Patient Information

Name: _____ **Date of Birth**: _____

Address: _____

City: _____ **State:** _____ **Zip code:** _____

Phone: _____ [ ] Home [ ] Cell [ ] Work [ ] Other

Phone: _____ [ ] Home [ ] Cell [ ] Work [ ] Other

Email: _____

Social Security #: _____

Primary Physician: _____

[ ] **Male** [ ] **Female** **Marital Status:** [ ] Married [ ] Single [ ] Divorced [ ] Widowed [ ] Other

Ethnicity: [ ] Hispanic or Latino [ ] Non-Hispanic or Latino [ ] Decline

Race: [ ] African American [ ] Asian [ ] Caucasian [ ] Chinese [ ] Filipino [ ] Japanese [ ] Native American [ ] Native Hawaiian [ ] Pacific Islander [ ] Other [ ] Decline

Guarantor: [ ] Same as Patient

Name: _____ **Date of Birth:** _____

Address: _____

or [ ] Same as Patient

Relationship to Patient: _____

Employment Information (Patient or Responsible Party):

Employer: _____

Employer Address: _____

Occupation: _____

Employer Phone Number: _____ **Ext:** _____

Consent to Release Information and Acknowledgement of Receipt of Notice of Privacy Practice

I authorize Collins Orthopaedics & Sports Medicine, LLC to release medical information and supporting documentation contained in my medical records maintained in this office to any entity that may be financially responsible for payment of expenses related to treatment, including my insurer, health plan, Medicare, Medicare carriers, the Health Care Financing Administration and any external professional review organization acting on their behalf, for the purpose administering benefits under such plans. If my treatment is work-related, I authorize Collins Orthopaedics & Sports Medicine, LLC to release medical information regarding such treatment to my employer and/or its designee. I authorize Collins Orthopaedics & Sports Medicine, LLC to release medical records to the applicable above-listed entities that may require medical review pursuant to a quality improvement program. I hereby consent to Collins Orthopaedics & Sports Medicine, LLC using any of my protected health information for any treatment, payment or healthcare operation activity, as described in this Notice of Privacy Practices which have been made accessible to me.

I authorize Collins Orthopaedics & Sports Medicine, LLC to release medical records and reports to any health care provider participating in the care rendered by Collins Orthopaedics & Sports Medicine, LLC, including but not limited to referring physicians, hospitals, home health providers or

_____

(example: Spouse and/or Family member)

I CERTIFY THAT I HAVE READ THE FOREGOING FINANCIAL POLICY AGREEMENT AND CONSENT TO RELEASE INFORMATION AND THAT I UNDERSTAND THE PROVISIONS THEREIN.

_____ _____

Name of Patient (Please Print) Date

_____ _____

Signature of Responsible Party Relationship to Patient