NEW PATIENT REFERRAL INFORMATION

Please complete *ALL* fields. Use "N/A" if not applicable.
Incomplete information could result in denial of treatment.

You Can Present the Completed Form at your next visit to Ortho Plus OR **Fax it to 405.216.3743**

General Information

Name: _____ Date of Birth: _____

Street Address: _____ City: _____

State: _____ Zip: _____ Gender: Male Female

Home Phone: _____ Cell Phone: _____

Email Address: _____

Emergency Contact Information

Emergency Contact Name: _____ Relationship to Patient: _____

Emergency Contact's Home Phone: _____ Cell Phone: _____

Emergency Contact's Email: _____

Insurance Information

Patient's Car Insurance Carrier: _____

Policy Number: _____ Claim Number: _____

Adjuster's Name: _____ Adjuster's Phone Number: _____

Car Insurance Carrier for Other Party: _____

Policy Number: _____ Claim Number: _____

Adjuster's Name: _____ Adjuster's Phone Number: _____

Accident Information

Date of Accident: _____ Date of First Treatment: _____

Attorney Name: _____ Attorney's Phone Number: _____

IRREVOCABLE ASSIGNMENT OF PROCEEDS

Patient's Name:_____ Patient's Date of Birth:

Date of Accident:

I, the undersigned patient (or legal guardian of a minor Patient), of (the SyndeoCare Provider), forever and irrevocably assign any and all proceeds that I receive from any insurance company(ies), to be paid directly to SyndeoCare LLC ("SyndeoCare") for professional medical services rendered to me by a provider within SyndeoCare's contracted network of providers ("SyndeoCare Provider") in connection with the Date of Incident noted above. I also acknowledge that I have executed a HIPAA Authorization directing SyndeoCare to provide certain information to the insurance company(ies).

As consideration for my execution of this Irrevocable Assignment of Proceeds, I represent that the SyndeoCare Provider has provided me medical services upon my request, that I am aware of the nature and expense of all such services so provided, and that as consideration for the forbearance of its legal right to require payment by me at the time such services were rendered, said SyndeoCare Provider relied upon my express declaration and intention to execute and instruct that this Irrevocable Assignment of Proceeds shall apply to the insurance proceeds to which I am entitled, and direct that the amount of such proceeds be paid to SydeoCare, at such time as I receive an insurance settlement or other monetary settlement/award.

In the event there is no recovery or insufficient recovery from the insurance company(ies) or other sources to reimburse SyndeoCare for the amounts it has paid to the SyndeoCare Provider for my care, I understand that I am directly and fully responsible for reimbursing SyndeoCare for such unrecovered amounts of my medical bills. If I do not have an attorney and later decide to retain one, then I agree to promptly (1) furnish SyndeoCare with contact information concerning that attorney; and (2) notify that attorney concerning the existence of this Irrevocable Assignment of Proceeds. I acknowledge that the SyndeoCare Provider will be paid by SyndeoCare for all medical bills associated with the services rendered to me; and therefore, I agree to allow SyndeoCare to file a Uniform Commercial Code-1 (UCC-1) Financing Statement and/or Hospital/Emergency Services/Healthcare Provider Lien, as applicable, as a security instrument to ensure payment of professional medical services rendered during my recovery and specifically agree and affirm that the insurance company(ies) should pay SyndeoCare one hundred percent (100%) of the invoice amount submitted by SyndeoCare for any care that I receive during my treatment. If for any reason whatsoever, I, rather than SyndeoCare, am paid by way of settlement, judgment, or verdict, I agree not to accept any money from either the insurance company(ies) or attorney from any of the proceeds that I have herein assigned to SyndeoCare and will instruct the insurance company(ies) or attorney to deliver such payment, settlement, judgment or verdict's proceeds to SyndeoCare to ensure that SyndeoCare shall be paid in full out of the first proceeds received or paid by insurance company(ies) or attorney.

Print Name of Patient:_____ Date:_____

SIGNATURE OF PATIENT/LEGAL REP:

(If signed by other than patient, state relationship with signature)

NOTE: IF INSURANCE COMPANY POLICY REQUIRES A RECORDED/FILED LIEN FOR DIRECT PAYMENT, PLEASE CONTACT THE SYNDEOCARE OFFICE PRIOR TO SETTLING YOUR CASE. SYNDEOCARE WILL PROVIDE YOU WITH THE NECESSARY PAPERWORK.

AUTHORIZATION FOR USE & DISCLOSURE OF HEALTH INFORMATION

PATIENT INFORMATION:

_____ _____
Name of Individual/Previous Names Date of Birth

_____ _____(_____)_____
Street Address City, State, Zip Phone

HEREBY AUTHORIZES: TO OBTAIN FROM AND/OR DISCLOSE PROTECTED HEALTH INFORMATION TO:

_____ _____
Name of individual or organization making disclosure Name of individual or organization receiving protected health information

_____
Street Address

_____
City, State, Zip Code

PROTECTED HEALTH INFORMATION TO BE USED OR DISCLOSED:
The following is a specific description of the health information I authorize to be used and/or disclosed _____
_____
_____

I specifically approve the disclosure of the following medical records: [Check all that apply]
Treatment of Injuries Arising from an Incident on (Date)_____ Developmental Disabilities HIV test results Mental Health Records (Excluding Psychotherapy Notes) Other (Specify): _____
_____

For the Following

Date(s):From_____To_____

From date of injury to two years after date of injury

PURPOSEOF DISCLOSURE: (Check applicable categories)
Coordinating Care Insurance Eligibility/Benefits Further Medical Care Claims Resolution Other (Specify):
_____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION :

Right to Receive Copy of This Authorization - I understand that if I sign this authorization, I will be provided with a copy of this authorization.

Right to Refuse to Sign This Authorization - I understand that I am under no obligation to sign this form. Refusal to sign this authorization will not prevent me from receiving treatment from providers, submitting claims to any applicable insurance company to obtain payment for such treatment, or eligibility for any benefits due under the insurance coverage. If I do not sign this form, SyndeoCare will not be able to provide financial and administrative assistance in obtaining reimbursement for my injury claim against the applicable insurance company. This means that I will be obligated to pay my providers of care for the services I receive and handle the submission of claims to insurance carriers without SyndeoCare's assistance.

Right to Withdraw This Authorization - I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to SyndeoCare. I am aware that my withdrawal will not be effective until received by SyndeoCare and will not be effective regarding the uses and/or disclosures of my health information that a covered entity has made pursuant to this authorization, prior to receipt of my withdrawal statement.

Right to Inspect or Copy the Health Information to Be Used or Disclosed - I understand that I have the right to inspect or copy (copies may be provided at a reasonable fee) the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting SyndeoCare at the address listed above**.**

REDISCLOSURE NOTICE: I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

EXPIRATION DATE: This authorization is good until (indicate date or event) _____. By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE OF PATIENT/LEGAL REP: _____ DATE: _____
(If signed by other than the patient, state relationship with signature)