Dear Patient:

Thank you for choosing Gotham City Sports Medicine, PLLC. To provide outstanding patient care, we ask that all patients take the time to complete the attached forms which include information that will allow us to accurately process your demographic, insurance information and patient history. Any incorrect or illegible information provided may cause delay and/or errors in your insurance billing. If you need assistance or have any questions regarding the attached paperwork, our Patient Registration Specialists will be more than happy to assist you.

We thank you for choosing Gotham City Sports Medicine, PLCC, where every patient is treated like an MVP.

Sincerely,

The Management and Staff of
Gotham City Orthopedics

Visit our website at www.gothamcityorthopedics or follow us on Facebook for up-to-date information.

Today's Date: _____

Name: _____
Last Name First Name MI

Address: _____
Street Apt. #

_____
City State Zip

Marital Status: [ ]Single [ ]Married [ ]Widowed [ ]Divorced [ ]Domestic Partnership [ ]Separated

Date of Birth: _____ Age: _____ Sex: [ ] M [ ] F

Social Security #: _____ Email Address: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Occupation: _____

Emergency Contact: _____
Name Phone

Ethnicity: _____ Race: _____ Preferred language: _____

Pharmacy Name and Address: _____

Pharmacy Phone Number: _____

Referring Doctor: _____ Primary Care Doctor: _____

What body part(s) are you being seen for?_____

Primary Insurance: _____ Secondary Insurance: _____

Subscriber's Name: _____ Subscriber's Name: _____

Subscriber's DOB: _____ Subscriber's DOB: _____

Relationship to Patient: _____ Relationship to Patient: _____

Subscriber's SSN: _____ Subscriber's SSN: _____

ID#: _____ ID#: _____

Copay: _____ Copay: _____

Is this visit the result of?: [ ]Auto Accident [ ]Work Injury [ ]School Injury **If yes, please complete page 2.**

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Gotham City Orthopedics or insurance company to release any information required to process my claim.

_____ _____ _____
Patient/Guardian Signature Print Name of Patient/Guardian Date

If you answered yes to an auto accident, work injury or school injury, you MUST complete the following:

Please describe in detail how the accident or injury occurred including from date of injury and progression of symptoms: _____

_____

Are you currently working? [ ] Yes [ ] No [ ] Retired [ ] Disabled [ ] Student

Were you working at the time of the injury/accident? [ ] Yes [ ] No

If yes, who were employed by: _____ And, occupation: _____

Address and Phone #:_____

What body part(s) was/were injured at the time of injury/accident?: _____

Please list work restrictions, if any (ex. Lifting, prolonged sitting, etc.) _____

_____

Present Occupation: _____

Present Employer: _____

Workers' Comp/No Fault Carrier:

_____ Date of Accident:

_____ State where accident occurred: _____ Policy Holder:

_____

WCB Case #: _____ Claim #: _____

Adjuster's Name: _____ Phone #: _____

Adjuster's Address: _____ Fax #: _____

_____

Attorney's Name: _____ Phone #: _____

Fax #: _____

School Insurance Plan: [ ] Yes [ ] No

School Name and Address: _____

Legal Assignment of Benefits & Designation of Authorized Representative

I, the undersigned, represent that I have valid and in-force insurance and/or employee healthcare benefits coverage, and hereby assign and convey directly to **Gotham City Sports Medicine, PLLC and all medical professionals, including physician assistants of this practice, including, but not limited to [Sean Lager, MD, F.A.A.O.S, Andrew Farber, DO, Sarah Weinmann, PA-C, and Jennifer Arapian, PA-C** (the "provider(s)") as my Statutory Derivative Beneficiary (SDB), commonly known as an Designated Authorized Representative, and a Claimant under the "Patient Protection and Affordable Care Act" (PPACA), existing ERISA and other applicable federal and state laws, of all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from the provider(s), regardless of the provider's managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the provider(s) to release all medical information necessary to process my claims under HIPAA.

I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to the Designated Authorized Representative(s) any and all plan documents, including Governing Plan Documents, including, but not limited to a written explanation of how level of benefit payments are determined for out-of-network providers, Summary Plan Description, 5500 Form (Plan Annual Return), Certificate for PPACA Grandfathered Health Plan, where applicable, insurance policy and/or settlement information upon written request from the Designated Authorized Representative(s) in order to claim certain medical benefits in connection for healthcare services provided to the undersigned. This, includes, but is not limited to, receiving disbursement benefit checks for claims submitted, member's rights to appeal claim denials, as well as to claim any applicable statutory penalties on behalf of the plan participant and beneficiary. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the Designated Authorized Representative(s) to the full extent permissible under the law and under any applicable employee group health plan(s), insurance policies or liability claim, any claim, cause of action, or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s) under any applicable insurance policies, employee benefits plan(s) or public policies with respect to medical expenses incurred as a result of the medical services I received from the provider(s), and to the full extent permissible under the law to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but not limited to, (1) obtaining information about the claim to the same extent as the assignor, including, but not limited to, issuance of reimbursement checks, Explanation of Benefits and any/all correspondence related to claims reimbursement; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by the Designated Authorized Representative(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, to bring suit by the Designated Authorized Representative(s) against any such liable party or employee group health plan in my name with derivative standing but at such Designated Authorized Representative(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original.

I have read and fully understand this agreement.

_____	_____	_____
Patient/Guardian Signature	Print Name of Patient/Guardian	Date

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__ Limited Power of Attorney

I do not believe my employee health benefits plan would prohibit this assignment, but should same be the case or should my assignment be challenged or deemed invalid, I execute this limited/special power of attorney and appoint and authorize your collection attorney as my agent and attorney-in-fact to collect payment for your medical services directly against the carrier in the case, in my name, including filing an arbitration demand or lawsuit. I specifically authorize that attorney to file directly against that carrier in my name or in your name as a medical provider rendering services to me and designate your collection attorney as my attorney in fact. I further grant limited power of attorney to you as my medical provider to receive and collect directly from the insurance carrier money due you for services rendered to me in this matter, and hereby instruct the insurance carrier to pay you directly any monies due you for medical services you rendered to me. I authorize you and or your attorney to receive from my insurer, immediately upon verbal request, all information regarding last payment made by said insurer on my claim, including date of payment and balance of benefits remaining. **Initials**_____

Medical Records Authorization

I authorize you and or your attorney to obtain medical information regarding my physical condition from any other healthcare provider, including hospitals, diagnostic centers, etc., and I specifically authorize such health care provider(s) to release all such information to you about me, including medical reports, x-ray reports, narrative reports and any other report or information regarding my physical condition**. Initials**_____

AUTHORIZATION TO RELEASE INFORMATION

Date: _____

Patient's Name: _____
(please print)

I hereby authorize Gotham City Sports Medicine, PLLC and its associates to provide treatment and or examination and release any information pertinent to my case in the course of my examination or treatment to my physician, insurance company, adjuster or attorney if applicable in this case.

I hereby authorize Gotham City Sports Medicine, PLLC to obtain any medical information from my referring physician including, but not limited to, clinical history and office notes.

_____
Patient/Guardian Signature

_____
Print Name of Patient/Guardian

_____
Date

Thank you for your cooperation.

Gotham City Sports Medicine, PLLC

Financial Policy

The surgeons, physicians and staff at our offices are dedicated to providing you with the best possible treatment, care and service, and regard your understanding of, and agreement with, our financial policies as an essential element of your care and treatment. If you have any questions, please feel free to discuss them with our staff.

Unless other arrangements have been made by yourself or your health coverage carrier, full payment of what, if anything, is due, will be payable at the time of service. For your convenience, **we accept cash, checks, Visa, MasterCard, Discover American Express and Care Credit**.

To ensure that you are qualified to be able to make payment arrangements of balances owed to *Gotham City Sports Medicine, PLLC.* you hereby authorize

the practice to check your credit and employment history and to answer any questions about *Gotham City Sports Medicine, PLLC's* credit history with you. I **AGREE THAT *GOTHAM CITY SPORTS MEDICINE, PLLC* WILL RETAIN MY CREDIT CARD INFORMATION UNTIL ANY UNPAID BALANCES OWED IS PAID. This will stay in effect until written notice is given. Any payments made by check and returned by the bank for any reason, will incur a fee of $30.00.**

Your Insurance Plan

If *Gotham City Sports Medicine, PLLC* participates with your insurance, the fees for our services will be billed to your insurance plan provided the procedure or treatment you are receiving is considered medically necessary. However, you will be responsible for the payment of your innetwork deductible, co-payments and/or co-insurance no later than at the time of treatment. These fees are mandated by your insurance carrier and cannot be waived. **We accept cash, checks, Visa, MasterCard, Discover, American Express and Care Credit**. Payment is required at time of service.

In the event your health plan determines a service /treatment to be "not covered"; you will be responsible for the services rendered. Patients will receive a statement via mail. Payment is expected within 30 days from receipt of statement.

There are other instances where some insurance plans will send a payment directly to you. If you receive payments for the services you received, you are responsible for forwarding that payment directly to *Gotham City Sports Medicine, PLLC*. It is your responsibility to ensure the practice is paid the amount that has been sent to you plus any remaining balance. Be advised that not remitting such payment to *Gotham City Sports Medicine, PLLC* constitutes a breach of contract and an illegal, criminal conversion of funds not belonging to you and *Gotham City Sports Medicine, PLLC* will pursue all legal and criminal remedies available to it to obtain such payment.

Minor Patients

For all services rendered to minor patients, the adult accompanying the minor patient is responsible for payment.

Missed Appointment & Return Check Fee

In order to provide the best possible service and availability to all our patients, it is Gotham City Sports Medicine, PLLC's policy to charge a $25.00 fee for any missed or cancelled appointments without 24 hour advanced notice. Please contact us as soon as possible if you are unable to keep your appointment. **Any payments made by check and returned by the bank for any reason, will incur a fee of $30.00.**

Collection Accounts

All past due accounts with outstanding balances, including payments owed to Gotham City Sports Medicine, PLLC for services rendered, sent to the patient directly, will be submitted to our collection agency/legal firm for collection. Those collection fees, legal fees, court costs as well as interest accruing from the date of service will be your responsibility.

Disability & FMLA Forms

Forms will be processed in 7-10 business days and may require a fee for processing. Please ask the receptionist for more information

I have read and understand the financial policy of Gotham City Sports Medicine, PLLC and I agree to be bound by its terms.

_____	_____	_____
Patient/Guardian Signature	Print Name of Patient/Guardian	Date

Personal Release of Medical Information

Date: _____

Patient Name: _____
(please print)

D.O.B.: _____ SS #: _____-_____-_____

I would like to give Gotham City Sports Medicine, PLLC authorization to release my health/ billing information to all of the following parties listed below: (Please exclude Physicians. This is strictly for any of your family members or friends whom you entrust with your healthcare information.)

	Name	D.O.B	Relationship
1.	_____	_____	_____
2.	_____	_____	_____

If you Do Not wish to list or release any of your private healthcare information, please check NA box below:

Not Applicable: ☐

Patient/Guardian Name: _____
(please print)

Patient/Guardian Signature: _____

Witness Signature: _____

CREDIT CARD AUTHORIZATION FORM

Gotham City Sports Medicine, PLLC requires keeping your credit or debit card information on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. **All patients are required to complete this form.** Your credit card information is kept confidential and only authorized staff will have access to the information. Payments to your credit card are processed only after the claim has been filed and processed by your insurer and the insurance portion of the claim has been paid and posted to the account.

_____MasterCard _____Visa _____Amex _____Discover _____Debit

Card Number: _____ Expiration Date: _____ Security

Code on Card: _____

Name **(Print Full Name As It Appears On Card):** _____

Billing Address: _____

City/ Sate/ Zip: _____

Telephone: ( ) _____-_____ Cell: ( ) _____-_____

Email: _____

I, the undersigned, authorize and request Gotham City Sports Medicine, PLLC to charge my credit card, indicated above, for the remaining balance due for services rendered that my insurance company identifies as my financial responsibility.

Signature of card holder: _____

Patient/Guardian Name: _____
(please print)

Patient/Guardian Signature: _____

Date: _____

[ ] DECLINED _____(initials)