



**Bruce R. Weiner, MD; David C. Randall, MD; E. Brooke Roberts, MD and David M. Wallace, DO**

**PATIENT INFORMATION** – *Please Print*

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_ E-Mail \_\_\_\_\_

Sex  M  F Marital Status  Minor  Single  Married  Long-Term Partner  Divorced  Widowed  Separated

Social Security # \_\_\_\_\_ Drivers License # \_\_\_\_\_ State \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Business Phone # \_\_\_\_\_

Employer Address \_\_\_\_\_  
Street City State Zip

In case of an emergency, whom should we contact? \_\_\_\_\_ Phone # \_\_\_\_\_

Referring Physician / Family Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Pharmacy \_\_\_\_\_ Address \_\_\_\_\_ Phone # \_\_\_\_\_

**REQUIRED** – *If Patient is a Minor*

Father's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Employer \_\_\_\_\_ Business Phone # \_\_\_\_\_

Mother's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Employer \_\_\_\_\_ Business Phone # \_\_\_\_\_

Patient (*check one*)  Lives with Both Parents  Lives with Mother  Lives with Father  Lives with Relative/Guardian  
 School Status (*check one*)  Full-time Student  Part-time Student  Not in School (specify) \_\_\_\_\_

**INSURANCE INFORMATION** – *A Copy of Your Insurance Card & Driver's License (Photo ID) is Required*

Primary Insurance \_\_\_\_\_ Phone # \_\_\_\_\_

Policy Holder \_\_\_\_\_ SS # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employer \_\_\_\_\_ ID/Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Phone # \_\_\_\_\_

Policy Holder \_\_\_\_\_ SS # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employer \_\_\_\_\_ ID/Policy # \_\_\_\_\_ Group # \_\_\_\_\_

**RELEASE OF MEDICAL INFORMATION AUTHORIZATION**

In order to protect your privacy, East Houston Orthopedics & Sports Medicine, PA, asks you to list the family members, friends or any person(s) who can request or inquire regarding your Protected Health Information which includes medical condition and/or billing and financial information.

<i>Name of Family Member / Friend / Other Person(s)</i>	<i>Relationship to Patient</i>

**COMMUNICATION AUTHORIZATION** – *Please Complete*

We are committed to providing private and efficient communication with you. Please indicate the preferred method(s) of contact, should we need to reach you by phone. Place a (X) in the appropriate box(es).

- Home       message to return call    detailed message (results, treatment)    NO message    voice mail    with an individual
- Work       message to return call    detailed message (results, treatment)    NO message    voice mail    with an individual
- Cell       message to return call    detailed message (results, treatment)    NO message    voice mail    with an individual

Other \_\_\_\_\_

**HIPAA & RELEASE OF INFORMATION POLICY** – *Please Read & Initial* \_\_\_\_\_

I hereby authorize East Houston Orthopedics & Sports Medicine, PA to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and other health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, East Houston Orthopedics & Sports Medicine, PA can refuse to treat me.

I have been provided the “Notice of Privacy Policies” for East Houston Orthopedics & Sports Medicine, PA, which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and other health care operations. I understand that I have the right to review such “notice” prior to signing this consent.

I understand that I may revoke this consent at any time by notifying East Houston Orthopedics & Sports Medicine, PA, in writing, but if I revoke my consent, such revocation will not affect any actions that East Houston Orthopedics & Sports Medicine, PA took before receiving my revocation. I understand that East Houston Orthopedics & Sports Medicine, PA has reserved the right to change its privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that East Houston Orthopedics & Sports Medicine, PA restrict how my individually identifiable health information is used and/or disclosed to carry out treatment, payment, or other health care operations. I understand that East Houston Orthopedics & Sports Medicine, PA does not have to agree to such restrictions, but that once such restrictions are agreed to, East Houston Orthopedics & Sports Medicine, PA must adhere to such restrictions.

**FINANCIAL POLICY** – *Please Read & Initial* \_\_\_\_\_

I acknowledge full financial responsibility for services rendered by East Houston Orthopedics & Sports Medicine, PA and authorize transfer of all unpaid amounts to me, which includes, but is not limited to, **CO-PAYS, DEDUCTIBLES, CO-INSURANCE, PRE-EXISTING CLAUSES, EXCLUDED CONDITIONS, and/or TERMINATION OF COVERAGE.**

I agree to pay all legal fees including attorney and court fees as well as collection costs in the event of default of payment of charges that are my financial responsibility. I further authorize and request that all insurance payments be made directly to East Houston Orthopedics & Sports Medicine, PA.

**ACKNOWLEDGEMENT** – *Signature Required*

- I acknowledge that I have received the “Notice of Privacy Policies” for East Houston Orthopedics & Sports Medicine, PA.
- I hereby authorize East Houston Orthopedics & Sports Medicine, PA to release any information requested by the above named Insurance Company or Companies or respective representatives and act as my agent to secure payment for any and all services rendered.
- I understand that I am financially responsible to the physician for any charges incurred by myself and/or my dependents.

I have read and understand the “HIPAA & Release of Information Policy” and the “Financial Policy” established by East Houston Orthopedics & Sports Medicine, PA. I further acknowledge that I accept the terms outlined in each of the policies.

\_\_\_\_\_  
Signature of Patient or Patient’s Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient or Patient’s Representative

\_\_\_\_\_  
Representative’s Relationship to the Patient

\_\_\_\_\_  
Account Number (*office use*)