Founder of

BIG HORN BASIN ORTHOPAEDIC CLINIC, P.C.

Founder of

YELLOWSTONE SPORTS MEDICINE L.L.C.

JIMMIE G. BILES, JR., M.D.
Diplomate of American Board of Orthopaedic Surgery

Sports Medicine • Orthopaedic Surgery • Joint Replacement • Arthroscopic Surgery

PATIENT INFORMATION

New ___ Update___ Doctor:_____ Pt. #_____

Patient's Legal Name_____ Today's Date_____

Address _____Zip Code _____ Home Phone _____
(Leave Message? **Y / N**)

Sex_____ Age _____ D.O.B. _____ SS# _____ Work Phone_____
(Leave Message? **Y / N**)

Marital Status _____ Employment Status _____ Cell Phone _____
(Leave Message? **Y / N**)

Employer's Name _____ Employer's Address_____

Spouse Name _____ Home Phone_____

Spouse Address (if different)_____ Cell Phone_____

Patient's Emergency Contact:_____ D.O.B. _____ Phone_____

Emergency Contact Relation to Patient: _____

Patient's Pharmacy/Location:_____

Patient's Primary Care Physician _____ Patient's Referring Doctor: _____

PARENT INFO IF PATIENT IS UNDER 18 YEARS OF AGE:
Please list all parent names, work phone for each, home address & phone number if different from patient:

_____

Relationship _____ Address _____ Phone_____

DO YOU HAVE INSURANCE? Yes ___ No ___ If Yes, Name of Carrier: _____ID#_____
Insurance Card Holder Name _____ Social # of Card Holder:_____
Home Phone Number _____ D.O.B. _____ Relation to Patient _____
Home Address _____

SECONDARY INSURANCE? Yes ___ No ___ If Yes, Name of Carrier _____ID#_____
Insurance Card Holder Name _____ Social # of Card Holder: _____
Home Phone Number _____ D.O.B. _____ Relation to Patient _____
Home Address _____

WORKER'S COMPENSATION:
Workers' Comp Insurance Company _____ Claim #:_____
Injured Body Part: _____ Date of Injury: _____
Employer's Name & Phone Number (**at time of injury**) _____
Are you working now? **Yes** _____ **No** _____ Have you filed a claim with your employer?_____

******IS LEGAL ACTION OR LITIGATION PENDING FOR THIS INJURY? ___ Yes ____ No*******
If so, due to time constraints, Yellowstone Sports Medicine may not be able to become involved in your care.

Yellowstone Sports Medicine, L.L.C. is committed to providing the best treatment possible for our patients at rates that <u>are</u> usual and customary for our area. You are responsible for payment in full regardless of the interpretation of what is "usual and customary" by a given insurance company.

PAYMENT IS EXPECTED AT TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS ARE MADE
ALL APPOINTMENTS NOT CANCELLED WITHIN 24 HOURS OR NO SHOWS ARE SUBJECT TO A $50.00 FEE

Dr. Biles has a financial interest in the MRI machine located in Yellowstone Imaging. If you desire to have your MRI done at any other facility, please let us know and we will be happy to facilitate this for you.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received a Notice of Privacy Practices of Yellowstone Sports Medicine, L.L.C. I understand that my Protect Health Information (PHI) may be used and disclosed for the purposes of TREATMENT, PAYMENT and HEALTHCARE OPERATION of the practice.

_____ _____
Date Patient Signature

_____ _____
Signature of Patient Representative Relationship
(Required if the patient is a minor or an adult who is unable to sign)

WRITTEN AUTHORIZATION FOR RELEASE OF PHI

I hereby authorize Yellowstone Sports Medicine, L.L.C. to discuss my Protected Health Information (PHI) with the following person. Should I wish to revoke this authorization I understand I must do so in **WRITING**.

NAME_____ PHONE _____

RELATIONSHIP _____

_____ _____
Date Patient Signature

_____ _____
Signature of Patient Representative Relationship
(Required if the patient is a minor or an adult who is unable to sign)

CONSENT TO ASSIGNMENT OF BENEFITS AND PROMISE TO PAY

Benefits to Physicians:
I hereby assign all of my rights to insurance benefits and instruct my insurance company to make payments directly to Yellowstone Sports Medicine, L.L.C. and/or its physicians for the benefits provided.

Promise to Pay:
I understand and agree that I am responsible to pay for all services provided to me by Yellowstone Sports Medicine, L.L.C. and its staff, and other orthopedic physicians and assistants that may be utilized during surgery. If I fail to pay for the services when they are rendered or on a signed agreed payment schedule, I will be responsible for all costs of collection, including but not limited to, interest at the rate of one and a half percent (1.5%) per month or eighteen percent (18%) per year, court costs and fees, attorney fees, and a collection fee of thirty five percent (35%) of the unpaid balance assigned for collection.

_____ _____
Date Patient Signature

_____ _____
Signature of the patient Representative Relationship
(Required if the patient is a minor or an adult unable to sign)