Today's Date: _____

Last Name: _____ **First Name** _____ **MI** _____
Date of Birth _____ **Age** _____ **Gender** _____ **Marital Status:** _____
Race (optional): **Black** **White** **Asian** **Hispanic** **American Indian** **Other**
Address _____ **Apt #** _____**City** _____ **State** ____ **Zip** _____
Home Phone (_____) _____ **Cell Phone** (_____) _____ **E-Mail:** _____@_____
Employer _____ **Occupation** _____

How did you hear about us? _____

EMERGENCY CONTACT
Name _____ **Relationship** _____
Home Phone (_____)_____**Cell Phone** (_____)_____

INSURANCE INFORMATION
Primary Insurance Co Name _____ **Policy/Member #** _____
Policy Holder's Name (if other than self) _____**Date of Birth** _____
Policy Holder's Relationship to Patient _____

Secondary Insurance Co Name _____ **Policy/Member #** _____
Policy Holder's Name (if other than self) _____**Date of Birth** _____
Policy Holder's Relationship to Patient _____

WORKERS COMPENSATION INFO
Company Name: _____
Company Address: _____**City**_____**State**_____**Zip**_____
Date Of Injury: _____ **Case #** _____
Caseworker Name: _____ **Telephone** (_____) _____

Primary Care Doctor
Name _____
Phone (_____)_____

Preferred Pharmacy
Name _____
Address _____**Phone #** _____

PATIENT REGISTRATION FORM

Patient Registration (continued):

INSURANCE AUTHORIZATION, RELEASE AND ASSIGNMENT OF BENEFITS

I hereby authorize SpecOrtho to furnish and/or release any information necessary to insurance carriers concerning my illness and treatments, and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. It may be used to process my insurance claim acquired in the course of my examination or treatment, to allow a photocopy of my signature to be used to process my insurance claim for the period of a lifetime. This order will remain in effect until revoked by me in writing.

I have requested the medical service of **SpecOrtho** on behalf of myself and/or dependents, and I understand by making this request, I become fully financially responsible for any and all charges occurred in the course of the treatment authorized. I further understand that fees are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original. I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s) including Medicare, Medigap, Medicaid, private insurance and any other health/medical plan to issue payment directly to SpecOrtho for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand I am responsible for any amount not covered by insurance, regardless of insurance coverage. **Initials: _____**

NOTICE OF PRIVACY

I acknowledge that upon request I received a copy of the **SpecOrtho** "Notice of Privacy Practices". I have read and understand all the above and agree to comply. **Initials: _____**

CONSENT TO USE PHOTOS

I authorize SpecOrtho to use my photograph or that of my child in print publications, online publications, presentations, websites and social media for the publication of the practice. I also understand that no royalty, fee or other compensation shall become payable to me by reason of such use. **Initials**: _____

CONSENT TO TREAT

The purpose of medical care is to facilitate the treatment of disease, injury and disability. Medical services are provided through examination, testing and use of procedures to the aid of diagnosis or treatment of a medical condition. I request and authorize **SpecOrtho** to provide me with medical services as described above. I agree to cooperate fully, to participate in all medical procedures and to comply with the plan of medical care/services that is established**.**

Initials: _____

RESPONSIBLE PARTY (Adult Present signing consent to treat if the patient is a minor or Power of Attorney is necessary)

Last Name _____ **First Name** _____

Patient Relationship to Responsible Party _____ **Date of Birth** _____

Address _____ **Apt** _____**City** _____ **State** _____ **Zip** _____

Home Phone (_____) _____ **Work Phone (_____)**_____ **Cell Phone (_____)**_____

SpecOrtho
Specialty Orthopaedics and Sports Medicine, LLC

Financial Policy

Welcome to SpecOrtho, and thank you for choosing us as your orthopaedic healthcare provider. We are committed to providing you with exceptional convenient & personalized care. Our practice will work with you to help fullfill your payment responsibility. As the patient, you are responsible for any unpaid balance not contracturally covered by your insurance, including: copays, non-covered services, deductibles and co-insurance. Your participation in this process is essential to prevent any interruption in care.

By signing below, you confirm you have read this policy and understand the following:

- It is your responsibility to inform our office of any address, telephone number, or insurance changes.
- Copayments are collected at the time of service. Coinsurance and deductible amounts are also collected at time of service where possible.
- Self-pay patients, and patients with an insurance SpecOrtho does not participate with, will be provided a cost estimate which will be collected at time of service. **Pre-collection amounts are estimates only as we are unable to determine exact services performed prior to being seen.** You will be billed for any remaining amount due or refunded should you overpay.
- There is a $20 charge for completion of paperwork (disability, FMLA, etc).
- If you are unable to keep your appointment, please notify us in advance so we may offer that time slot to another patient.
- A pattern of repetitive "no show" or late cancellations may regretfully result in an assessment of a $50 cancellation / no show fee.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account. If you have questions about the above information, please do not hesitate to ask us. We are here to help you!

I have read and understand the above Financial Policy and agree to meet all financial obligations.

_____ _____

Patient signature (or parent, if under age 18) Date

Specialty Orthopaedics and Sports Medicine, LLC

HIPAA Notice of Privacy & Patient Consent Form

This Notice of Privacy Practices provides information about how we may use or disclose protected health information, and how you can get access to this information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change; if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
-The practice reserves the right to change the privacy policy as allowed by law.
-The patient has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
-The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
-The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointment? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with anyone other than yourself? YES NO

If Yes, please name the person / people with whom we may discuss your medical condition:

_____

This consent was signed by: _____
(print name please)

Signature: _____ Date: _____