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 every 30 days or more past due. I agree to reimburse any collection agency and legal fees. I acknowledge that if do not provide a 24-hour cancellation notice for a scheduled appointment, I may be charged a $50 No-Show fee. 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*