UNREMEDIATED CLINIC PDF - FAILS 14 HHS SECTION 504 & WCAG 2.1 AA SCREEN-READER CHECKS

# SUMMIT ORTHOPEDICS & SPINE GROUP

Post-Operative Physical Therapy Schedule & Fee Table - Form Rev. 2026 | Medicare & Commercial Intake

## SECTION 1: PATIENT DEMOGRAPHICS & MEDICARE / MEDICAID ID

Patient Legal Name: _____ DOB: ____/____/_____ Sex: [ ] M [ ] F

Primary Phone: (_____) _____-_____ Email Address: _____

Medicare / Medicaid Beneficiary ID (MBI): _____ SSN (Last 4): _____

## SECTION 2: INSURANCE COVERAGE & RESPONSIBLE PARTY TABLE

Plan Tier | Carrier Name | Policy / Group # | Copay / Deductible | Prior Auth

Primary Plan | _____ | _____ | $_____ | [ ] Yes [ ] No

Secondary Plan | _____ | _____ | $_____ | [ ] Yes [ ] No

## SECTION 3: CLINICAL HISTORY, ALLERGIES & PAIN DIAGRAM

[Untagged Visual Figure: Anterior/Posterior Anatomical Pain & Symptom Map - No Alt Text]

Current Medications & Dosages: _____

Known Drug / Latex Allergies: [ ] None [ ] Penicillin [ ] Sulfa [ ] Other: _____

## SECTION 4: HHS / HIPAA CONSENT & ASSIGNMENT OF BENEFITS

I hereby authorize direct payment of Medicare/Medicaid and commercial medical benefits to Summit Orthopedics & Spine Group and acknowledge receipt of the Notice of Privacy Practices.

Patient / Guardian Signature: _____ Date: ____/____/2026