

**Orthopaedic & Sports Specialists  
Intake Form**

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

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Age: \_\_\_\_\_

Address: \_\_\_\_\_

Home Ph: \_\_\_\_\_

Cell: \_\_\_\_\_

SS#: \_\_\_\_\_

**1st Ins:** \_\_\_\_\_

**2nd Ins:** \_\_\_\_\_

Subscriber:  Self  Spouse  Parent

Subscriber:  Self  Spouse  Parent

ID# \_\_\_\_\_

ID# \_\_\_\_\_

Grp # \_\_\_\_\_

Grp # \_\_\_\_\_

**IS THIS RELATED TO AN INJURY AT WORK OR TO A MOTOR VEHICLE ACCIDENT?**  Yes  No

Employer: \_\_\_\_\_

Date of Injury: \_\_\_\_\_

Address: \_\_\_\_\_

Body Part: \_\_\_\_\_

Phone: \_\_\_\_\_

**INSURANCE AUTHORIZATION AND ASSIGNMENT**

PROVIDING QUALITY MEDICAL CARE FOR OUR PATIENTS IS OUR PRIMARY CONCERN. WE ARE MORE THAN WILLING TO PROVIDE THAT CARE WITHIN YOUR INSURANCE CONTRACT GUIDELINES IF YOU LET US KNOW AT EACH TIME OF SERVICE, EXACTLY WHAT THOSE GUIDELINES ARE.

UNFORTUNATELY, IF YOU DO NOT INFORM US OF ANY SPECIAL REQUIREMENTS IN YOUR CONTRACT AND WE SUBSEQUENTLY ORDER SERVICES SUCH AS X-RAYS, TESTING, MEDICAL SUPPLIES, THERAPY, OR HOSPITALIZATION THAT ARE NOT COVERED, WE OR THE SELECTED MEDICAL FACILITY WILL HAVE NO CHOICE BUT TO BILL YOU DIRECTLY FOR THOSE CHARGES. INJECTIONS MAY NOT BE COVERED BY YOUR INSURANCE PLAN. IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT YOUR PLAN. PAYMENT FOR THOSE CHARGES WILL THEN **BECOME YOUR RESPONSIBILITY**.

**THERE WILL BE A \$35.00 CHARGE FOR ALL RETURNED CHECKS.**

I HEREBY AUTHORIZE ORTHOPAEDIC AND SPORTS SPECIALISTS, P.C. TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN THE PHYSICIAN(S) ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MY DEPENDENTS OR MYSELF. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. I HAVE READ AND UNDERSTAND THE OFFICE POLICY STATED ABOVE AND AGREE TO ACCEPT RESPONSIBILITY AS DESCRIBED.

SIGNATURE \_\_\_\_\_

**AUTHORIZATION TO OBTAIN MEDICAL RECORDS**

PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT I \_\_\_\_\_

(PLEASE PRINT NAME)

HEREBY AUTHORIZE ORTHOPAEDIC & SPORTS SPECIALISTS TO OBTAIN MEDICAL RECORDS SPECIFICALLY RELATED TO MY TREATMENT. THIS PROTECTED HEALTH INFORMATION IS BEING USED BY THE FACILITY FOR THE PURPOSE OF PREPARATION FOR AN OUTPATIENT VISIT AT ORTHOPAEDIC AND SPORTS SPECIALISTS. THIS AUTHORIZATION SHALL BE IN FORCE AND EFFECT UNTIL WITHDRAWN BY MYSELF OR MY REPRESENTATIVE. I HAVE READ AND UNDERSTAND ORTHOPAEDIC AND SPORTS SPECIALISTS PRIVACY NOTICE ON HOW TO REVOKE OR WITHDRAW THIS AUTHORIZATION.

SIGNATURE \_\_\_\_\_

**ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE**

IN THE EVENT THAT A REPRESENTATIVE OR FAMILY MEMBER WISHED TO DISCUSS YOUR PROTECTED HEALTH INFORMATION WITH THE DOCTOR, WE MUST HAVE YOUR PERMISSION TO DO SO. PLEASE FILL IN THE SPACE BELOW TO INDICATE THE NAME OF SUCH PERSON THAT YOU WILL ALLOW THE DOCTOR TO DISCUSS THE PROTECTED HEALTH INFORMATION WITH. I AUTHORIZE ORTHOPAEDIC AND SPORTS SPECIALISTS TO RELEASE MY PROTECTED HEALTH INFORMATION TO THE FOLLOWING REPRESENTATIVE/FAMILY MEMBER ON MY BEHALF: \_\_\_\_\_

I ACKNOWLEDGE THAT I HAVE RECEIVED ORTHOPAEDIC AND SPORTS SPECIALISTS PRIVACY NOTICE.

\_\_\_\_\_  
Signature Patient or Personal Representative

