



**CONSENT FOR TREATMENT  
RELEASE OF INFORMATION AND PAYMENT POLICY**

PLEASE NOTE THAT THIS INFORMATION IS SHARED **ONLY** FOR TREATMENT, PAYMENT OR OPERATION, ACCORDING TO HIPAA LEGISLATION. PLEASE DO NOT LEAVE ANYTHING BLANK ON THIS FORM.

**This Information is Needed to Properly Bill Your Insurance Company**

TODAY'S DATE: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

Relationship to Patient: Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Other \_\_\_\_\_

PATIENT'S DATE OF BIRTH: \_\_\_\_\_ PATIENT'S PRIMARY CARE PHYSICIAN: \_\_\_\_\_

PATIENT'S SOCIAL SECURITY NUMBER (OPTIONAL): \_\_\_\_\_

**PRIMARY INSURANCE NAME:** \_\_\_\_\_ **POLICY #:** \_\_\_\_\_ **GROUP #:** \_\_\_\_\_

**PRIMARY INSURANCE COMPANY ADDRESS:** \_\_\_\_\_

*(THIS ADDRESS CAN BE FOUND ON THE BACK OF YOUR INSURANCE CARD)*

POLICY HOLDER'S NAME: \_\_\_\_\_ POLICY HOLDER'S DATE OF BIRTH: \_\_\_\_\_

POLICY HOLDER'S SSN: \_\_\_\_\_

**SECONDARY INSURANCE NAME:** \_\_\_\_\_ **POLICY #:** \_\_\_\_\_ **GROUP #:** \_\_\_\_\_

**SECONDARY INSURANCE COMPANY ADDRESS:** \_\_\_\_\_

POLICY HOLDER'S NAME: \_\_\_\_\_ POLICY HOLDER'S DATE OF BIRTH: \_\_\_\_\_

POLICY HOLDER'S SSN: \_\_\_\_\_

I consent to treatment necessary for the medical care of the above-named patient. I authorize the release of any or all medical records to the referring or family physician(s), to any health care provider the above-named patient may be referred to, and to the insurance company or third party payer indicated above and/or noted in the patient's chart, if applicable. I understand that, unless I/patient specifically state otherwise, this may include information relating to HIV testing, substance abuse and psychological disorders that may be included in the medical records. I acknowledge that information authorized to any entity, other than a health care provider or health plan, may no longer be protected by the Federal privacy law. I understand this authorization may be revoked in writing by me/patient at any time, except to the extent that action has been taken in reliance to this authorization. Unless revoked, I confirm that this authorization will be in effect as long as the patient is under care at **Hess Orthopaedic Center & Sports Medicine, PLC**, unless I/patient indicated otherwise. Fax transmittal of medical records is allowed, if indicated.

I further understand that payment on charges incurred, is due at the time of service or according to the office payment policy, unless other financial arrangements have been made with our business office prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment. I authorize and request that insurance payments be made directly to **Hess Orthopaedic Center & Sports Medicine, PLC**, should they elect to receive such payment.

I authorize **Hess Orthopaedic Center & Sports Medicine, PLC**, to release medical information regarding the above-named patient to: (Name, telephone number, relationship to patient – **please note that ONLY THE NAMES LISTED will be able to obtain medical information about you**). This includes your spouse, children, trainer, coach, etc.

\_\_\_\_\_

\*May we leave a message for you on your answering machine? Yes \_\_\_\_\_ No \_\_\_\_\_ Patient Initials \_\_\_\_\_

**Non-Covered Services:** I understand that the service(s) being provided may be non-covered by my health insurance plan, and that I am financially responsible for the entire amount of the service(s) being provided today and agree to pay for same. Patient Initials \_\_\_\_\_

**MEDICAL & PERSONAL INFORMATION** \*If you are a college student, please provide your permanent address\*

Home Address, City, State, Zip: \_\_\_\_\_ Type of work: \_\_\_\_\_

Mailing Address, if different from home address \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Cell Phone : ( ) \_\_\_\_\_

Current employer: \_\_\_\_\_

Reason for this visit today: \_\_\_\_\_ Referring Physician \_\_\_\_\_

**(OVER)**

Did you have an accident that caused your injury? Yes \_\_\_\_\_ No \_\_\_\_\_ Work \_\_\_\_\_

Accident Information: If you had an accident, what type of accident did you have? \_\_\_\_\_

Date of your accident: \_\_\_\_\_ The estimated time was \_\_\_\_\_ AM \_\_\_\_\_ PM

Date first seen by any Physician for this injury: DATE: \_\_\_\_\_ TIME: \_\_\_\_\_

WERE YOU INJURED ON THE JOB OR WHILE WORKING? YES \_\_\_\_\_ NO \_\_\_\_\_ (IF YES, ASK FOR A WORK COMP FORM)

**Patient Medical History (please check if you ever had or now have)**

**TODAY'S DATE:** \_\_\_\_\_

- |   |   |   |                                    |  |
|---|---|---|------------------------------------|--|
| <input type="checkbox"/> High Cholesterol   | <input type="checkbox"/> Blood Transfusion      | <input type="checkbox"/> Metal Clips (aneurysm) | <input type="checkbox"/> Asthma    | <input type="checkbox"/> Depression    |
| <input type="checkbox"/> Bleeding Tendency  | <input type="checkbox"/> Pulmonary Tuberculosis | <input type="checkbox"/> Pace Maker             | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Heart Trouble |
| <input type="checkbox"/> Sexual Disease     | <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> Thyroid Problems       | <input type="checkbox"/> Gout      | <input type="checkbox"/> Arthritis     |
| <input type="checkbox"/> Osteoporosis       | <input type="checkbox"/> Seizures               | <input type="checkbox"/> Glaucoma               | <input type="checkbox"/> Ulcer(s)  | <input type="checkbox"/> Disability    |
| <input type="checkbox"/> Serious Infections | <input type="checkbox"/> Pneumonia              | <input type="checkbox"/> Severe Back Pain       | <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Cancer        |

**Other:** \_\_\_\_\_ **Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_

**List all surgeries you have had:**

- 1) \_\_\_\_\_ 2) \_\_\_\_\_  
3) \_\_\_\_\_ 4) \_\_\_\_\_

**List all hospitalizations you have had, beginning with most recent:**

<u>Year</u>	<u>Reason</u>	<u>Physician</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Current Medications:**

Please list all (e.g. sprays, inhalers, ointment, drops, pills, injections and dosage). Include all vitamins, herbal, alternative & over-the-counter medications.

- 1) \_\_\_\_\_ 2) \_\_\_\_\_  
3) \_\_\_\_\_ 4) \_\_\_\_\_  
5) \_\_\_\_\_ 6) \_\_\_\_\_  
7) \_\_\_\_\_ 8) \_\_\_\_\_

**MEDICATION ALLERGIES:**

\_\_\_\_\_  
\_\_\_\_\_

**Social History:**

Marital Status:  Single  Divorced  Married  Separated  Widowed  Other

Ethnic Origin or Language: \_\_\_\_\_

Current use of tobacco:  Never  Used to; quit date: \_\_\_\_\_  Current user; packs per day: \_\_\_\_\_  Chewing tobacco

Have you ever been treated for any orthopaedic problem by:

- Dr. Hess  Dr. Hendren  Dr. Kime  Dr. Feltham  Mrs. Koogler  Dr. Barnes  Dr. Hardigree  
 Dr. Schwartz  Dr. Danisa  Dr. Battaglia

**Note we will contact the person below in an emergency or if we cannot contact you. If patient is a minor, please include name of legal guardian.**

**Emergency Name-Relationship to Patient:** \_\_\_\_\_

Their Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone #: \_\_\_\_\_ Work phone #: \_\_\_\_\_ Cell phone #: \_\_\_\_\_

**PRIVACY POLICY:**

I HAVE BEEN OFFERED THE PRIVACY POLICY  YES, OR ASK FOR A COPY IF DESIRED.

**PATIENT SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_