



# Sports Medicine and Orthopaedic Center

Today's Date \_\_\_\_\_

## Confidential Patient Information

Patient's Name: \_\_\_\_\_ DOB \_\_\_\_\_ AGE \_\_\_\_\_  
(Last Name First)

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone # (H) \_\_\_\_\_ (W) \_\_\_\_\_ Soc Sec.# \_\_\_\_\_

Place of Birth: \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_ Marital Status: M S W D

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
(Name) (Address)

Referred By: \_\_\_\_\_  
(Name) (Address)

Primary/Family Physician: \_\_\_\_\_  
(Name) (Address) (Tel #)

NJ Driver's Lic # \_\_\_\_\_

How did you hear about Dr. Rizio?

\_\_\_\_ Physician Referred Physician Name: \_\_\_\_\_

\_\_\_\_ Athletic Trainer Trainer's Name: \_\_\_\_\_

\_\_\_\_ Dr. Rizio's Website \_\_\_\_\_ Insurance Book \_\_\_\_\_ Friend

---

Insured's Name: \_\_\_\_\_ Insured's DOB: \_\_\_\_\_ Insured's SS# \_\_\_\_\_

Insured's Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Tel # \_\_\_\_\_

---

## Insurance Information

Primary Ins: \_\_\_\_\_ Address: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_ Medicare # \_\_\_\_\_

Insured DOB \_\_\_\_\_ Insured's SS # \_\_\_\_\_

Secondary Ins: \_\_\_\_\_ Address: \_\_\_\_\_

ID # \_\_\_\_\_ Group #: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**Automobile Or Other Accident Related Injury**

Date of Accident: \_\_\_\_\_ Location of Accident: \_\_\_\_\_

How did Accident Occur: \_\_\_\_\_

Auto Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_ Tel # \_\_\_\_\_

Name of Adjuster: \_\_\_\_\_ Claim # \_\_\_\_\_

Attorney: \_\_\_\_\_ Tel #: \_\_\_\_\_

Address: \_\_\_\_\_

---

**Workers Compensation Injury**

How did the Accident Occur: \_\_\_\_\_

Please note that the patient is liable for the bill, unless we receive authorization from your employer or worker's compensation carrier to treat you. Do you have approval? \_\_\_\_\_

Date of Accident: \_\_\_\_\_ Insurance Co: \_\_\_\_\_

Address: \_\_\_\_\_ Tel # \_\_\_\_\_

Name Of Adjuster: \_\_\_\_\_ Claim # \_\_\_\_\_

Attorney: \_\_\_\_\_ Tel # \_\_\_\_\_

Address: \_\_\_\_\_

---

**Guarantee To Pay**

I understand that payment is expected at the time of service unless payment will be made directly by either worker's compensation or auto insurance carrier for the injuries sustained in the accident.

I authorize and request payment of my medical benefits for treatment and/or surgery directly to Dr. Louis Rizio. I further authorize my attorney to pay Dr. Louis Rizio directly any money due to them on accounts deducted from any settlement on my behalf. I will direct my attorney to pay Dr. Louis Rizio directly any outstanding balance immediately upon settlement of my case.

A valid credit card is required on file. The credit card will not be charged without consent from the patient in writing, verbally by phone, or in person for balances unpaid and less than 30 days old. Patients paying by check cannot be seen without a valid credit card.

**Type of Credit Card:** Amex \_\_\_\_\_ Mastercard \_\_\_\_\_ Visa \_\_\_\_\_

**Name as it appears on credit card** \_\_\_\_\_

**Card #** \_\_\_\_\_ **Exp. Date** \_\_\_\_\_ **Security Code** \_\_\_\_\_

**Signature:** \_\_\_\_\_

I understand that any outstanding balance not covered or paid by my insurance will be my responsibility to pay. If my accounts are turned over to an attorney or collection agency to obtain payment, I shall be responsible for attorney's fees, court costs and any other costs incurred by the collection agency.

I have read and agree to this information.

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Copy of my signature shall have the same force and effect as the original.

**Authorization For Release Of Patient Records**

I \_\_\_\_\_ authorize the office of Dr. Louis Rizio to  
(Patient's Name)  
disclose medical records to \_\_\_\_\_  
(person to whom disclosure is made)

**I understand that if my medical records contain information related to the history, diagnoses and/or treatment of any psychiatric problems, mental illness, drug abuse, alcoholism, sexually transmitted or communicable diseases, AIDS, or test for infection with human immunodeficiency virus (HIV), that my signing this document authorizes Dr. Louis Rizio to release that information.**

**I acknowledge and am aware that New Jersey has a statutory privalage accorded to confidential communications between a patient and a licensed physician or psychologist and that my signing this form waives the privilege.**

This consent may be revoked at any time by Dr. Louis Rizio except to the extent that Dr. Louis Rizio has already taken action in reliance on it. If not previously revoked, this consent will terminate upon \_\_\_\_\_.  
(Indicate date or an expiration event)

Dr. Louis Rizio will not make decisions concerning treatment, payment, enrollment or eligibility for benefits based on signing, refusing to sign or revoking this authorization.

I acknowledge and understand that uses and disclosures of my health information authorized by this document may be subject to redisclosure by the recipient and may not be protected by the privacy and confidentiality laws.

**Patient Signature:** \_\_\_\_\_