CHARLOTTESVILLE ORTHOPAEDIC CENTER
Innovation that moves you

David Nielsen, D.O.
Board-certified Orthopaedic Surgeon
Fellowship-trained in Upper Extremity
Certificate of Added Qualification (CAQ): Hand Surgery

183 Spotnap Road, Suite C | Charlottesville, VA 22911 | 434-244-8412 | www.cvilleortho.com

PATIENT INFORMATION

Patient's last name:	First:	Middle	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid / Partner
Birth date: / /	Age:	Social Security no.:	Sex: ☐M ☐F		Home phone no.: ( )
Physical address:		Email Address:			Cell Phone: ( )
P.O. box/Mailing (if different):		City:	State:		ZIP Code:
PCP/Family Doctor:		Is this visit result of an injury? Y or N ☐ ☐			Date/Time of injury_____

INSURANCE/PAYMENT INFORMATION

Is this patient covered by insurance? ☐ Yes ☐ No

Person responsible for bill: ☐Self	Birth date: / /	Address (if different):	
Home phone no.: ( )	Work no: ( )	Cell No: ( )	Is this person a patient here? ☐Yes ☐No

(Please give your insurance card to the receptionist.)

Primary insurance:	Policy no.:	Group no.:	
Subscriber's name: ☐Self	Subscriber's S.S. no.:	Birth date: / /	Patient's relationship to subscriber: ☐Self ☐Spouse ☐Child ☐Other
Secondary insurance:	Policy no.:	Group no.:	
Subscriber's name: ☐Self	Subscriber's S.S. no.:	Birth date: / /	Patient's relationship to subscriber: ☐Self ☐Spouse ☐Child ☐Other

WORKCOMP Patients (You must have proper written authorization or you may be considered a selfpay patient.)

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

Authorization for Treatment, Release of Information, Insurance Authorization and Assignment & Financial Agreement

I hereby authorize treatment. I authorize Charlottesville Orthopaedic Center to furnish to insurance carriers any medical information necessary to process my claims. I hereby assign to Charlottesville Orthopaedic Center all payments, for medical good/services rendered to myself or my dependents. I understand that I am responsible for payment of any amount not covered by insurance. **AFTER INSURANCE PAYMENT IS RECEIVED, I AUTHORIZE CHARLOTTESVILLE ORTHOPAEDIC CENTER TO BILL ANY REMAINING BALANCE TO THE CREDIT CARD I PRESENT AND TO MAIL ME A RECEIPT.** I understand that an additional amount of 1% interest will be added to patient balances 30 days or more past due. I agree to reimburse the fees of any collection agency, equaling 30% of the debt, and all costs and expenses, including reasonable attorney's fees, incurred in such collection efforts. I hereby acknowledge responsibility for obtaining any referrals needed. I authorize Charlottesville Orthopaedic Center to download my medication history automatically from pharmacy benefit managers. I consent to receive reminders/messages regarding my care by way of phone call, text, or email.

Patient or Guardian signature *Date*