TUSCALOOSA ORTHOPEDIC & JOINT INSTITUTE

PATIENT INFORMATION

PATIENT NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____

ZIP CODE: _____ CITY: _____ STATE: _____

HOME PHONE #: (_____) _____-_____ CELL PHONE #: (_____) _____-_____ SECONDARY PHONE #: (_____) _____-_____

EMAIL ADDRESS: _____ Race _____ Ethnicity: Hispanic Not Hispanic

DATE OF BIRTH: _____/_____/_____ SOCIAL SECURITY NUMBER: _____-_____-_____

MARITAL STATUS: (circle one) SINGLE MARRIED DIVORCED WIDOWED OTHER

PATIENT RELATIONSHIP TO THE RESPONSIBLE PARTY: (circle one)
SELF SPOUSE CHILD OTHER

SEX: (circle one) FEMALE MALE

PRIMARY CARE PHYSICIAN: _____ REFERRED BY: _____

PATIENT'S EMPLOYER INFORMATION: COMPANY: _____

CITY: _____ PHONE #: _____

RESPONSIBLE (OR INSURED) PARTY INFORMATION

RESP. PARTY NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____

DATE OF BIRTH: _____/_____/_____ SEX: (circle one) FEMALE MALE

HOME PHONE #: (_____) _____-_____ WORK PHONE #: (_____) _____-_____

SOCIAL SECURITY NUMBER: _____ - _____ - _____

RESPONSIBLE PARTY'S EMPLOYER INFORMATION: COMPANY: _____

CITY: _____ PHONE #: _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____

ADDRESS: _____ PHONE: _____

CONTRACT (ID#) NUMBER: _____ SUBSCRIBER'S NAME: _____

PATIENT RELATIONSHIP TO SUBSCRIBER: (circle one) SELF SPOUSE CHILD OTHER

GROUP NAME: _____ GROUP NUMBER: _____

COPAYMENT AMOUNT: $ _____ INSURED'S DATE OF BIRTH: _____/_____/_____

SECONDARY INSURANCE COMPANY: _____

ADDRESS: _____ PHONE: _____

CONTRACT (ID#) NUMBER: _____ SUBSCRIBER'S NAME: _____

PATIENT RELATIONSHIP TO SUBSCRIBER: (circle one) SELF SPOUSE CHILD OTHER

GROUP NAME: _____ GROUP NUMBER: _____

COPAYMENT AMOUNT: $ _____ NSURED'S DATE OF BIRTH: _____/_____/_____

Medical Information Release Form

Name:_____ Date of Birth:_____

Release of Information

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

[ ] Spouse_____

[ ] Child (ren) _____

[ ] Other_____

[ ] Information is not to be released to anyone.

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

Messages

Please call [ ] My home [ ] My cell number_____

If unable to reach me

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ]_____

The best time to reach me is (day)_____ between (time)_____

Signed:_____ Date:_____

Witness:_____ Date:_____

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 for this account.

SIGNED: _____ DATE: _____

Patient, Parent, or Guardian

IN CASE OF EMERGENCY PLEASE CONTACT:

NAME: _____

PHONE NUMBER: _____ RELATIONSHIP: _____

ADDRESS: _____