECONDARY INSURANCE COMPANY: _____

Name of policyholder:_____ **Social Security** _____ **Date of birth:** _____

Relationship to patient _____ **Home phone:** _____**Work phone:** _____

Address_____ **City:** _____ **State:**_____ **Zip:**_____

Employer_____

(please see back)

River Valley Orthopedics & Sports Medicine P.C.

FINANCIAL POLICY

We are pleased that you have chosen River Valley Orthopedics & Sports Medicine, P.C. We are committed to providing you with the best possible care. We encourage you to discuss with us any concerns you may have about our professional fees and financial policies. While we make every attempt to assist you by filing insurance claims, payment for services is your responsibility. For your convenience, we accept cash, personal checks and most credit cards. There is a $25.00 service charge for returned checks.

Disability, FMLA, AFLAC and all other forms will be charged $15.00 per form completed by our office.

FINANCIAL AGREEMENT

1. In consideration of the services to be rendered to me, I hereby, obligate myself to pay the account of River Valley Orthopedics & Sports Medicine, P.C. in accordance with the regular rates and terms of River Valley Orthopedics & Sports Medicine, P.C. If my account is referred to an attorney or licensed agency for collection, I shall pay all reasonable fees.

2. I hereby authorize direct payment to River Valley Orthopedics of any insurance benefits otherwise payable to me for this treatment at a rate not to exceed River Valley Orthopedics regular charges. It is agreed that payment to this office, pursuant to this authorization, by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. I understand that I am financially responsible for charges not covered by this assignment.

*I authorize messages to be left at my home: Yes No

*I authorize my health information to be disclosed to the following people: (Please note: if the name is not listed, we are unable to discuss anything regarding your health information)

_____

_____

_____

CONSENT FOR TREATMENT

I hereby give my consent to River Valley Orthopedics & Sports Medicine, P.C. to evaluate and treat. I understand that River Valley Orthopedics & Sports Medicine, P.C. has my permission to use, obtain, and disclose my health information to or from others, for the purposes of providing treatment, obtaining payment for treatment and conducting day-to-day operations of the practice.

.

I understand that River Valley Orthopedics and Sports Medicine, P.C. shall have the right at any time to refuse to provide medical care or treatment for me.

I certify that I am the patient, or am duly authorized by the patient as the patient's general agent, to execute this document and accept its terms.

*I have been provided a copy of the Notice of Privacy Practices for River Valley Orthopedics & Sports Medicine, P.C.

* This notice is being provided to you as a requirement of Indiana Law: John M. Graham, D.O. has a financial interest in Riverpointe Surgery Center and Unity Medical and Surgical Hospital. You may choose to be referred to another health care entity if you so desire.

I acknowledge that I have received this Notice of Financial Interest.

_____ _____

Signature Date

PLEASE COMPLETE ENTIRE PAGE

DATE_____

PATIENT NAME_____

What problem are you here for? _____

How long have you had this problem? _____

If injury, how & where did it happen? _____

Is this a work-related injury/condition? Yes_____ No_____

Is this a motor vehicle related accident/condition? Yes_____ No_____

Did the injury/condition occur in someone's home? Yes_____ No_____

Did someone else (a third party) cause this accident? Yes_____ No_____

If yes, are you pursuing recovery from an attorney? Yes _____No _____

Attorney's name_____
Address_____
Phone number_____

Is another insurance company involved?

Insurance Co. Name_____
Address_____
Policy/Claim Number_____
Contact person_____

I acknowledge that I am financially responsible for all services rendered to me by River Valley Orthopedics & Sports Medicine, P.C., regardless of the fault of a third party.

Patient Signature _____ Date_____

Parent or Guardian Signature (if patient is a minor/dependent) _____

(Please see back)

River Valley Orthopedics
& Sports Medicine, P.C.

John M. Graham, D.O.

320 Lincolnway East
Osceola, IN 46561

(574) 674-6700
Fax (574) 674-7171

Name: _____ Today's Date: _____

Age: _____ Birthdate: _____

MEDICAL CONDITIONS

☐ AIDS	☐ Chemical dependency	☐ High cholesterol	☐ Prostate problems
☐ Alcoholism	☐ Chicken pox	☐ HIV positive	☐ Psychiatric care
☐ Anemia	☐ Depression	☐ Kidney disease	☐ Rheumatic fever
☐ Anorexia	☐ Diabetes	☐ Liver disease	☐ Scarlet fever
☐ Anxiety	☐ Emphysema	☐ Measles	☐ Seasonal allergies
☐ Arthritis	☐ Epilepsy	☐ Migraine headaches	☐ Stroke
☐ Asthma	☐ Goiter	☐ Mononucleosis	☐ Suicide attempt
☐ Bleeding disorders	☐ Gout	☐ Multiple Schlerosis	☐ Thyroid
☐ Blood clots	☐ Heart disease	☐ Mumps	☐ Tuberculosis
☐ Bronchitis	☐ Hepatitis	☐ Pacemaker	☐ Typhoid fever
☐ Bulimia	☐ Herpes	☐ Pneumonia	☐ Ulcers
☐ Cancer (specify)	☐ High blood pressure	☐ Polio	☐

SURGERIES

Year	Hospital	Procedure

MEDICATIONS and dosages

MEDICATION ALLERGIES Are you allergic to Latex? NO YES Reaction: _____

Do you smoke: NO YES How much? _____

Do you drink alcohol? NO YES How often? Rarely Occasionally Socially Daily

Height: _____ Weight: _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of patient (unless minor): _____

Date: _____