



M.O.S.T.

Metro Orthopedics & Sports Therapy

James E. Gilbert, M.D.
Phillip H. Omohundro, M.D.
Joseph A. Shrout, M.D.
Eran Kessous, M.D.
Teresa Koebel, P.A.-C.
Barry Thompson, P.A.-C.

PLEASE COMPLETE ALL PAGES AND HAVE YOUR INSURANCE CARD(S) AND DRIVERS LICENSE READILY AVAILABLE WHEN SUBMITTING THIS FORM. PLEASE PRINT.

PERSONAL INFORMATION

Today's Date: ___/___/___ Acct# _____ SSN#: ___-___-___ Driver Lic#: _____

Patient Name _____ Mr. Mrs. Ms. Dr.
First M Last (Please circle)

Home Address: _____
Number Street Name Apt#

City State Zip code Home phone# Cell Phone#

Date of Birth: ___/___/___ Age: ___ Sex: M F Occupation: _____

Status: Single Married Separated Divorced Widowed

Email _____

Employer: _____ Phone#: (____) _____ - _____

Number/Street City State Zip Code

INSURANCE INFORMATION

Responsible Party: _____ Mr. Mrs. Ms. Date of Birth: ___/___/___

Address: (if different from patient) _____
Number/Street City State Zip Code

Relationship to patient: Parent Legal Guardian Spouse

Home: (____) _____ - _____ Work: (____) _____ - _____

Cell: (____) _____ - _____ SSN#: ___-___-___

Method of payment: Cash Check Credit Card

Primary Insurance _____ Address _____
Phone#: (____) _____ - _____

Policy Number _____ Group _____

Subscriber Name _____ Date of Birth: ___/___/___

Relation to Patient _____ SSN#: ___-___-___

Secondary Insurance _____ Address _____
Phone#: (____) _____ - _____

Policy Number _____ Group _____

Subscriber Name _____ Date of Birth: ___/___/___

Relation to Patient _____

Please check if applicable: Workers Comp Auto Accident Other Liability

Lawyer or contact person (if applicable): _____ Phone#: (____) _____ - _____



M.O.S.T.

Metro Orthopedics & Sports Therapy

James E. Gilbert, M.D.
Phillip H. Omohundro, M.D.
Joseph A. Shrout, M.D.
Eran Kessous, M.D.
Teresa Koebel, P.A.-C.
Barry Thompson, P.A.-C.

Workers Comp. Claim Number: _____

Have you filed a personal injury protection (PIP) for this injury: Yes No (please circle)

What is the reason for today's visit? _____

History of present illness:

Location of symptoms? _____ [] Left [] Right

Date symptoms started? _____

How symptoms/injury occurred? _____

Severity of symptoms (scale 1-10, 10 being worse) _____

What has made symptoms better or worse? _____

Height: _____ (ft) _____ (in) Weight _____ (lbs)

Name of your regular physician: _____ Tel# (____) _____ - _____

Address: _____

Number/Street City State Zip Code

Person to contact in case of emergency _____ Phone 1: (____) _____ - _____

Phone 2: (____) _____ - _____ Relationship: _____

Address: _____

Number/Street City State Zip Code

Pharmacy Preference: _____

Fax: (____) _____ - _____ Phone: (____) _____ - _____

Responsible Party: _____

Address: (if different from patient) _____

Number/Street City State Zip Code

Relationship to patient: [] Parent [] Legal Guardian [] Spouse [] Other

Home: (____) _____ - _____ Work: (____) _____ - _____ Cell: (____) _____ - _____

Section Optional

Ethnicity: _____

Race: _____

Preferred Language: _____

How did you find out about us? _____

What sports do you currently participate in? _____

How many days/week do you participate in sports? _____

Please note: If prescribed a therapy program, it may include strenuous exercise. If you have any concerns about starting an exercise program, please inform us and check with your regular physician.

PHYSICIANS SIGNATURE: _____



M.O.S.T.

Metro Orthopedics & Sports Therapy

James E. Gilbert, M.D.
Phillip H. Omohundro, M.D.
Joseph A. Shrout, M.D.
Eran Kessous, M.D.
Teresa Koebel, P.A.-C.
Barry Thompson, P.A.-C.

PAYMENT RESPONSABILITY

I understand that I have a personal and primary obligation to pay for all medical services when rendered and I agree to pay all bills promptly. I further understand that although Metro Orthopedics & Sports Therapy may submit a bill to my insurance company for payments as a service to me, that service does not relieve me of my personal responsibility to ensure that the insurance company makes payment according to the terms of my policy. I am aware that insurance payment/reimbursement may not cover the total balance due for the medical services I received. I agree to pay any outstanding on my account, if such action is deemed necessary. In addition, I agree to pay interest (at 1 1/2 % per month) on my outstanding account balance if this balance extends beyond thirty (30) days of receipt of my bill. I agree to pay any additional fees and/or costs incurred in order to collect payments on my account(s). I waive my rights under Maryland's statute of limitation should reconciliation of my account extend beyond three (3) years from date of service.

Patient/Responsible party signature: _____ Date: _____

INSURANCE AUTHORIZATION

AUTHORIZATION OF ASSIGNMENT:

I hereby authorize Metro Orthopedics & Sports Therapy to apply for benefits from my insurance company on my behalf for covered services by Metro Orthopedics & Sports Therapy. Finally, I authorize the release of any medical or other information necessary to process claims submitted to my insurance company.

Patient/Responsible party signature: _____ Date: _____

AUTHORIZATION OF PAYMENT:

I authorize payment to be made directly to Metro Orthopedics & Sports Therapy.

Patient/Responsible party signature: _____ Date: _____

MEDICARE INSURANCE ONLY

I HEREBY AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS, ANY INFORMATION NEEDED TO DETERMINE THE BENEFITS PAYABLE FOR RELATED SERVICES. I ALSO AUTHORIZE M.O.S.T. AND DR.S' GILBERT & OMOHUNDRO P.A. TO INVESTIGATE THE NON-PAID STATUS OF MY ACCOUNT WITH MEDICARE.

Patient/Responsible party signature: _____ Date: _____



M.O.S.T.

Metro Orthopedics & Sports Therapy

James E. Gilbert, M.D.
Phillip H. Omohundro, M.D.
Joseph A. ShROUT, M.D.
Eran Kessous, M.D.
Teresa Koebel, P.A.-C.
Barry Thompson, P.A.-C.

PAYMENT RESPONSABILITY

Please be advised that we have found that most insurance carriers have limited or no benefits for durable medical equipment (slings, braces, orthotics, etc). Therefore we must collect from you the fee for the equipment at the time of service. Custom made braces are partially covered by some insurance carriers. At the time of measuring you for the custom made brace, we will contact your insurance carrier to verify coverage and give you an estimate of your responsibility.

Thank you for your cooperation. X _____ (Please Initial)

NO RETURNS POLICY: If I receive any durable medical equipment (slings, braces, orthotics, etc) I understand that MOST will replace any product for manufacturer's defect within 30 days from receipt of the product. I also understand that once I accept the product, as a medical product, it cannot be returned to MOST for credit, exchange, or refund.

Patient/Responsible party signature: _____ Date: _____



**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF
PRIVACY PRACTICES**
(TO BE FILED IN CHART)

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Signed: _____ Date: ____/____/____

Print Name: _____

Relationship (if not signed by patient) _____

I wish to place the following restrictions on disclosure of my health insurance:

{Internal Use Only}

Patient/Patient Representative Refuses to sign acknowledgement, place document date and time notice was presented to patient and sign below.

Presented: Date ____/____/____ Time: _____am/pm

Office Representative: _____ Title: _____