



PATIENT INFORMATION

(Please Print)

Patient's Name (Last) \_\_\_\_\_ First) \_\_\_\_\_ (MI) \_\_\_ Previous Name \_\_\_\_\_

Address Line 1 \_\_\_\_\_

City, State \_\_\_\_\_ ZIP \_\_\_\_\_ Pharmacy \_\_\_\_\_ Pharmacy Phone \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell No. \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Primary Care Provider (PCP) \_\_\_\_\_

Date of Birth MM \_\_\_\_/DD \_\_\_\_/YYYY \_\_\_\_\_ Sex  F – Female  M - Male  Transgender

Race  American Indian or Alaska Native  Asian  Native Hawaiian or Other Pacific Islander  Black or African American  White  Declined

Ethnicity  Hispanic or Latino  Not Hispanic or Latino  Declined

Language  English  Spanish  Indian  Japanese  Chinese  Korean  French  German  Russian  Other \_\_\_\_\_

Marital Status  Married  Single  Divorced  Widowed  Legally Separated  Partner

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Employer Name \_\_\_\_\_

Employment Status  1 - Full-Time  2 - Part-Time  3 - Not Employed  4 - Self-Employed  5 - Retired  6 - Active Military

Student Status  F - Full-Time Student  P - Part-Time Student  N - Not a Student

Emergency Contact Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Phone Number \_\_\_\_\_ Do you have a living will?  Yes  No

Emergency Contact Relationship to Patient \_\_\_\_\_  Guardian

How did you hear about us? \_\_\_\_\_

RESPONSIBLE PARTY INFORMATION – ONLY IF PATIENT IS A MINOR (Or Power of Attorney relationship)

Responsible Party (If minor)  Another Patient  Guarantor  Self Check here if information is same as patient

Responsible Party Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

Guarantor Account Number \_\_\_\_\_ Date of Birth MM \_\_\_\_/DD \_\_\_\_/YYYY \_\_\_\_\_

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Telephone \_\_\_\_\_

E-Mail Address \_\_\_\_\_ Sex  F – Female  M - Male

Address Line 1 \_\_\_\_\_

City, State \_\_\_\_\_ ZIP \_\_\_\_\_

Employer \_\_\_\_\_ Employer Phone Number \_\_\_\_\_

PRIMARY INSURANCE INFORMATION

(provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_

Name of Insured \_\_\_\_\_ Patient Relationship to Insured \_\_\_\_\_

Subscriber ID (Policy Number) \_\_\_\_\_ Group ID \_\_\_\_\_ Copay Amount \_\_\_\_\_

Effective Date \_\_\_\_\_ Termination Date \_\_\_\_\_ Date of Birth MM \_\_\_\_/DD \_\_\_\_/YYYY \_\_\_\_\_

SECONDARY INSURANCE INFORMATION (If Medicare, please provide reason)

(provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_

Name of Insured \_\_\_\_\_ Patient Relationship to Insured \_\_\_\_\_

Subscriber ID (Policy Number) \_\_\_\_\_ Group ID \_\_\_\_\_ Copay Amount \_\_\_\_\_

Effective Date \_\_\_\_\_ Termination Date \_\_\_\_\_ Date of Birth MM \_\_\_\_/DD \_\_\_\_/YYYY \_\_\_\_\_

Medicare Secondary reason  Working Aged Beneficiary/Spouse  Disabled Beneficiary under age  Other liability

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature \_\_\_\_\_ Date \_\_\_\_\_

**ORTHOONE AT NORTH SUBURBAN MEDICAL CENTER  
PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM**

Patient Name (Printed): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Notice of Privacy Practice/clinics.**

\_\_\_\_\_ (Patient/Representative initials) I acknowledge that I have received the practice/clinic's Notice of Privacy Practice/clinics, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice/clinic's Notice of Privacy Practice/clinics.

**Disclosures to Friends and/or Family Members**

**DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?"**

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

**Consent for Photographing or Other Recording for Security and/or Health Care Operations**

**I consent** \_\_\_\_\_ (Patient/Representative Initials) to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice/clinic's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

**-OR-**

**I do not consent** \_\_\_\_\_ (Patient/Representative Initials) to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice/clinic's health care operations purposes (e.g., quality improvement activities).

**Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications:**

**We want to stay connected with our patients. Patients in our practice/clinic may be contacted via email, calls to your cellular telephone (including prerecorded/artificial voice messages and/or calls from an automatic dialing device), and/or text messaging to confirm an appointment, to obtain feedback on your experience with our healthcare team, and to be provided general health reminders/information.** If at any time, you provide an email, cellular telephone number, address or text number below, you understand that you may get these communications from the Practice/clinic. You may opt out of these communications at any time (see next page). The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

**I authorize** to receive text messages and/or cellular telephone calls for appointment reminders, feedback, and general health reminders/information and **the cell phone number is** \_\_\_\_\_.

**I authorize** to receive email messages for appointment reminders and general health reminders/feedback/information and **the email that is** \_\_\_\_\_.

**-OR-**

**I decline** \_\_\_\_\_ (Patient/ Representative Initials) to receive communication via text.

**I decline** \_\_\_\_\_ (Patient/ Representative Initials) to receive communication via cellular telephone call.

**I decline** \_\_\_\_\_ (Patient/ Representative Initials) to receive communication via email.

**Note:** This clinic uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated clinics that share an electronic health record in which you have a relationship

**Release of Information.**

I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior service(s) at other HCA affiliated providers may be made available to subsequent HCA-affiliated providers to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

**Prescription Order Pick-up.** There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

- ***I do want***      (Patient/Representative Initials) to designate the following individual to pick up a prescription order on my behalf:
  - Name: \_\_\_\_\_ Date: \_\_\_\_\_
  - Name: \_\_\_\_\_ Date: \_\_\_\_\_
- ***I do not want***      (Patient/ Representative Initials) to designate anyone to pick-up my prescription order.

**Patient/Parent/Guardian/Patient Representative Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient/Parent/Guardian/Patient Representative Name (Printed)** \_\_\_\_\_

**Patient Name (Printed):** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Only If you have previously consented to receive communication via text/cellular telephone call/email and wish to remove the consent/Opt Out/Revocation of communications via email and/or text or cellular telephone call. In other words, I do not want my email address or cell number to be used any longer for the above mentioned communications.**

- I hereby revoke my request to receive any future appointment reminders, feedback, and general health via **text**.
- I hereby revoke my request to receive any future appointment reminders, feedback, and general health via **cellular telephone call**.
- I hereby revoke my request to receive any future appointment reminders, feedback, and general health via **email**.

**Patient Name:** \_\_\_\_\_

**Patient/Patient Representative Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

I, the undersigned, authorize North Denver Bone and Joint Specialists to leave a (circle one)

DETAILED                      OR                      GENERAL

Voicemail messages regarding future appointments, test results, and personal information on the number I specify:

Phone number: ( \_\_\_\_\_ ) \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## General Consent for Care and Treatment Consent

***TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).***

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

\_\_\_\_\_  
**Signature of Patient or Personal Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed Name of Patient or Personal Representative**

\_\_\_\_\_  
**Relationship to Patient**

\_\_\_\_\_  
**Printed Name of Witness**

\_\_\_\_\_  
**Employee Job Title**

\_\_\_\_\_  
**Signature of Witness**

\_\_\_\_\_  
**Date**

1. \_\_\_\_\_(Patient or Guardian Initials)

**Financial Agreement.**

- I acknowledge, that as a courtesy, **North Denver Bone and Joint Specialists** may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand that there is a fee for returned checks.

2. \_\_\_\_\_(Patient or Guardian Initials)

**Third Party Collection.** I acknowledge that **North Denver Bone and Joint Specialists** may utilize the services of a third party business associate or affiliated entity as an extended business office (“EBO Servicer”) for medical account billing and servicing.

3. \_\_\_\_\_(Patient or Guardian Initials)

**Assignment of Benefits.** I hereby assign to **North Denver Bone and Joint Specialists** any insurance or other third-party benefits available for health care services provided to me. I understand **North Denver Bone and Joint Specialists** has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to **North Denver Bone and Joint Specialists**, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

4. \_\_\_\_\_(Patient or Guardian Initials)

**Medicare Patient Certification and Assignment of Benefit.** I certify that any information I provide, if any, in applying for payment under Title XVIII (“Medicare”) or Title XIX (“Medicaid”) of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to **North Denver Bone and Joint Specialists** by the Medicare or Medicaid program.

5. \_\_\_\_\_(Patient or Guardian Initials)

**Consent to Telephone Calls for Financial Communications.** I agree that, in order for **North Denver Bone and Joint Specialists**, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that **North Denver Bone and Joint Specialists** or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or **North Denver Bone and Joint Specialists** or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

6. \_\_\_\_\_(Patient or Guardian Initials)

A photocopy of this consent shall be considered as valid as the original.

Patient/Patient Representative Signature:

X \_\_\_\_\_ Date \_\_\_\_\_

If you are not the Patient, please identify your Relationship to the Patient.

(Circle or mark relationship(s) from list below):

- |                |                              |
|----------------|------------------------------|
| Spouse         | Guarantor                    |
| Parent         | Healthcare Power of Attorney |
| Legal Guardian | Other (please specify) _____ |

**HCA Physician Services**  
**Authorization for Release of Protected Health Information (PHI)**

<b>Section A: This section must be completed for all Authorizations</b>					
<b>Patient Name:</b>		<b>Date of Birth:</b>	<b>Patient's Phone:</b>	<b>Last 4 digit SSN (optional):</b>	
<b>Provider's Name:</b>		<b>Recipient's Name:</b>			
<b>Provider's Address:</b>		<b>Address 1:</b>			
		<b>Address 2:</b>		<b>Recipient's Phone:</b>	
		<b>City:</b>	<b>State:</b>	<b>Zip:</b>	
<b>Request Delivery (If left blank, a paper copy will be provided):</b> <input type="checkbox"/> Paper Copy <input type="checkbox"/> Electronic Media, if available ( <i>e.g.</i> , USB drive, CD/DVD) <input type="checkbox"/> Encrypted Email <input type="checkbox"/> Unencrypted Email <b>NOTE:</b> In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided ( <i>e.g.</i> , paper copy). There is some level of risk that a third party could see your PHI without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks ( <i>e.g.</i> , virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.					
<b>Email Address (If email checked above. Please print legibly):</b>					
This authorization will expire on the following: (Fill in the Date or the Event but not both.)					
<b>Date:</b>		<b>Event:</b>			
<b>Purpose of disclosure:</b>					
<b>Description of information to be used or disclosed</b>					
Is this request for psychotherapy notes? <input type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input type="checkbox"/> No, then you may check as many items below as you need.					
<b>Description:</b>	<b>Date(s):</b>	<b>Description:</b>	<b>Date(s):</b>	<b>Description:</b>	<b>Date(s):</b>
<input type="checkbox"/> All PHI in medical record <input type="checkbox"/> Admission form <input type="checkbox"/> Dictation reports <input type="checkbox"/> Physician orders <input type="checkbox"/> Intake/outtake <input type="checkbox"/> Clinical test <input type="checkbox"/> Medication sheets		<input type="checkbox"/> Operative information <input type="checkbox"/> Cath lab <input type="checkbox"/> Special test/therapy <input type="checkbox"/> Rhythm strips <input type="checkbox"/> Nursing information <input type="checkbox"/> Transfer forms <input type="checkbox"/> ER information		<input type="checkbox"/> Labor/delivery summary <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input type="checkbox"/> Itemized bill: <input type="checkbox"/> UB-04: <input type="checkbox"/> Other: <input type="checkbox"/> Other:	
I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, genetic information, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial)					
I understand that:					
1. I may refuse to sign this authorization and that it is strictly voluntary. 2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it. 6. I get a copy of this form after I sign it.					
<b>Section B: Is the request of PHI for the purpose of marketing and/or does it involve the sale of PHI?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.					
Will the recipient receive financial remuneration in exchange for using or disclosing this information?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, describe:					
May the recipient of the PHI further exchange the information for financial remuneration?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Section C: Signatures</b>					
I have read the above and authorize the disclosure of the protected health information as stated.					
<b>Signature of Patient/Patient's Representative:</b>				<b>Date:</b>	
<b>Print Name of Patient's Representative:</b>				<b>Relationship to Patient:</b>	