ASPEN Orthopedics
www.aspenors.com

Phone - **262/395-4141**

Brookfield - 19475 W. North Avenue, Suite 201
Brookfield PT – 2205 N. Calhoun Road, #17
New Berlin - 12555 W. National Avenue, Suite 100

Date:_____

BILLING FORM *(Please Print)*

Patient Name:_____Age: _____ Date of Birth:_____

Employer:_____Work Phone:_____

Occupation:_____

Is this auto accident related? ☐Yes ☐No Is this a work related injury? ☐Yes ☐No

Is this a personal injury? ☐Yes ☐No If yes, who is responsible?_____

Is an attorney involved? ☐Yes ☐No If yes, name of attorney:_____

INSURANCE INFORMATION - *If the patient is under 18 years of age, who is the responsible party?*	
NAME	RELATIONSHIP TO THE PATIENT
ADDRESS	CITY STATE ZIP
HOME PHONE	WORK PHONE
PRIMARY INSURANCE ☐MEDICAL INSURANCE ☐MEDICARE ☐SELF-PAY ☐WORK COMP ☐LEGAL	
INSURANCE COMPANY NAME	POLICY HOLDER'S EMPLOYER
NAME OF POLICY HOLDER	PATIENT'S RELATIONSHIP TO POLICYHOLDER
POLICY HOLDER'S SOCIAL SECURITY NUMBER	POLICY HOLDER'S DATE OF BIRTH
SECONDARY INSURANCE ☐MEDICAL INSURANCE ☐MEDICARE ☐SELF-PAY ☐WORK COMP ☐LEGAL	
INSURANCE COMPANY NAME	POLICY HOLDER'S EMPLOYER
NAME OF POLICY HOLDER	PATIENT'S RELATIONSHIP TO POLICYHOLDER
POLICY HOLDER'S SOCIAL SECURITY NUMBER	POLICY HOLDER'S DATE OF BIRTH

PROFESSIONAL FEES: Fees for professional services are based on our own experience and not on payment schedules promoted by insurance companies as usual and customary, average, median, etc., except for prepaid plans with which we have contracted. In many cases the entire fee will be paid by an insurance company while in other cases an insurance company will pay only a portion of the fee. We will furnish a reasonable number of medical and disability insurance reports to expedite your insurance claims. Services must be paid for when rendered unless other advance arrangements have been made.

FINANCIAL AGREEMENT: I hereby authorize payment of medical insurance benefits due me to be made directly to Aspen Orthopedics. I understand that I am responsible for that portion of fees not paid by insurance and that a balance over 60 days old will be considered past due. There will be a charge for checks returned for non-sufficient funds. Should the account be referred to an attorney or agency for collection, I will be responsible for reasonable attorney's fees, collection expenses and interest.

Signature of: ☐PATIENT ☐PARENT ☐GUARDIAN Date:

_____ _____

YOU MUST PRINT THIS FORM OUT AND BRING IT WITH YOU TO YOUR APPOINTMENT.
THIS FORM DOES NOT AUTOMATICALLY GET SENT TO ASPEN.
IF YOU DO NOT PRINT THIS FORM OUT, THE INFORMATION WILL BE LOST.

PRINT CLEAR