orthopedic ONE

Patient Information

Patient Name: Last ______ First ______ Middle ______

Patient Address: ______

City: ______ State: ______ Zip: ______ Email: ______

Home Phone: ______ Work Phone: ______ Cell Phone: ______

Marital Status: ☐ M ☐ S ☐ D ☐ W Sex: ☐ M ☐ F

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

Preferred Language ______ Do you need an Interpreter? ☐ Yes ☐ No

Date of Birth: ______ Age: ______ Social Security: ______

Employer: ______ Occupation: ______

Emergency Contact: ______ Emergency Contact Phone Number: ______

Relationship: ______ May we share your health information with this person? ☐ Y ☐ N

Primary Doctor: Last ______ First ______ City ______ State ______

Referring Doctor: Last ______ First ______ City ______ State ______

Is your injury work-related: ☐ Y ☐ N If yes, date of injury: ______

Claim number: ______ MCO: ______

PRIMARY INSURER

Insurance Company: ______

Name of Person Insured: ☐ Same as Patient Last ______ First ______ Middle ______

DOB of Insured: ______ SS# of Insured: ______

Relationship to Insured: ☐ Self ☐ Spouse ☐ Dependent ☐ Mother ☐ Father ☐ Other ______

Address: ______ City: ______ State: ______ Zip: ______

SECONDARY INSURER (If Applicable)

Insurance Company: ______

Name of Person Insured: ☐ Same as Patient Last ______ First ______ Middle ______

DOB of Insured: ______ SS# of Insured: ______

Relationship to Insured: ☐ Self ☐ Spouse ☐ Dependent ☐ Mother ☐ Father ☐ Other ______

Address: ______ City: ______ State: ______ Zip: ______

FINANCIALLY RESPONSIBLE PERSON (Person who will pay what Insurance does not cover)

Name of Financially Responsible Person: ☐ Same as Patient Last ______ First ______ Middle ______

DOB of Financially Responsible Person: ______ SS# of Financially Responsible Person: ______

Relationship to patient: ☐ Self ☐ Spouse ☐ Dependent ☐ Mother ☐ Father ☐ Other ______

Address: ______ City: ______ State: ______ Zip: ______

Home Phone: ______ Cell Phone: ______

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

x ______ ______

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

x ______ ______ ______

Legal Representative / Parent of Minor (if applicable) **Relationship to Patient** **Date**

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Patient Last Name ______ First ______ Date of Birth ______

Preferred Pharmacy Name: ______
Pharmacy Location (street name & city): ______
Mail Order Pharmacy Name: ______ Phone # ______

Prescription History Consent

By initialing below, I authorize Orthopedic One to request and use any and all available prescription history from external sources for treatment purposes, including other healthcare providers and pharmacy benefit payers.

Patients Initials ______

Confidential Communications

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

Appointment Messages: Preferred method(s): ☐ voice call ☐ text message ☐ email (select providers only) ☐ Prefer NOT to receive appointment reminders

Patient Web Portal: If you have provided an email address we will automatically enable your secure personal Health Portal Access.
You may choose to NOT enable a personal Health Portal by initialing here DO NOT WEB ENABLE 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 initialing here DO NOT SEND ME GENERAL NOTICES Initials ______

Voicemail: May we leave a voicemail containing your health information if we are unable to reach you? ☐ Yes ☐ No

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 provides more detailed information about how Orthopedic ONE may use and disclose health information. I have the legal right to review the Notice of Privacy Practices before I sign this consent, and Orthopedic ONE encourages reading it in full. My signature below verifies that I have received the Notice of Privacy Practices. I understand that the terms of the Notice of Privacy Practices 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.

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.

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 with 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.

By signing this form, you are acknowledging both the Notice of Privacy Practices and Insurance Assignment.

x ______
Patient Signature (if 18 and older) ______ Date

x ______
Legal Representative / Parent of Minor (if applicable) ______ **Relationship to Patient** ______ Date

I do not wish Orthopedic ONE to bill my insurance company and agree to be responsible for all charges incurred. Initials ______