Orthopedic Associates of SW Ohio

The HAND CENTER of Southwestern Ohio

REGISTRATION FORM

PATIENT INFORMATION:

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	SOCIAL SECURITY #

STREET ADDRESS/P.O. BOX	CITY	STATE	ZIP

HOME PHONE	WORK PHONE	CELL PHONE	SEX ☐ M ☐ F	MARITAL STATUS ☐ M ☐ W ☐ S ☐ D

EMAIL ADDRESS	☐ Yes ☐ No Would you like to receive practice information	RELATIONSHIP TO RESPONSIBLE PARTY ☐ SELF ☐ SPOUSE ☐ PARENT ☐ CHILD ☐ OTHER

EMPLOYER	EMPLOYER STREET ADDRESS	CITY	ZIP

PRIMARY PHYSICIAN	NAME OF CUSTODIAL PARENT

RESPONSIBLE PARTY: (If different from above)

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	SOCIAL SECURITY #

STREET ADDRESS/P.O. BOX	CITY	STATE	ZIP

EMAIL ADDRESS	HOME PHONE	WORK PHONE	CELL PHONE

EMPLOYER	EMPLOYER STREET ADDRESS	CITY	ZIP

EMERGENCY CONTACT: (Person not living with you)

NAME	PHONE	RELATIONSHIP
NAME	PHONE	RELATIONSHIP

INSURANCE/POLICY HOLDER INFORMATION: (Please present insurance cards to receptionist)

PRIMARY INSURANCE	EFFECTIVE DATE	POLICY HOLDER NAME	SEX ☐ M ☐ F	EMPLOYER

POLICY HOLDER BIRTHDATE	POLICY NUMBER	RELATIONSHIP TO PATIENT ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Other	WORK PHONE

SECONDARY INSURANCE:

SECONDARY INSURANCE	EFFECTIVE DATE	POLICY HOLDER NAME	SEX ☐ M ☐ F	EMPLOYER

POLICY HOLDER BIRTHDATE	POLICY NUMBER	RELATIONSHIP TO PATIENT ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Other	WORK PHONE

ADVANCED DIRECTIVES:

Do you have an advanced directive (living will)? ☐ Yes ☐ No
If yes, at which hospital is it filed? ____________________

HOW DID YOU HEAR ABOUT OUR OFFICE?

1. ☐ PHA 2. ☐ Friends/Family 3. ☐ Physician 4. ☐ Advertisement 5. ☐ Other ____________
Whom may we thank for your referral to this office? ____________________
Name Address (if known) Phone #

IS THIS WORK RELATED ☐ YES ☐ NO DATE OF INJURY ____________________

Please complete the reverse side.

FOR OFFICE USE ONLY: 1 ________ ________ 2 ________ ________ 3 ________ ________ 4 ________ ________

I acknowledge that I have received a copy of the privacy policies of Orthopedic Associates of SW Ohio

______________________________ ______________________________

Patient Signature Date

Authorization for Treatment and Disclosure of Information for Treatment, Payment, and Operations

AUTHORIZATION FOR TREATMENT

I authorize examination, diagnosis, and general treatment (including, but not limited to, the use of x-rays and other non-invasive procedures such as diagnostic tests) to be performed by physicians and staff of OASWO. I realize that if a medical procedure or surgery is required, I will be given additional information.

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

I consent to OASWO using and disclosing my protected health information to carry out treatment, payment, or health care operations.

I understand and have been provided with a Notice of Privacy Practices, which provides a more complete description of how my protected health information may be used or disclosed. I understand that I have the right to review the notice prior to signing this consent.

I understand that OASWO reserves the right to change their notice and information practices and that I may obtain a copy of the revised notice by requesting a copy from the office manager.

I have the right to revoke this consent by notifying OASWO in writing, except to the extent that OASWO has taken action in reliance on my consent.

MEDICARE PATIENTS ONLY-PLEASE COMPLETE THIS SECTION

1. Are you currently working? Yes No
   If yes, employer? ______________________________
2. Do you have insurance through your employer? Yes No
3. Is your spouse currently working? Yes No
   If yes, employer? ______________________________
4. Do you have insurance through your spouse's employer? Yes No
5. Is your visit related to an accident or injury? Yes No
   If yes, do you have any other insurance responsibilities for this bill? Yes No

If you answered yes to any questions above, please provide insurance information to the staff.

I hereby authorize any holder of medical information about me to release to the Centers for Medicare/Medicaid services and its agents any information needed to determine those benefits payable for related services. I hereby authorize Medicare/Medicaid to furnish to OASWO any information regarding my Medicare claims under title XVII and XIX of the Social Security Act.

FINANCIAL AGREEMENT

I realize the bill is my responsibility. I assign and authorize payments be made directly to OASWO of all insurance benefits and agree to pay any balance due.

______________________________ ______________________________

Signature of patient or patient's representative Date

______________________________ ______________________________

Printed name of patient or patient's representative Relationship to patient or representative's authority to act for the patient.