HCA HealthONE

Excellence in Motion

WESTERN ORTHOPAEDICS

Patient HIPAA Acknowledgment and Consent Form

WESTERN ORTHOPAEDICS			
Patient Last Name (Type)	Patient First Name (type)	MI	Type Date of Birth (MM/DD/YYYY)

Notice of Privacy Practice

_____(**Patient/Representative initials)** I acknowledge that I have received the Notice of Privacy Practice, 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 Notice of Privacy Practice.

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

_____(**Patient/Representative initials)** Some messages relevant to your visit may be sent regardless of explicit consent, including instructions or communications directly related to your care. These instructions may include, but not be limited to: post-procedure instructions, follow-up instructions, educational information, and prescription information. For other types of communications, I consent to receiving, by telephone call, text message, or voicemail transmission, communications by or on behalf of the practice/clinic at the email, telephone number or text address I have provided in my patient record. I also consent to receiving such communications to any email, text address or telephone number forwarded or transferred from that address or telephone number. Other healthcare communications may include, but are not limited to, healthcare communications to family or designated representatives regarding my treatment or condition, reminder messages to me regarding appointments for medical care, communications regarding insurance or billing or requests for feedback about my visit via satisfaction surveys and/or public-facing reviews. I authorize and acknowledge that these instructions and other communications may be transmitted using an automated system for the selection or dialing of telephone numbers or the playing of prerecorded messages and may be made by the practice/clinic or someone calling on their behalf even if my phone number is listed on any federal or state "do not call" registry. To the extent these instructions and other communications could be deemed telephonic sales calls, solicitations or advertisements, I consent to receiving them. I understand that I am not required to consent directly or indirectly to communications in order to receive healthcare services.

Note: This location 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 locations that share an electronic health record in which you have a relationship. My consent to access the location's Electronic Health Record's Patient Portal shall be considered separate and apart from the consent in this form *(section: Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications).*

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 to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice's/clinic's health care operations purposes (e.g., quality improvement activities). I understand that the practice/clinic 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.

I authorize that Dr. Hatzidakis or Dr. Sears may use clinical photographs for educational purposes, including scientific presentations or manuscripts.

I agree to the above statement (select one): _____Yes_____No

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Patient Last Name (Type)	Patient First Name (type)	MI	Type Date of Birth (MM/DD/YYYY)

Communications about My Healthcare

I agree the Provider or an agent of the Provider or an independent physician's office may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

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.

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

Patient/Representative Signature	Relationship to Patient (self, parent, legal guardian/representative, etc)	Date

Practice:OPTIONAL ON FORM- REMOVE THIS Prescription Order Pick up Section **ONLY** if NA to your practice/clinic

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	Relationship to Patient

- _____***I do not want*** ____ (Patient/ Representative Initials) to designate anyone to pick-up my prescription order.

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Western Orthopaedics

Patient name: _____

Date of birth: _____

Patient Consent for Financial Communications

Financial Agreement

- I acknowledge, that as a courtesy, WESTERN ORTHOPAEDICS 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 there is a fee for returned checks.

Third Party Collection. I acknowledge WESTERN ORTHOPAEDICS may use the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

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

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 WESTERN ORTHOPAEDICS by the Medicare or Medicaid program.

Consent to Telephone Calls for Financial Communications. I agree that, in order for WESTERN ORTHOPAEDICS, 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 WESTERN ORTHOPAEDICS or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or WESTERN ORTHOPAEDICS 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.

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

Patient/patient representative signature: _____ **Date:** _____

If you are not the patient, please identify your relationship to the patient. Circle or mark relationship(s) from list below:

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

PATIENT REGISTRATION FORM

PATIENT INFORMATION (Please print)

Patient's Legal Name: (Last)_____(First)_____(MI) _____

Preferred Full Name (if different from above): _____Preferred Pronoun: _____

Address: _____

City, State, Zip: _____

Home Phone Number (landline):_____Cell:_____Work: _____

E-Mail Address_____Sex Assigned at Birth_____Date of Birth: _____

Sexual Orientation: ☐ Bisexual ☐ Lesbian, gay, or homosexual ☐ Straight or heterosexual ☐ Do not know ☐ Choose not to disclose
☐ Something else, please describe _____

Gender Identity: ☐ Female ☐ Male ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer ☐ Choose not to disclose
☐ Additional Gender category not listed _____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ White
☐ Hispanic ☐ Chose not to disclose ☐ Other not listed _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Choose not to disclose

Preferred Language: ☐ English ☐ Spanish ☐ ASL ☐ Japanese ☐ Mandarin ☐ Korean ☐ French ☐ Indian: Hindi, Tamil, Gujarati etc
☐ Swahili ☐ Russian ☐ Arabic ☐ Vietnamese ☐ Haitian Creole ☐ Bosnian/Croatian/Serbian/Serbo-Croatian
☐ Albanian ☐ Burmese ☐ Tagalog ☐ Farsi-Iranian/Persian ☐ Portuguese ☐ Cambodian ☐ Other not listed_____

Marital Status: ☐ Married ☐ Partner ☐ Single ☐ Divorced What is or was your occupation? _____

Pharmacy Name: _____Address_____ Phone_____

Primary Care Physician _____Address_____ Phone_____

Patient Social Security Number: _____

RESPONSIBLE PARTY INFORMATION (*if not self*) (Information used for patient balance statements)

Responsible party: ☐ Another patient ☐ Guarantor ☐ Self Check here if address and telephone information is same as patient ☐
Responsible party name: (Last)_____(First)_____(MI) _____
Date of birth: MM_____/DD_____/YYYY_____ Sex: ☐ Female ☐ Male
Responsible Party Social Security Number: _____Phone number: _____
Address:_____
City, State:_____ZIP: _____

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last)_____ (First) _____
Phone number:_____ Do you have a living will? ☐ Yes ☐ No
Emergency contact relationship to patient:_____ ☐ Guardian
Address_____City, State:_____
ZIP: _____Home phone:_____Work phone:_____

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: _____

PLEASE LIST ALL MEDICATIONS CURRENTLY BEING USED (PLEASE PRINT NEATLY) **None**

If you need more space for your medications, please provide a list on a separate sheet

Name, dose (i.e., 2 mg, 60 mg, etc)	**Frequency** (i.e. twice daily, at bedtime)	**Problem being treated Prescribing Doctor**

PAST MEDICAL HISTORY

Please ✓ box next to any condition with which YOU have been diagnosed, or list other:

Medical	**Medical**	**Neurological**	**Pertinent to Surgery**
□ None	□ GERD / Reflux	□ Aneurysm	□ Anticoagulation
□ Anemia	□ Glaucoma	□ CVA/Stroke	□ Bleeding Disorder
□ Anxiety	□ Heart Disease	□ Brain Tumor	□ Chronic Pain
□ Asthma	□ Hepatitis	□ Hydrocephalus	□ Clotting Disorder
□ Atrial Fibrillation	□ HIV	□ Migraines	□ DVT
□ Autoimmune Disorder	□ High cholesterol/lipids	□ Multiple Sclerosis	□ Hemophilia
□ Enlarged Prostate	□ High Blood Pressure	□ Parkinson's Disease	□ Narcotic use > 6 mo
□ Cancer – Breast	□ Irritable bowel disease	□ Peripheral Neuropathy	□ Anesthesia Problems
□ Cancer – Lung	□ Myocardial infarction	□ Pituitary Tumor	□ Pulmonary Embolism
□ Cancer – Renal	□ Nasal Allergies	□ Seizure Disorder	□ Other:
□ Cancer – Colon	□ Osteoarthritis	□ Spinal Cord Injury	
□ Cancer – Prostate	□ Osteoporosis	□ TIA	
□ COPD	□ Renal Disease	□ Traumatic Brain Injury	
□ Depression	□ Rheumatoid Arthritis	□ Trigeminal Neuralgia	
□ Diabetes – Type I	□ Thyroid Disease	□ Other:	
□ Diabetes – Type 2	□ Vision Loss		
□ Fibromyalgia	□ Other:		

ALLERGIES:

Are you allergic to ANY medication, food, or non-medications (such as pollen, etc.)? ☐ *No* ☐ *Yes*

If yes, please list below. Name of Medication / Food / Agent Type of Reaction, i.e. rash, breathing problems, swelling, etc.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

SURGERIES :

Have you ever had surgery? ☐ **No** ☐ **Yes**

If **yes**, list name / type of surgeries and when they were done.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____