

ALL SECTIONS MUST BE COMPLETED

Date: _____

Patient ID#: _____

PATIENT INFORMATION

Is this job related? Yes No

Long-Term Facility Skilled Nursing Facility Hospice (Specify) _____

Name: _____ Date of Birth: _____ Age: _____
(Last) (First) (Middle Initial)

Address: _____ SS#: _____ Male Female

City: _____ State: _____ Zip: _____ Single Married Divorced Widowed

Home Phone: _____ Work Phone: _____ Student Full Time Part Time

Cell Phone: _____ E-mail: _____ Employed Unemployed Retired

Language Preference: _____

Race: African-American/Black Caucasian Hispanic Native American Other

Ethnicity: Hispanic or Latino Non-Hispanic or Latino Other or Undetermined

Employer: _____ Address: _____

REASON for this visit: _____ Date of first symptoms/injury: _____

Is this? Home Job Related Auto Accident Sports Liability Other _____

Is an Attorney involved? Yes No If Yes, Attorney's Name and Phone: _____

Where and how were you injured? _____

Were x-rays taken? Yes No Where? _____ When? _____ X-rays with you? Yes No

Referring Physician: _____ Family Physician: _____ Disk Film

Pharmacy Preference: _____

EMERGENCY CONTACTS

Emergency Contact: _____ Relationship: _____ Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

INSURANCE POLICY HOLDER INFORMATION

Co-Pay \$ _____ Deductible \$ _____ THIS SECTION MUST BE COMPLETED

PRIMARY COMPANY: _____

Address: _____

City, State: _____ Zip: _____

ID#: _____ Group#: _____

SECONDARY COMPANY: _____

Address: _____

City, State: _____ Zip: _____

ID#: _____ Group#: _____

Subscribers Name: _____

Date of Birth: _____ SS#: _____

Address: _____

City, State: _____ Zip: _____

Employer: _____

Subscribers Name: _____

Date of Birth: _____ SS#: _____

Address: _____

City, State: _____ Zip: _____

Employer: _____

RESPONSIBLE PARTY (IF PATIENT IS A MINOR)

Responsible Party: _____ Responsible Party Date of Birth: _____

Address: _____

Relationship to patient: _____ SS#: _____ Home Phone: _____

Responsible Party Employer: _____ Work Phone: _____

I request that payment of authorized benefits be made to **Southern Oklahoma Multiple Services**, on my behalf for any services provided to me or my dependents. I authorize the release of any medical information to any insurance company, any third party payer, state agency, employer, or any other governmental or private payer responsible for paying such benefits. I agree to pay for all charges not covered by a third party payer. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for services rendered without obtaining my signature on each and every claim to be submitted for myself or my dependents. I authorize a copy of this document to be used in place of the original.

Signature of Patient/Insured: _____ Date: _____

Bone & Joint Clinic of Southern Oklahoma

Patient

Account #

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations**

I understand that as part of my health and medical care, the Bone and Joint Clinic of Southern Oklahoma originates and maintains medical and health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I further understand that this information serves as:

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

I further understand and agree that this agreement to release information shall apply to all information accumulated up to this date and to any information acquired in the future. This agreement to release future information shall remain in force until such time as I shall revoke it in writing.

I understand and have been provided with a **PATIENT PRIVACY NOTICE** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the **PATIENT PRIVACY NOTICE** prior to signing this consent. I understand that the Bone and Joint Clinic of Southern Oklahoma reserves the right to change their notice and practices, but that prior to implementation a copy of any revised notice will be posted at the Bone & Joint Clinic of Southern Oklahoma. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the Bone and Joint Clinic of Southern Oklahoma is not required to agree to the restrictions requested. I understand that I must revoke this consent in writing, except to the extent the organization has already taken action in reliance thereon.

By Oklahoma law we are required to notify you **that the information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).**

In addition to the releases outlined above, information may be released to the following individuals/organizations for the indicated purpose:

PLEASE PRINT

I request the following restrictions to the use and/or disclosure of my health information: _____

By signing this form, I agree that the Bone & Joint Clinic of Southern Oklahoma may leave appointment reminders or medical information messages via phone, email, and fax information as appropriate for me with the information I have provided. Additionally, I give permission to request my prescription history. If permission is not given, I understand that I may be redirected for pain medication.

Signature of Patient or Legal Representative

Date Notice Effective

The Bone and Joint Clinic of Southern Oklahoma accepts _____ denies _____ accepts
conditionally the restrictions imposed on release of information as stated above.

Signature

/

Title

Date