NASHVILLE
HIP INSTITUTE
PRESERVATION, RECONSTRUCTION
& SPORTS MEDICINE

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Personal Information

Today's Date: _____ Account #: _____ SSN: _____
First Name: _____ MI: _____ Last Name: _____
Address: _____ Apt./Suite: _____
Zip: _____ City: _____ State: _____
Date of Birth: _____ Age: _____ Marital Status: _____ Sex: _____
Home Phone: _____ Cell Phone: _____
May we leave info. on your voicemail? ☐Yes ☐No
Email Address: _____ May we email you? ☐Yes ☐No
Occupation: _____ Work phone: _____
Employer: _____ Full Time Student ☐Yes ☐No

In the event of an emergency, please contact:

Name: _____ Relationship: _____ Phone No: _____
Minor Patients: Name of Parent/Guardian _____
Who referred you? Physician Family Friend Internet Insurance Co. Other_____
Referring Physician's Name: ___ _____ Phone No: _____
Address: _____

Insurance Information

Please present your insurance card(s) to the receptionist. Please give complete information.

Primary Insurance: _____ Insured's Name: _____
Patient's relationship to insured: ☐Self ☐Spouse ☐Child ☐Other
Policy #: _____ Group #: _____
Employer: _____ SSN: _____ DOB: _____
Secondary Insurance: _____ Insured's Name: _____
Patient's relationship to insured: ☐Self ☐Spouse ☐Child ☐Other
Policy #: _____ Group #: _____
Employer: _____ SSN: _____ DOB: _____

NOTICE REGARDING INSURANCE CLAIMS/PAYMENTS:

If we are filing insurance for your visit, we must have complete information and any required referral at the time of the visit. If you cannot provide the information, we will be unable to file your insurance, and payment in full will be required.

Payment of your charges cannot be determined until the claim is submitted to your insurance company. Payment will be based on your individual health plan, and the amount applied to your plan deductible and/or coinsurance will be your responsibility. Procedures that are excluded from coverage, based on your plan's determination of medical necessity, will also by your responsibility. Your office visit co-pay is due at the time of the visit and, in many cases, covers only the office visit charge. Any procedures performed will be considered surgery by your insurance company, and deductibles and coinsurance may apply.

For all other patients, payment is required at the time of service. We will provide you with the necessary documentation to file for reimbursement upon your request.

I have read the above information and understand that I am responsible for payment for services I receive.

Patient/Guardian Signature: _____ Date: _____