

Welcome to Springfield Orthopaedic & Sports Medicine Institute, LLC

Patient Information-Please Print and Fill out ALL information

Patient Name _____ SS# _____ Sex: M / F
Street Address _____ Birth Date _____
City/State/Zip Code _____ Email _____
Home Phone _____ Cell Phone _____
Race: White/Caucasian American Indian/Alaska Native Asian Black/African American Native Hawaiian /Other
Pacific Islander Other Decline to State
Ethnicity: Non Hispanic or Latino Hispanic or Latino Decline to State
Preferred Language: English Spanish Other
Place of Employment _____ Work Phone _____
Occupation _____ Job Description (sit-down work, typing, lifting, climbing, etc.): _____

Referred by: _____ Family Physician: _____
Name of pharmacy, location, and phone (if known): _____

Spouse's Information OR Parent/Guardian (If patient is under 18 years old)

Name _____ SS# _____ Sex: M / F
Street Address _____ Birth Date _____
City/State/Zip Code _____ Email _____
Home Phone _____ Work Phone _____ Cell Phone _____
Place of Employment _____

Insurance Coverage: ____ Yes ____ No

Primary Insurance: (Please List the Policy Holder's Information)

Policy Holder's Name _____ Birth Date _____ SS # _____
Place of Employment _____
Insurance Company _____
Policy # _____ Group # _____

Secondary Insurance: (Please List the Policy Holder's Information)

Policy Holder's Name _____ Birth Date _____ SS # _____
Place of Employment _____
Insurance Company _____
Policy # _____ Group # _____

Workman's Compensation: (If Applicable)

Company where accident occurred _____
Claim # _____ Date of Injury _____

PLEASE READ THE FOLLOWING CAREFULLY AND SIGN WHERE INDICATED

I certify that I, and/or my dependent(s) have insurance coverage with the company(ies) listed above and assign all benefits to be paid directly to Springfield Orthopaedic & Sports Medicine Institute, LLC. I understand that I am financially responsible for services rendered. I understand the co-payments, if applicable, are due **AT THE TIME OF SERVICE**. If it becomes necessary to effect collections of any amount owed on this or any subsequent visits or procedures, I agree to pay for all costs and expenses, including reasonable attorney fees and interest for overdue payments.

I also acknowledge that it is my responsibility to obtain a referral if my insurance company or HMO requires one.

I understand the physician has the right to discharge me from the practice for, but not limited to, non-compliance, failure to keep appointments, inappropriate language, or behavior towards him and/or his staff.

This facility may use my health care information and may disclose such information to my insurance company(ies) and their agents or other entities for the purposes of obtaining payment for services and determining insurance benefits or the benefit payable for related services.

I permit a copy of this authorization to be used in place of the original note and that I may withdraw my authorization at any time via written notification to the parties involved.

I recognize the need for healthcare and consent to services as ordered by the physician.

Signature of Patient, Guardian, or Personal Representative

Date

SPRINGFIELD ORTHOPAEDIC & SPORTS MEDICINE INSTITUTE, LLC.

Patient Name: _____ Birth Date: _____

Due to all of the changing regulations and new restrictions that are being implemented by HIPAA, it is necessary to ask you these questions. These new rules are for your protection and this information will help us better serve you, while safeguarding your personal health information. We may ask you and your family certain questions to verify identification. Thank you for your help.

1. Please list the family members or other persons whom we may inform about your general medical health, release sample medications, prescriptions, lab copies, other private health information, or contact in case of an emergency. Some of this information may include your diagnosis(es), plan of treatment, billing information, and medication use. Please list the person(s) full name, relationship, and phone number if possible. You are not required to list anyone.

Name	Relationship	Phone #
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. Do we have your permission to leave confidential messages, such as appointment reminders, on your voice mail or answering machine? This is not inclusive of all the confidential information that may be involved.
Yes _____ No _____

If your answer is NO, may we call your home and leave a message simply stating to please call our office?
Yes _____ No _____

3. Please indicate if all correspondence from our office, *other than billing statements*, should be sent to you in a **Confidential** sealed envelope.
Yes _____ No _____

4. Please print where you would want your billing statements sent **if** other than your home address. Please include the street address, apartment or lot number, city, state, zip, and persons name and relationship to patient, if applicable.

I have received a copy of the Notice of Privacy Policy for this office. I understand as a patient, I have rights and have been informed.

Signature of Patient or Guardian _____ Date _____

Patient Consent to the Use and Disclosure of Health Information For Treatment, Payment, or Healthcare Operations

I, _____ (patient name) understand that as part of my health care, Springfield Orthopaedic & Sports Medicine Institute originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communicating among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Springfield Orthopaedic & Sports Medicine Institute is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Springfield Orthopaedic & Sports Medicine Institute reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Springfield Orthopaedic & Sports Medicine Institute change their notice, they will provide me with a revised copy upon my next scheduled visit at the office.

I wish to have the following restrictions to the use or disclosure of my health information:

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

Signature of Patient or Guardian

Date

Birth Date of Patient

* Dr. Thompson and Dr. Galluch are investors in Ohio Valley Medical Center. At times they refer patients to Ohio Valley Medical Center in connection with their care and treatment.

FOR OFFICE USE ONLY

{ } Consent received by _____ staff initials on _____ (date)
{ } Consent refused by patient, and treatment refused as permitted.