HEIDI M. HULLINGER, M.D., P.C.
Orthopaedic Spine Surgeon
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1. Patient Information

please print clearly and complete ALL fields

Name: _____ Social Security No: ___ - ___ - ___

Date of Birth: _____ Sex: ☐ Male ☐ Female Marital Status: _____

Address: _____ City, State, Zip: _____

Home phone: (___) _____ Cell: (___) _____ Work: (___) _____ Ext. _____

Email: _____ Personal info. ☐ may ☐may not be sent to this e-mail

Family Physician: _____ Phone: (___) _____

Address: _____ City, State, Zip: _____

Referred by: _____ Address: _____

City, State, Zip: _____

Patient Employer: _____ Occupation: _____ Phone: (___) _____

Employer Address: _____ City, State, Zip: _____

Spouse's Name: _____ Spouse's Employer: _____

Employer Address: _____ City, State, Zip: _____

Spouse's Work Phone: Work: (___) _____ Ext. _____ Spouse's Date of Birth: _____

Party response for Payment (if minor): _____ Relationship to patient: _____

Address: _____ City, State, Zip: _____

Injury/accident: ☐ yes ☐ no (If yes check one and complete #3 below): ☐ motor vehicle ☐ work-injury ☐ other

Date of Injury or Onset of Problem: _____ Injury Location: _____

Reason for Visit: Major Complaint/Injury details: _____

_____

2. Insurance Information

Insurance Company: #1 _____ # 2 _____

Address: _____ _____

City, State, Zip: _____ _____

Member ID: _____ _____

Group/Plan #: _____ _____

Subscriber's name: _____ _____

Subscriber's Date of Birth: _____ _____

Relationship to patient: _____ _____

3. Work/Auto Related Injuries

For Work or Auto Related Injuries Only

Insurance Company: _____ Claim Number: _____

Address: _____ City, State, Zip: _____

Insurance Phone #: (___) _____ Insurance Contact person: _____

Was work injury reported to employer? ☐ yes ☐ no If so, to whom? _____

4. In Case of Emergency

Name of Friend or Relative not living with you (other than spouse): _____

Address: _____ City, State, Zip: _____

Home phone#: (___) _____ Work#: (___) _____ Ext. _____ Cell#: (___) _____

Please complete the reverse side of this form

5. Medication Allergies

☐ I do not have any medication allergies that I know of.

Please list all medication allergies:

_____ _____

_____ _____

_____ _____

_____ _____

Treatment Authorization

Personal information ☐ may be ☐ may not be left on my ☐ home phone ☐ cell phone

I authorize the release of my personal information to the following individual(s): _____

_____

I hereby authorize **Heidi M. Hullinger, M.D., P.C.** to furnish any designated insurance company all information necessary to file an insurance claim.

Legal Assignment Of Benefits And Release Of Medical And Plan Documents

I have provided complete and accurate demographic and insurance information, allowing **Dr. Heidi M. Hullinger** to act as my billing agent for services rendered. In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to **Heidi M. Hullinger, MD, PC** all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments which I am entitled to, including: Medicare, other government sponsored programs, private insurance, personal injury protection, workman's compensation, and any other insurance plans to **Heidi M. Hullinger, MD, PC**. I hereby authorize the doctor to release all medical information necessary to process this claim and all claims associated with his care whether or not billed directly by him. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan, please advise and disclose to my provider in writing such anti-assignment provision within 30 days upon receipt of my assignment, otherwise this assignment should be reasonably expected to be effective and such anti-assignment is waived.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Arbitration

I authorize **Dr. Heidi M. Hullinger** to arbitrate any Personal Injury protection (PIP) insurance based denials of coverage/claims on my behalf and to release all pertinent medical records required to pursue such arbitration.

I certify that I have read the foregoing information and understand the above contents.

I understand that I am financially responsible for all charges whether or not paid by my insurance company.

Signature of Insured or Guardian: _____

Date: _____