



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.**

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: _____

MEDICAL & PERSONAL INFORMATION PLEASE PROVIDE YOUR PERMANENT MAILING ADDRESS

HOME ADDRESS, CITY, STATE, ZIP: _____

TYPE OF WORK: _____

MAILING ADDRESS, IF DIFFERENT FROM HOME ADDRESS _____

HOME PHONE:() _____ WORK PHONE:() _____ CELL PHONE:() _____

*MAY WE LEAVE A MESSAGE FOR YOU ON YOUR ANSWERING MACHINE? YES ___ NO ___ PATIENT INITIALS _____

INSURANCE INFORMATION

This Information is Needed to Properly Bill Your Insurance Company

CURRENT EMPLOYER: _____

PRIMARY INSURANCE NAME: _____ MEMBER ID #: _____ GROUP ID #: _____

PRIMARY INSURANCE COMPANY ADDRESS: _____

(THIS ADDRESS MAY BE FOUND ON YOUR INSURANCE CARD)

POLICY HOLDER'S NAME: _____ POLICY HOLDER'S DATE OF BIRTH: _____

POLICY HOLDER'S SSN: _____

SECONDARY INSURANCE NAME: _____ MEMBER ID #: _____ GROUP ID #: _____

SECONDARY INSURANCE COMPANY ADDRESS: _____

POLICY HOLDER'S NAME: _____ POLICY HOLDER'S DATE OF BIRTH: _____

POLICY HOLDER'S SSN: _____

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** _____

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 Orthopaedics & 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 Orthopaedics & Sports Medicine, PLC.** should they elect to receive such payment. **Patient Initials** _____

(OVER)

Reason for this visit today: _____ Referring Physician _____

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. Dantsa 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. I authorize Hess Orthopaedics & Sports Medicine, P.L.C. 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.

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:** _____

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____