Welcome To Our Practice

Today's Date:	JMH Orthopedic Surgery and Sports Medicine

PATIENT INFORMATION

Patient Last Name:	First:	Middle:	Prefix:
Street Address/City/State/Zip:	Home Phone:	Cell Phone:	Work Phone:

Primary Care Physician: Referring Physician:	DOB: Sex: Marital Status:	SSN:

Race: _____ African-American _____Asian ___Hispanic ____ Native-American ___ White ____ Other	Ethnicity: ___Hispanic ___ Non-Hispanic	Language of Preference:

Personal Email Address: _____

[ ] I want access to my medical records (email address required) **[ ] I do not want access to my medical records**

RESPONSIBLE PARTY INFORMATION

Person responsible for bill:	Relationship to Patient (If other than self)
Address if different from Patient:	
Employer Name:	Employer Address & Phone:

ACCIDENT INFORMATION (IF APPLICABLE)

How did injury/problem occur? Date: _____ Where: _____
How:_____
Have you had xrays for this problem? YES / NO If yes, Where: _____
Is this condition work related? YES / NO Auto Accident: YES / NO
If yes, date of accident or onset: _____

INSURANCE INFORMATION
*********** PLEASE GIVE YOUR INSURANCE CARD(S) TO THE RECEPTIONIST ***********
☐ ***Please check this box if you do NOT have insurance coverage***

Primary Ins:	Secondary Ins:
Identification #	Identification #
Subscriber's Name:	Subscriber's Name:
Group #	Group #
Subscriber's DOB:	**Subscriber's DOB:**
Patients Relation to Subscriber:	Patients Relation to Subscriber:
Subscriber's SSN:	**Subscriber's SSN:**
** If Patient is a minor: Father's Name: Date of Birth:	** If Patient is a minor: Mother's Name: Date of Birth:

ADDITIONAL INFORMATION

Emergency Contact Name:	Phone: Relationship to Patient:
Pharmacy Name: Phone Number:	
I CERTIFY THAT THE INFORMATION I HAVE PROVIDED IS ACCURATE AND CURRENT:	
Signature of patient or responsible party:	Date:

New Patient Consent to the Use and Disclosure of Health Information For Treatment , Payment, or Healthcare Operations

I, _____ understand that as part of my health care, Johnson Memorial Physician Network originates and maintains paper and/or electronic records describing my health history, prescriptions, symptoms, examination, test results, diagnoses, treatment and any plans for future care. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party-payer can verify that services billed were actually provided, and
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I understand and have been provided with a *HIPAA Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Johnson Memorial Physician Network is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Johnson Memorial Physician Network reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Johnson Memorial Physician Network change their notice, we will provide you an opportunity to receive an updated policy at your next visit.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I also permit you to discuss with parties indicated below, my health and/or financial status.

Party's Name: _____ Phone Number: _____ ☐Health Status ☐Financial Status

Party's Name: _____ Phone Number: _____ ☐Health Status ☐Financial Status

I fully understand and accept the terms of this consent. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions. I shall also be responsible for any fees required to collect for past due balances which may include court costs, and collection agency fees, to which may be added pre-judgement and/or post-judgement. By providing my telephone number (landline and/or cell) I am allowing Franklin Surgical Associates and our collection agency to contact me regarding collections of my account. Methods of contact may include using pre-recorded/artificial voice messages and/or use of any automatic dialing device, as applicable.

_____ _____

Patient's Signature (authorized representative signing for the patient) Date

FOR OFFICE USE ONLY

☐ Consent received by:_____(initials)

☐ Consent refused by patient, and treatment refused as permitted.

☐ Consent added to the patient's medical record