

TRENTON ORTHOPAEDIC GROUP, PA
1225 WHITEHORSE-MERCERVILLE ROAD, BLDG. D, SUITE 220, MERCERVILLE, NJ 08619
116 WASHINGTON CROSSING ROAD, PENNINGTON, NJ 08534
PHONE (609)581-2200 FAX (609)581-1212

DATE _____

Acknowledgement of Receipt of Notice of Privacy Practices.

I, _____, (Patient Name) have received the Notice of Privacy Practices from Trenton Orthopaedic Group.

Signature _____ Date _____

In Lieu of patient signature, I _____ a staff member of Trenton Orthopaedic Group, state that the Patient listed below has been given our current Notice of Privacy Practices.

Staff Signature _____ Date _____

LAST NAME	
FIRST NAME	
MIDDLE NAME	
GENDER	MALE FEMALE
PREVIOUS LAST NAME	
DATE OF BIRTH	
SOCIAL SECURITY #	
ADDRESS	
ADDRESS LINE 2	
ZIP	
CITY	
STATE	
HOME PHONE	
WORK PHONE	
MOBILE PHONE	
MARITAL STATUS:	S M W D SEP

EMERGENCY CONTACT NAME	
EMERGENCY CONTACT RELATION	
EMERGENCY CONTACT PHONE	
PATIENT'S EMPLOYER NAME	
PATIENT'S EMPLOYER PHONE	
PATIENT'S RELATIONSHIP TO GUARANTOR	SELF CHILD SPOUSE OTHER
GUARANTOR INFORMATION (Name to whom statements should be sent)	
GUARANTOR'S LAST NAME	
GUARANTOR'S FIRST NAME	
GUARANTOR'S MIDDLE NAME	
SAME ADDRESS AS PATIENT	YES NO
IF ANSWERED "NO" ABOVE please complete items 1-5 below	
1. GUARANTOR ADDRESS	
2. GUARANTOR ADDRESS LINE 2	
3. GUARANTOR ZIP	
4. GUARANTOR CITY	
5. GUARANTOR STATE	

PLEASE COMPLETE INSURANCE INFORMATION ON NEXT PAGE

PATIENT SIGNATURE _____

NAME (LAST, FIRST):	
PRIMARY INSURANCE POLICY INFORMATION	
INSURER	
PATIENT'S RELATIONSHIP TO POLICY HOLDER	SELF CHILD SPOUSE OTHER
ID/CERTIFICATION NUMBER	
POLICY/GROUP NUMBER	
REFERRING PROVIDER	
PHYSICIAN NAME	
PHONE	
PRIMARY CARE PHYSICIAN (PCP)	
Please complete if different then "Referring Physician"	
PCP NAME	
PHONE	

ATHENA ID #	TOG CHART #	
PRIMARY POLICY HOLDER (IF NOT SELF)		
LAST NAME		
FIRST NAME		
MIDDLE NAME		
ADDRESS		
ADDRESS LINE 2		
ZIP		
CITY		
STATE		
SOCIAL SECURITY #		
DATE OF BIRTH		
GENDER	MALE	FEMALE
EMPLOYER		

SECONDARY INSURANCE POLICY INFORMATION	
INSURER	
PATIENT'S RELATIONSHIP TO POLICY HOLDER	SELF CHILD SPOUSE OTHER
ID/CERTIFICATION NUMBER	
POLICY/GROUP NUMBER	

SECONDARY POLICY HOLDER (IF NOT SELF)		
LAST NAME		
FIRST NAME		
MIDDLE NAME		
ADDRESS		
ADDRESS LINE 2		
ZIP		
CITY		
STATE		
SOCIAL SECURITY #		
DATE OF BIRTH		
GENDER	MALE	FEMALE
EMPLOYER		

Please Note: All charges are payable at the time of service.

Charges for professional services are the responsibility of the patient regardless of insurance coverage. Past due balances are subject to a service charge of 1% per month.

Insurance Authorization Assignment

I hereby authorize payment from my insurance company for services rendered to be sent directly to Trenton Orthopaedic Group, P.A. If payment is not made at the time of service, I also authorize the release of medical or incidental information to my insurance company concerning my treatment. Further, by affixing my signature below I assign Trenton Orthopaedic Group the right to appeal insurance claims on my behalf. I certify that the attached information given by me is correct. I understand that I am responsible to comply with my insurance company's policy and procedures and are responsible for any amount not covered by insurance. This may include services denied or deemed non-covered by my insurance company.

Signature _____

Date _____

Please be advised a phone call will be placed to the patient's home phone number listed above to confirm appointments.

Please check box if you object to this reminder or please provide alternative phone number for confirmations: _____