Ashay A. Kale, MD ▪ Soheil Motamed, MD ▪ Ricardo Molina, MD ▪ Co V. Banh, MD
Joshua Van Gompel, DPM ▪ Gabriel Van Gompel, DPM ▪ Erik Schuenke, DPT ▪ Sarah Wanlin, DPT
Ava Novotny, PA-C ▪ Joshua Ninichuck, PA-C ▪ Van Nguyen, PA-C ▪ Kelli Kern, PA-C

Orthopaedic Surgery ▪ Arthroscopy & Sports Medicine ▪ Shoulder & Elbow Surgery ▪ Joint Replacement
Podiatry: Foot & Ankle Surgery ▪ Physical Medicine & Rehabilitation ▪ Interventional Spine Care
▪ Physical Therapy

CHART #:

REFERRING PHYSICIAN: **PRIMARY CARE PHYSICIAN:**

Patient Information

Last Name:____________________________ ***First Name***: _________________________ ***Date of Birth***: __________

Address: _______________________________________ ***City/State/Zip***:___________________________________

Phone (1): ____________________________________ ☐ HOME ☐ CELL ☐ WORK

Phone (2): ___________________________________ ☐ HOME ☐ CELL ☐ WORK

How would you like to be reminded of your appointment: ☐PHONE ☐E-MAIL ☐TEXT, If by TEXT, please provide cell phone carrier: _________________________

Email Address: ____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widow ***Gender***: ☐Male ☐ Female

Employer Name: ____________________________ ***Occupation***: ___________________ ***Veteran***: ☐ YES ☐NO

Race: Primary___________________________ Secondary_________________________________

Ethnicity: ☐Not Hispanic or Latino ☐Hispanic or Latino ***Language Preferred***: _________________________

Emergency Contact: ____

Relationship to Patient: ____________________________ *Phone*: _______________________________

For X-Ray Purposes:

Are you pregnant or is there a possibility you may be pregnant? ☐ NO ☐ YES

What is the DATE of the current injury that you will be seen for: ____________ What are we seeing you for today?

1) _________________________ ☐ RIGHT ☐ LEFT 2) ___________________________ ☐ RIGHT ☐ LEFT

Have you received HOME HEALTH CARE? ☐ YES ☐NO If so, what is the discharge date from HOME HEALTH? _________

Primary Insurance Information	Secondary Insurance Information
Insurance Co. Name: __________________________________	Insurance Co. Name: _____________________________
Policy/ID #: _______________________________	Policy/ID #: ________________________________
Group #: _________________________________	Group #: _________________________________
Policy Holder Information	Policy Holder Information
Last Name: ______________ First Name: _____________	Last Name: _______________ First Name: __________
DOB: ___________ Employer: ________________________	DOB: __________ Employer: _______________________
Relationship to Patient: ______________________	Relationship to Patient: ______________________

IF PATIENT IS A MINOR, please fill out the following CONSET FOR MEDICAL TREATMENT:

I, ___________________________ (print name), am the parent/legal guardian of __________________________ (print name of minor), currently a minor, whose date of birth is __________________. I authorize Mission Peak Orhtopaedics to provide medical care to my son/daughter, including, but not limited to, diagnostic examinations (including radiological and laboratory testing).

IF PATIENT IS A MINOR, PERSON RESPONSIBLE FOR PATIENT'S MEDICAL BILLS:

Last Name: _________________________________ First Name: ____

Relationship to the Minor: ____

Address (if different than the minor): ____

Phone (1): _____________________________________ ☐ HOME ☐ CELL ☐ WORK

ASSIGNMENT OF BENEFITS-FINANCIAL AGREEMENT

I hereby give authorization for payment of insurance benefits to be made directly to Mission Peak Orthopaedic Medical Group for services rendered. I understand that **I am financially responsible for all charges whether or not they are covered by insurance**. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all necessary information to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

If you are a Medicare patient, please read and sign.

MEDICARE AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I REQUEST THAT PAYMENT OF AUTHORIZED Medicare benefits be made or on my behalf to Mission Peak Orthopaedic Medical Group for any services rendered by physician/supplier. 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 complete, my signature authorizes releasing information to the insurer of the agency shown. In Medicare assigned cases, the physician/supplier agrees to accept the charge determination of Medicare. The patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and deductibles are based upon the charge determination made by the Medicare carrier.

______________________________ ___________________

PATIENT OR GUARDIAN SIGNATURE DATE