



**Insurance/Billing Information**

Will this visit be covered under Workers Compensation or Motor Vehicle/Liability Insurance?  YES  NO  
Do you have Insurance?  YES  NO

If YES, please complete insurance information below:

**Primary Insurance Company:** \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_  
Insured Name: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_ Employer: \_\_\_\_\_  
Insurance Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Insurance Phone Number: \_\_\_\_\_

**Secondary Insurance Company:** \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_  
Insured Name: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_ Employer: \_\_\_\_\_  
Insurance Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Insurance Phone Number: \_\_\_\_\_

**Authorizations (HIPAA law makes it illegal for information to be released without the Patient's written authorization.)**

I authorize Denali Orthopedic Surgery, P.C. to discuss billing/medical information with the individual below:

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

I authorize the below individual to be present in the exam room while I am being treated and care is discussed:

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

I authorize Denali Orthopedic Surgery, P.C. to release medical information to my child's school nurse at:

\_\_\_\_\_  
Name of School (Minors Only)

\_\_\_\_\_  
**Signature** **Date**

If signed by someone other than the patient, please state relationship: \_\_\_\_\_

**Notice of Billing / Collection Policy / Authorization for Treatment / Privacy Practices**

I have been provided a copy of Denali Orthopedic Surgery's financial policy which outlines their billing/collection procedures. I authorize all proceeds from insurance to be assigned to this office where applicable. I confirm that the information I have provided is true to the best of my knowledge. Additionally, I authorize treatment of the named patient contained in this registration packet.

I understand that Denali Orthopedic Surgery, P.C. may share my health information for treatment, billing, and healthcare operations. I have been given a copy of the practice's Notice of Privacy Practices that describes how my health information is used and shared. I understand that Denali Orthopedic Surgery, P.C. has the right to change this notice at any time. I may obtain a current copy by contacting the office, or the Privacy Officer/Practice Manager.

\_\_\_\_\_  
**Signature** **Date**

If signed by someone other than the patient, please state relationship: \_\_\_\_\_