SOUTHERN BONE & JOINT SPECIALISTS

1500 ROSS CLARK CIRCLE DOTHAN, AL / 4300 WEST MAIN STREET, SUITE 14 DOTHAN, AL
404 NORTH MAIN STREET, ENTERPRISE, AL

PLEASE PRINT
Payment due at time of services.

PATIENT INFORMATION			SPOUSE OR (IF PATIENT IS A MINOR) FATHER'S INFORMATON		
LAST NAME	FIRST	MID. INITIAL	NAME		
ADDRESS			ADDRESS		
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE
HOME PHONE / CELL PHONE		WORK PHONE	HOME PHONE		WORK PHONE
SEX M F	AGE	BIRTH DATE	RELATIONSHIP TO PT.		CELL PHONE
SOCIAL SECURITY NUMBER		MARITAL STATUS M S D W	SOCIAL SECURITY NO.		BIRTH DATE
EMPLOYER OR SCHOOL		OCCUPATION	EMPLOYER		
EMERGENCY CONTACT		PHONE	OCCUPATION		

MOTHER'S INFORMATON (IF PATIENT IS A MINOR)				
NAME			SOCIAL SECURITY NO.	BIRTH DATE
ADDRESS			EMPLOYER	
CITY	STATE	ZIP CODE	OCCUPATION	
HOME PHONE	WORK PHONE		CELL PHONE	

REASON FOR APPOINTMENT
DESCRIBE SYMPTOM / PROBLEM & WHEN IT BEGAN
PLEASE LIST THE NAME OF THE REFERRING PHYSICIAN

ACCIDENT INFORMATION (IF NOT AN ACCIDENT SKIP TO NEXT SECTION)		
IS THIS PROBLEM DUE TO AN ACCIDENT? YES NO	ACCIDENT DATE:	TYPE OF ACCIDENT: ON THE JOB AUTO HOME OTHER
ACCIDENT OCCURRED IN STATE OF:		IF YOU HAVE AN ATTORNEY, LIST THEIR NAME & NUMBER BELOW
IF AUTO ACCIDENT, LIST AUTO INSURANCE INFORMATION BELOW		
,		IF ON THE JOB INJURY, LIST WORKERS COMP INFORMATION BELOW

LIST IMMEDIATE FAMILY MEMBERS WHO ARE PATIENTS OF SBJS BELOW
NAME(S) & DATE(S) OF BIRTH

INSURANCE INFORMATION	
PRIMARY INSURANCE	SECONDARY INSURANCE
SUBSCRIBER & RELATION TO PATIENT	SUBSCRIBER & RELATION TO PATIENT
POLICY # / GROUP #	POLICY # / GROUP #

RELEASE, ASSIGNMENT, AUTHORIZATION FOR TREATMENT AND FINANCIAL AGREEMENT: I authorize release of my medical and financial records to my referring physician, my parents or guardian, my employer if the injury is job-related, school officials if injury is school-related, insurance companies, third party administrators or payors, or government agencies or their agents who may be responsible for payment. I certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I agree to the following terms regarding any outstanding balance that I owe: (1) I will incur interest at the rate of 1 & 1/2 percent per per month (18% PER ANNUM); (2) I agree and hereby consent that I will be responsible for reasonable collection costs and attorney's fees in the amount of 33 1/3%, in addition to the outstanding balance, and costs of court incurred by Southern Bone and Joint Specialists, in the collection of same, whether such outstanding balance is satisfied prior to, after initiation of a lawsuit, or after a judgment has been issued in a lawsuit; and (3) I agree and hereby consent that any lawsuit and/or legal proceeding surrounding the oustanding balance and debt, and fees and costs theron, shall be initiated and litigated in the court of appropriate jurisdiction of Houston County, Alabama, and I hereby waive any and all defenses and/or objections to said jurisdiction. By signing below, I consent to the terms contained herein and affirmatively acknowledge that I have read the same before signing. Furthermore, I agree that if a cell phone number has been provided I can be contacted regarding my balance on said cell phone. Additionally, if I reside in Florida I agree to waive my rights to any exemption that would prohibit a wage garnishment should same become necessary to secure payment of any outstanding balance. I also agree that at any time if my balance has not been paid according to policy I understand my credit history will be investigated and thoroughly reviewed. I have been furnished with a copy of Southern Bone & Joint Specialists Financial Policies.

SIGNATURE OF PATIENT/GUARDIAN AND/OR AUTHORIZED AGENT　　　　DATE