Patient Information

Last Name: _____
First Name: _____
Middle Initial: ____ ☐Dr. ☐Miss ☐Mr. ☐Mrs. ☐Ms.
Address: _____
City/State/Zip: _____
Home Phone: _____
Cell Phone: _____
Work Phone: _____
Email: (personal email address - not work):
__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __
@ __ __ __ __ __ __ __ __ __ __ __ __ __ • __ __ __

Primary Care Physician: _____
Referring Physician: _____

Date of Birth: _____ Gender: _____
Marital Status: _____
Social Security#:_____

Patient Employment:
Employed? ☐Yes ☐ No
Place of Employment: _____
Phone: ( ) _____
Occupation: _____

Emergency Contact:
Name: _____
Phone: _____
Relationship: _____
☐ Legal Guardian
We may release your Protected Health Information to this individual (HIPAA) ☐Yes ☐No

How did you hear about us?
☐Advertisement ☐Athletic Trainer ☐Class or Program
☐ Directory List ☐Existing Patient ☐Hospital
☐Internet ☐Insurance
☐Physician referral ☐Urgent Care
☐Social Media ☐Sport Club/Facility
☐Word of Mouth ☐Other _____

Race (may select more than one):
☐American Indian/Alaskan Native ☐Asian
☐Native Hawaiian or Other Pacific Islander
☐Black/African American ☐White
☐Hispanic ☐Other ☐Other Pacific Islander
☐Decline

Responsible Party: Same as Patient: ☐Yes ☐No
Relationship: _____
Name: _____
Address: _____
City/State/Zip: _____
Employer: _____
Phone: _____
Social Security #: _____
Date of Birth: _____
☐ Emergency Contact ☐ Legal Guardian

We may release your Protected Health Information to this individual (HIPAA) ☐Yes ☐No

Primary Insurance:
Insurance Company: _____
Policy Holder Name: ☐Same as Patient
_____
Policy Holder Date of Birth: _____
Policy Holder Social Security #: _____
Address:_____
City/State/Zip: _____
Relationship to patient: _____

Secondary Insurance:
Insurance Company: _____
Policy Holder Name: ☐Same as Patient
_____
Policy Holder Date of Birth: _____
Policy Holder Social Security #: _____
Address:_____
City/State/Zip: _____
Relationship to patient: _____

Ethnicity: ☐Hispanic/Latin
☐Non Hispanic/Latin
☐Decline

Preferred Language: _____

If the condition you are being seen for today is injury related involving a third party complete this section
Date of Injury: _____ Accident Related ☐Y ☐N Auto Accident ☐Y ☐N Work Related ☐Y ☐N
If work related please list your employer at the time of the injury:
_____
Workers Compensation Claim # _____

By signing below I certify the information above is complete and accurate.

𝒳 _____ _____
Patient Signature (if 18 and older) **Date**

𝒳 _____ _____ _____
Legal Representative (if applicable) **Relationship to patient** **Date**

Patient Information continued

Patient Name: _____ Date of Birth: _____

Confidential Communications

I request to receive confidential communications from Orthopedic One in the following manner:

Patient Web Portal:
If you have provided an email address we will automatically enable your secure personal Health Portal Access.
If you DO NOT want to enable access to a personal Health Portal for this patient,
please check this box: ☐ DO NOT WEB ENABLE Date: _____

Appointment Messages:
For appointment reminders **choose one**:

1. Prefer voice calls ☐ -preferred time of day: Morning ☐ Afternoon ☐ Evening ☐
2. Prefer text message ☐
3. Prefer NOT to receive appointment reminders ☐

If you selected voice calls for appointment reminders, please indicate ONE preferred number: Home ☐ Cell ☐ Work ☐

☐ I also understand my protected health information may be released as my physician determines appropriate in a medical emergency situation.
Initials: _____

Other Communication:
Orthopedic One may send general notices (including patient satisfaction surveys, clinic newsletters, practice promotions, etc.) via mail, email or text message using the contact information shared on Page 1. Medical information is protected under federal and state confidentiality regulations and no protected health information will be included in the communication.

You may choose to NOT receive notices by checking/ initialing here ☐ DO NOT SEND ME GENERAL NOTICES Initials_____

Insurance Assignment and Acknowledgement

I hereby authorize Orthopedic One, Inc. to furnish information to insurance carriers concerning my care and treatment, and assign to the provider all payments for medical services rendered. I understand I am financially responsible for all charges whether or not covered by my insurance. I understand I am also responsible for providing up-to-date and accurate insurance information.

By signing below, I certify I will pay to Orthopedic One, Inc. any co-payments, co-insurance, deductibles or cost of non-covered products or services. I will promptly pay to Orthopedic One, Inc. any payments that I receive from my insurance carrier for services provided to me and/or my dependants. I will also be responsible for any amounts not paid by insurance if I fail to provide appropriate insurance information for billing.

If I am insured by Medicare I further certify that the information given by me applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Health Care Financing Administration or its intermediaries or carrier, information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign benefits payable for covered Medicare services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

χ _____ _____
Patient Signature (if 18 and older) **Date**

χ _____ _____ _____
Legal Representative (if applicable) **Relationship to patient** **Date**

χ _____ _____
Guarantor Signature (if applicable**)** **Date**

OR

I do not wish Orthopedic One to bill my insurance company and therefore I agree to be responsible for all charges incurred.
If selecting do not complete the Insurance Assignment and Acknowledgement section above. Initials _____

Patient Information continued

Notice of Privacy Practices
Orthopedic One's Notice of Privacy Practices document is available at our registration desks or on our website at www.orthopedicone.com.

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights and responsibilities with respect to your health care information.

The Notice of Privacy Practices (Notice) provides more detailed information about how Orthopedic One may use and disclose health information. I have the right to review the Notice before I sign this consent and Orthopedic One encourages reading it in full. My signature below verifies that I have received the Notice as part of the registration process. I understand the terms of the Notice may change and I may obtain these revised notices by contacting the practice Privacy Officer by phone or in writing. I have the right to request how my health information is used and disclosed. I also have the right to restrict how this information is disclosed, but the practice is not legally required to agree to these restrictions. Orthopedic One must receive requests for any restriction of disclosure in writing

_____ _____
Patient Name Printed **Date of Birth**

_____
Guardian Name Printed (if applicable)

χ_____ _____
Patient Signature / Guardian Signature (if 18 and older) **Date**

_____
If not Patient, relationship to Patient

For Office Use Only:

Patient unable to sign due to: _____

Patient declined to sign Date: _____
