



Patients will not be seen until all required forms are completed in full. Incomplete paperwork may result in delayed care and extended wait times. This applies to new and established patients, and forms must be updated annually to ensure optimal treatment.

PATIENT INFORMATION

LAST: _____ FIRST: _____ MIDDLE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

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

EMAIL ADDRESS: _____ RACE: _____ ETHNICITY: ☐ HISPANIC ☐ NOT HISPANIC

DATE OF BIRTH: ____ / ____ / ____ SOCIAL SECURITY #: _____ - _____ - _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ OTHER SEX: ☐ FEMALE ☐ MALE

PRIMARY CARE PHYSICIAN: _____ REFERRED BY: _____

EMPLOYER NAME: _____ EMPLOYER CITY: _____

EMPLOYER PHONE: (____) _____ - _____

GUARANTOR

RELATIONSHIP TO RESPONSIBLE PARTY: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER _____

RESP. PARTY NAME: LAST: _____ FIRST: _____ MIDDLE: _____

ADDRESS: _____ DATE OF BIRTH: ____ / ____ / ____

SEX: ☐ FEMALE ☐ MALE SOCIAL SECURITY #: _____ - _____ - _____

CELL PHONE: (____) _____ - _____ EMAIL ADDRESS: _____

EMERGENCY CONTACT

NAME: _____ PHONE NUMBER: (____) _____ - _____

RELATIONSHIP: _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____

CONTRACT (ID#): _____ GROUP #: _____

SUBSCRIBER NAME: _____

SUBSCRIBER DATE OF BIRTH: ____ / ____ / ____ SOCIAL SECURITY #: _____ - _____ - _____

RELATIONSHIP TO SUBSCRIBER: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

Medical Information Release Form

Name: _____ Date of Birth: ____/____/____

Release of Information:

☐ I authorize the release of diagnosis, records, examination rendered to me and the claims information. This information may be released to:

OR

☐ INFORMATION IS NOT TO BE RELEASED TO ANYONE.

This Release of Information will remain in effect until terminated by me in writing.

PLEASE LIST NAMES DOWN BELOW:

☐ Spouse _____

☐ Child(ren) _____

☐ Other: _____

Messages

Please call: ☐ Call my home ☐ My cell number ☐ Other _____

Please select one in case we are unable to reach you:

☐ You may leave a detailed message

☐ Please leave a message asking me to return your call

Signed: _____ Date: ____/____/____

Witness: _____ Date: ____/____/____

Consent & Financial Responsibility

WE APPRECIATE THE OPPORTUNITY OF SERVING YOU.

I AUTHORIZE THE RELEASE AND DISCLOSURE OF ANY OR ALL OF MY MEDICAL AND TREATMENT RECORDS OR REPORTS TO ANY OTHER HEALTH CARE PROVIDER WHO MAY BE OF ASSISTANCE, IN THE OPINION OF *Tuscaloosa Orthopedic and Joint Institute, LLC*, AND/OR FOR ASSISTING IN ANY REIMBURSEMENT OR MEDICAL BENEFITS TO WHICH PATIENT MAY BE ENTITLED. I ALLOW FAX TRANSMITTAL OF MY MEDICAL RECORDS, IF NECESSARY. I FURTHER AUTHORIZE AND REQUEST THAT INSURANCE PAYMENTS BE MADE DIRECTLY TO *Tuscaloosa Orthopedic and Joint Institute, LLC*, MD, PC SHOULD THEY ELECT TO RECEIVE SUCH PAYMENT. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

I ACKNOWLEDGE FULL FINANCIAL RESPONSIBILITY FOR SERVICES RENDERED BY *Tuscaloosa Orthopedic and Joint Institute, LLC*, MD, PC. I UNDERSTAND THAT PAYMENT OF CHARGES INCURRED IS DUE AT THE TIME OF SERVICE UNLESS OTHER DEFINITE FINANCIAL ARRANGEMENTS HAVE BEEN MADE PRIOR TO TREATMENT. I AGREE TO PAY ALL REASONABLE ATTORNEY FEES AND COLLECTION COSTS IN THE EVENT OF DEFAULT OF PAYMENT OF MY CHARGES.

I AUTHORIZE TREATMENT BY *Tuscaloosa Orthopedic and Joint Institute, LLC*, MD, PC, PHYSICIANS AND PERSONNEL.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT FOR TREATMENT, FINANCIAL RESPONSIBILITY, RELEASE OF MEDICAL INFORMATION AND INSURANCE AUTHORIZATION. THIS AUTHORIZATION IS VALID FOR ONE YEAR.

I have read the above and accept financial responsibility in full of this account.

SIGNED: _____ **DATE:** _____

Patient, Parent, or Guardian

TUSCALOOSA ORTHOPEDIC & JOINT INSTITUTE, LLC

Authorization to Disclose Health Information

Patient Name: _____ Date of Birth: _____

1. I authorize _____ to disclose the above named individual's health information as described below to Dr. Bryan King, Tuscaloosa Orthopedic & Joint Institute, LLC, 100 Rice Mine Road Loop, STE 205, Tuscaloosa, AL 35406 or by fax to: (205)354-2679.
2. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)
☐ Entire record ☐ X-ray and imaging reports ☐ Other: _____
3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
4. This information may be disclosed at the request of the individual.
5. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Latricia Bass, Privacy/Security Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____ If I fail to specify an expiration date, event or condition, this authorization will expire in six months.
6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CRF 164.524 of the Federal Register Rules and Regulations. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure or my health information, I can contact Latricia Bass, Privacy/Security Officer.

Signature of Patient or Legal Representative: _____ Date: _____

If signed by Legal Representative, Relationship to Patient: _____

Legal Representative Name: _____

For Healthcare Organization Use Only

Staff Member Processing Request and Date Released: _____

Date Received: _____

Patient General Consent Form

Consent for Treatment: I, the undersigned, consent to the care and treatment by the attending physicians, his/her associates or assistants of Tuscaloosa Orthopedic & Joint Institute, LLC.

Patient Name: _____

Signature of Patient: _____ **Date:** _____

Person other than patient: _____ **Relationship to Patient:** _____

Assignment of Benefits and Guarantee of Account:

In consideration of all services and supplies provided by Tuscaloosa Orthopedic & Joint Institute, LLC, I understand and agree that I have full responsibility to pay Tuscaloosa Orthopedic & Joint Institute, LLC. I understand that the charges not covered by my insurance remain my responsibility and assign insurance benefits to Tuscaloosa Orthopedic & Joint Institute, LLC. I accept full financial responsibility for the immediate payment of any charges not covered by my insurance. I accept the fees charged as a legal and lawful debt and agree to pay said fee. I agree to reimburse Tuscaloosa Orthopedic & Joint Institute, LLC the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

I agree, in order for Tuscaloosa Orthopedic & Joint Institute, LLC to coordinate my care, service my account or to collect monies I may owe, Tuscaloosa Orthopedic & Joint Institute, LLC and/or their agents may contact me by telephone at any telephone number associated with my account, including my wireless telephone numbers, which could result in charges. Tuscaloosa Orthopedic & Joint Institute, LLC may also contact me by sending text messages or emails, using any e-mail address I provide. Methods of contacting may include prerecorded or artificial voice messages and/or use of automatic dialing devices, as applicable.

Signature of Patient: _____ **Date:** _____

Person other than Patient: _____ **Relationship to Patient:** _____

Notice of Privacy Practices Receipt

I have received the Notice of Privacy Practices provided by Tuscaloosa Orthopedic & Joint Institute, LLC.

Signature of Patient: _____ **Date:** _____

Person other than Patient: _____ **Relationship to Patient:** _____



No Show/Late Cancellation Policy

Effective 09/01/2025

This policy has been established to help us serve you better.

It is necessary for us to make appointments in order to see our patients as efficiently as possible. No Shows and Late Cancellations cause problems that go beyond a financial impact on our practice. When an appointment is made, it takes an available time slot away from another patient. No Shows and Late Cancellations delays the delivery of healthcare to other patients, some who are quite ill.

A "No Show" is missing a scheduled appointment. A "Late Cancellation" is cancelling an appointment without calling us to cancel within 24 hours of an office appointment or 72 hours in advance of a procedure.

We understand that situations such as medical emergencies occasionally arise. These situations will be considered on a case by case basis.

- A Charge of \$50.00 will be assessed for each no show or late cancellation office visit appointment if less than 24 hours notice is given.
- A Charge of \$200.00 will be assessed for each no show or late cancellation procedure appointment if less than 72 hours notice is given.

Please understand that insurance companies consider this charge to be entirely the patient's responsibility.

To cancel or reschedule an appointment, please call Tuscaloosa Orthopedics and Joint at 205-391-4440 and speak with the Front Office Staff. This policy is in effect to ensure that all of our patients have the opportunity to be seen in a timely manner.

Signature of Patient: _____ Date: _____

100 Rice Mine Road Loop Suite 205

Tuscaloosa, Alabama 35406

Phone: 205.391.4440 Fax: 205.391.4441