Saint Francis HEALTHCARE | Advanced Orthopedic Specialists

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**Appt** 573-335-7040
**Other Locations**
Jackson | Poplar Bluff | Sikeston

## PATIENT INFORMATION SHEET

***(PLEASE PRINT)***

Account # _____ Date _____

Patient's Legal Name _____
Last First MI

Address _____
Street City State Zip

SS# _____ Birth Date _____ Age: _____ Sex: _____

Home Telephone # _____ Cell Phone # _____

Email Address: _____

Marital Status (Select One): ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Race: ☐ American Indian ☐ Asian ☐ Black ☐ Native Hawaiian ☐ White ☐ Other _____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Other _____

Preferred Language: ☐ English ☐ Spanish ☐ Other _____

Patient's Employer _____ Occupation _____

Employer's Address _____ Phone # _____

Spouse's Name _____ Birth Date _____ SS# _____

Spouse's Employer's Address _____ Phone # _____

Patient's Family Physician _____

**EMERGENCY CONTACT** - Name of someone who ***does not*** live with you.

Name _____ Phone # _____

** IF THE PATIENT IS A MINOR OR STILL COVERED BY PARENT / STEPPARENT(S) INSURANCE, PLEASE FILL OUT INFORMATION BELOW **

Father's Name _____ Birth Date _____ SS# _____

Father's Employer _____ Occupation _____

Father's Employer Address _____ Phone # _____

Mother's Name _____ Birth Date _____ SS# _____

Mother's Employer _____ Occupation _____

Mother's Employer's Address _____ Phone # _____

Stepparent's Name _____ Birth Date _____ SS# _____

Stepparent's Employer _____ Occupation _____

# CONSENT FOR CARE & ASSIGNMENT OF BENEFITS
# ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I, the undersigned, consent to the use and disclosure of my protected health information by Advanced Orthopedic Specialists, P.C. for the purpose of carrying out my treatment, obtaining payment for my health care or for carrying out health care operations.

I understand that I have a right to review Advanced Orthopedic Specialists, P.C.'s Notice of Privacy Practices prior to signing this document. I hereby acknowledge that I received a copy of Advanced Orthopedic Specialists, P.C.'s Notice of Privacy Practices. The Notice of Privacy Practices provides information about how Advanced Orthopedic Specialists, P.C. may use and disclosure protected health information about me. A copy of this Notice of Privacy Practices is also provided in the waiting area of Advanced Orthopedic Specialists, P.C.

Advanced Orthopedic Specialists, P.C. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I acknowledge that I have the right to request that the use of my protected heath information be restricted in carrying out my treatment, obtaining payment for my health care or for carrying out the health care operations. However, I understand that Advanced Orthopedic Specialists, P.C. is not obligated to agree to any such restriction, unless I request that my protected health information not be disclosed to a health plan for purposes of payment and health operations if I paid out of pocket for that service. If Advanced Orthopedic Specialists, P.C. and I agree upon any restrictions, such restrictions will be in writing and both Advanced Orthopedic Specialists, P.C. and I will agree to terminate any such restriction in writing.

My "protected health information" includes all individually identifiable information which is created or received by Advanced Orthopedic Specialists, P.C. and which relates to my past, present or future physical or mental health or condition, the provision of health care to me or to the past, present or future payment for the provision of health care to me.

I hereby assign all medical, surgical, and/or third party payer benefits to which I am entitled, including private insurance, Medicare and/or any other health plan to: Advanced Orthopedic Specialists, P.C. for any services furnished me by Advanced Orthopedic Specialists, P.C. I authorize Advanced Orthopedic Specialists, P.C. to release any medical information to such private insurance, the Centers for Medicare & Medicaid Services and/or any other health plan to the extent such information is needed to determine benefits or benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. If the above services are being provided to a minor, the personal representative below agrees that he/she is financially responsible for all charges whether or not paid by said insurance.

I agree that Advanced Orthopedic Specialists, P.C. may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.

I also hereby authorize Advanced Orthopedic Specialists, P.C. to release and/or discuss my protected health information to the following individuals.

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

Phone: _____ Phone: _____

Relationship: _____ Relationship: _____

*A photocopy or fax copy of this consent and assignment of benefits is to be considered as valid as the original.*

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Name of Patient or Personal Representative Description of Personal Representative" Authority