



Bruce R. Weiner, MD David C. Randall, MD E. Brooke Roberts, MD

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.

Table with 2 columns: Name of Family Member / Friend / Other Person(s), Relationship to Patient

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*)