orthopedic ONE

Patient Information

Patient Name: Last _____ First _____ Middle _____ Preferred Name _____

Patient Address: _____

City: _____ State: _____ Zip: _____ Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

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: _____

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 _____

Preferred Pharmacy Name: _____

Pharmacy Location (street name & city):_____

Mail Order Pharmacy Name: _____ Phone # _____

PRIMARY INSURER

Insurance Company: _____

Policy Holder: ☐ 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: _____

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Patient Consents

Patient Last Name _____ First _____ Date of Birth _____

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 on record. 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