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Danny R. Engle, PA-C

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Mark J. Tenholder, MD

Kornelis A. Poelstra, MD, PhD

Lori L. Kellogg, MD

W/C _____
AUTO _____
OTHER _____

DOI

RECP. INT. _____

DATE _____

CHART _____

NEW / UPDATE

PERSONAL INFORMATION:

E-MAIL: _____

LAST NAME: _____ FIRST: _____ M: _____

LOCAL ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PERMANENT ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

SOCIAL SECURITY NO: _____ DATE OF BIRTH: _____ AGE: _____

HOME PHONE: _____ SEX: M F MARITAL STATUS: S M D W

EMERGENCY CONTACT PERSON: _____ RELATION: _____

EMERGENCY NUMBER: _____

EMPLOYMENT INFORMATION: PATIENT OR PARENT

EMPLOYER: _____ OCCUPATION: _____ EMPLOYEE NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____

ZIP CODE: _____ WORK PHONE: _____ EXT: _____

RESPONSIBLE PARTY:

NAME: _____ SOCIAL SECURITY: _____

MAILING ADDRESS: _____

PHONE: _____ DATE OF BIRTH: _____ MARITAL STATUS: _____

RELATION TO PATIENT: SPOUSE PARENT STEP-PARENT OTHER

HOW DID YOU HEAR ABOUT US: _____

PRIMARY CARE PHYSICIAN: _____ REFERRING PHYSICIAN: _____

MEDICARE: (for Medicare patients only)

I certify that the information given by me in applying for payment under the Title XVII of the Social Security Act is correct I authorize all medical records to be released to the Social Security Administration or its intermediaries or carriers and request that payment of authorized benefits be made on my behalf and I assign the benefits payable for physician service to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment for me.

Date: _____ Signature _____

ASSIGNMENT OF BENEFITS:(All Insurance and Selfpay)

I hereby request that my insurance company pay any/all benefits due and payable under the terms of my contract to Orthopaedic Associates. I hereby authorize Orthopaedic Associates to release such information as may be necessary for the completion of any insurance claim. Any parent or guardian who brings in a minor for treatment is and hereby agrees to be financially responsible for paying the minor's account in full. In the event that an account is referred to an outside collection agency and/or smalls claims suit, the responsible party will be subject to paying any/all fees associated with the collection processes. I hereby authorize Orthopaedic Associates to obtain a credit history for such collection purposes.

Date _____ Signature _____

Orthopaedic Associates' Equipment History

I consent to the use or disclosure of my protected health information by Orthopaedic Associates for the purpose of **diagnosing** or providing treatment to me, obtaining payment for my healthcare bills or to conduct health-care operations of Orthopaedic Associates. I understand that diagnosis or treatment of me by Orthopaedic Associates may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Orthopaedic Associates is not required to agree to the restrictions that I may request. However, if Orthopaedic Associates agrees to a restriction that I request, the restriction is binding on Orthopaedic Associates and.

I have the right to revoke this consent, in writing, at any time, except to the extent that Orthopaedic Associates has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review Orthopaedic Associates' "Notice of Privacy Practices" prior to signing this document. Orthopaedic Associates' "Notice of Privacy Practices" has been provided to me. The "Notice of Privacy Practices" describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Orthopaedic Associates. The "Notice of Privacy Practices" for Orthopaedic Associates is also provided in the waiting area. This "Notice of Privacy Practices" also describes my rights and Orthopaedic Associates duties with respect to my protected health information.

Orthopaedic Associates reserves the right to change the privacy practices that are described in the "Notice of Privacy Practices". I may obtain a revised notice of privacy practice by calling the office of Orthopaedic Associates and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority