LAKE ORTHOPAEDIC ASSOCIATES, INC.

PATIENT'S EMAIL	PHARMACY NAME AND ADDRESS	PHARMACY PHONE NUMBER

PATIENT'S LAST NAME	FIRST	MIDDLE	NICKNAME IF ANY	AGE

IS PATIENT A STUDENT? ❑ YES ❑ NO	NAME OF SCHOOL	❑ FULL TIME ❑ PART TIME

PATIENT'S STREET ADDRESS	APT/LOT #	CITY	STATE	ZIP

AREA CODE/**HOME** PHONE NUMBER	AREA CODE / **CELL** PHONE NUMBER	SEX: ❑ MALE ❑ FEMALE	DATE OF BIRTH
LEAVE MESSAGE ❑ YES ❑ NO	LEAVE MESSAGE ❑ YES ❑ NO	SOCIAL SECURITY NUMBER	

MARITAL STATUS ❑ SINGLE ❑ MARRIED ❑ WIDOWED ❑ DIVORCED ❑ SEPARATED	LANGUAGE	RACE	ETHNICITY ❑ HISPANIC ❑ NON HISPANIC

PATIENT'S EMPLOYER & OCCUPATION	❒ FULL TIME ❒ PART TIME ❒ RETIRED	BUSINESS PHONE	ARE CALLS ALLOWED? ❑ YES ❑ NO

NAME OF SPOUSE	SPOUSE'S PHONE NUMBER

RESPONSIBLE PARTY'S NAME **(if a minor)**	ADDRESS	HOME PHONE

WORK PHONE	BIRTHDATE	EMPLOYER

POLICY HOLDER FOR INSURANCE	ADDRESS

PHONE NUMBER	BIRTHDATE	EMPLOYER

REFERRING PHYSICIAN	ADDRESS	PHONE	FAMILY PHYSICIAN	ADDRESS	PHONE

INSURANCE INFORMATION (PLEASE WRITE NAMES OF INSURANCE COMPANIES)

PRIMARY_____

SECONDARY_____

DO YOU HAVE AN ADVANCE HEALTH CARE DIRECTIVE/LIVING WILL? ❑ YES ❑ NO

CONSENT TO DISCLOSE MEDICAL INFORMATION

I hereby authorize the doctors and/or staff of Lake Orthopaedic Associates Inc., to release or discuss details of my care, treatment and billing and to contact in case of emergency, the following person(s); (this could be a spouse, parent, friend, etc.)

1. Name_____ Phone # _____ Relationship_____

2. Name _____ Phone # _____ Relationship_____

3. Name _____ Phone # _____ Relationship_____

If assigned a power of attorney, identify the name of the person in writing:_____

❑ **DO NOT DISCLOSE MY MEDICAL INFORMATION TO ANYONE**

OVER →

PLEASE READ AND SIGN IN THE AREA INDICATED ON THE REVERSE SIDE OF THIS FORM.

PLEASE READ AND SIGN BELOW

- Please be advised that completing preliminary health and insurance questionnaires does not establish a physician – patient relationship with this practice. The doctor will review your health history and conduct an initial evaluation to determine whether you are a suitable candidate and whether the practice will accept you as a patient.
- I hereby give my consent for the Physicians and Staff of Lake Orthopaedic Associates, Inc. to examine and render medical treatment and care to the above named patient, including the performance of those diagnostic and therapeutic procedures deemed advisable. I authorize Lake Orthopaedic Associates, Inc. to obtain my prescription history from an external source.
- I understand that I will be fully responsible for payment of any and all charges not covered by medical insurance athe current rates established by Lake Orthopaedic Associates, Inc. for all services rendered to the above named patient. In the event that the balance due has to be collected by an outside agency or attorney, I agree to pay collection costs and attorney fees.
- In consideration of any medical care provided to the above named patient, I assign to Lake Orthopaedic Associates, Inc.all my rights to any and all medical insurance benefits to which I am or may be entitled by any private or public payors.
- I hereby authorize Lake Orthopaedic Associates, Inc. to disclose to employer groups, insurance companies, government agencies, or any other third party payors and their agents or to utilization management companies, information in the form of verbal conversations, copies of the patient medical record, and/or other documents concerning medical care or treament that may be necessary for the payment, on my behalf, for services rendered to the above named patient.
- I hereby authorize Lake Orthopaedic Associates, Inc. to disclose individually identifiable health information created or received by Lake Orthopaedic Associates, Inc., whether oral or recorded in any form of medium, to any health plans that may be responsible for providing or paying the cost of rendered services in order to carry out payment activities.
- I further authorize Lake Orthopaedic Associates, Inc. to disclose such health information to contractors or other persons who carry out, assist in the performance of, or perform functions or activities for Lake Orthopaedic Associates, Inc., including legal, auditing, consulting, data processing, billing and coding services, and services related to health care operations, provided that such persons have provided assurances that the information will be appropriately safeguarded.
- I consent to receive calls from Lake Orthopaedic Associates, Inc regarding my patient health information and other services at the phone number(s) listed, including my provided wireless number. These calls may include information such as appointment dates and times as well as other pertinent information. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system. I understand that I can revoke consent to receive such calls at any time.
- I authorize release of my medical records to my referring and treating Physicians upon their/my request. I authorize release of my medical records to any Physician or medical facility that I am referred to by Lake Orthopaedic Associates, Inc.
- This authorization may be revoked in writing at any time except to the extent that actions have been taken in reliance thereon.

SIGNATURE OF PATIENT OR RESPONSIBLE PERSON	DATE	PRINT NAME	PHONE NUMBER
UPDATED SIGNATURE	DATE	PRINT NAME	PHONE NUMBER
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UPDATED SIGNATURE	DATE	PRINT NAME	PHONE NUMBER

I have received the Practice's Notice of Privacy Practices and understand that my protected health information may be used by the Practice as described in the notice.

SIGNATURE DATE

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