Fair Oaks Orthopaedic Associates, Inc.

Brent R. Ain, MD
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Patient Name (Last, First, MI)							
Home Address			City		State	Zip	Phone #
SSN	DOB	Sex	Age	Marital Status		Email	
Employer		Occupation				Work #	
Referring Physician		Primary Care Physician				Cell #	
Emergency Contact Information							
Name			Phone#				Relationship
Address			City		State		Zip
Primary Insurance Information							
Insurance Company							
Insurance Company Address							Phone#
Subscriber's Name			DOB		SSN		Relationship
ID#				Group#			Effective Date
Secondary Insurance Information							
Insurance Company							
Insurance Company Address							Phone#
Subscriber's Name			DOB		SSN		Relationship
ID#				Group#			Effective Date

PATIENT AUTHORIZATION

- I, ____ hereby authorize Fair Oaks Orthopaedic Associates, Inc., to apply for benefits on my behalf to my primary and/or secondary health insurance carrier(s) for covered services rendered by Fair Oaks Orthopaedic Associates, Inc. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information, for this or any related claim, the above named billing agent and/or other insurance carrier. I permit a copy of this authorization to be used in place of the original.
- I understand that I am ultimately responsible for my bill and that Fair Oaks Orthopaedic Associates, Inc. has no control or authority over my insurance company. In the event of insurance claim denial or payment delay, I will be responsible for payment of all charges incurred. If my account is turned over to a collection agency I will be responsible for the balance due, plus and collection and court costs incurred.
- Cancellation policy: There is a $50 fee for appointments not cancelled at least 24 hours in advance. This fee is not billable to your health insurance and is your responsibility.

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Patient/Guarantor Signature Date