

WELCOME TO OUR OFFICE!



Channappa Chandra, M.D.
Robert C. Coddington, M.D.
Mark G. Freeman, M.D.

How did you learn about our practice? _____

Name: _____ Today's Date: _____

First Middle Last

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Birthdate: _____ Age: _____ SSN: _____

Employer: _____ Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Work Phone: _____ ext. _____

COMPLETE THIS SECTION ONLY IF FINANCIAL RESPONSIBLE IS OTHER THAN PATIENT.

Responsible Party Name: _____ Relationship: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Work Phone: _____ ext. _____

In Case of Emergency, contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Financial Responsibility Agreement:

Patients must provide accurate and up to date insurance information to ensure proper filing; otherwise the bill will become the patient's responsibility. Our office will file insurance for all reimbursable services however our policy requires that you pay fees due today, including co-payments, deductibles, and fees not covered by your insurance plan. I authorize the release of medical or other information about me to the above listed insurance provider(s) in order to process my claim. I authorize the payment of medical and surgical benefits to Orthopaedic Institute of Chattanooga. Accounts should be paid within 60 days of date of service to prevent further action. I/we agree to pay any collection or attorney fee owed in addition to court costs if charges are not paid.

Medicare: I/we authorize Medicare to furnish OIC any information regarding my medicare claim under Title XVIII of the Social Security Act. I also request payment of authorized Medigap benefits be made on my behalf to OIC for any services furnished me by our physicians.

Date: _____ Signature: _____