Central Carolina Orthopaedic Associates

Section I **Patient Information** **Date**_____

Name: _____Date of Birth: _____SS number: _____

Email Address: _____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Address: _____City: _____State: _____Zip: _____

Home #_____Cell # _____ Work # _____

Name of Employer_____

Person to contact in case of emergency _____Phone _____

Primary or Family Physician _____Referring Physician _____

Section II **Responsible Party**

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name: _____ Relationship to Patient: _____

Address: _____ Phone: (____) _____

City: _____State: _____Zip: _____

Section III **Insurance Information**

Name of Insured: _____DOB: _____ Relationship to Patient: _____

SSN#: _____Name of Employer: _____Work Phone: (____) _____

Insurance Company: _____Grp # _____ ID#_____

----- DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No -----

Please present card(s) to office staff

Authorization to release information: I hereby authorize CCOA to release information to insurance carriers concerning my illness/injury and treatment. I authorize CCOA to release information as requested by other practices upon my written consent.
Authorization to Pay: I hereby assign to CCOA any outstanding payments due for medical services rendered to me or my dependents. I understand that I am responsible for any amount not covered by my insurance carrier and that balances not paid within 30 days after the 1st notification may be referred for legal action. I agree to pay all costs of collections, including reimbursable attorney fees and court costs should I fail to pay the amount owed when due.

Patient/Guardian Signature: _____Date: _____

Consent Form

(For Use and Disclosure of Protected Health Information for
Treatment, Payment, or Healthcare Operations)

I understand that as part of my healthcare, **Central Carolina Orthopaedic Associates (CCOA)**, originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care and treatment. I also understand this information serves as:

- A basis for planning my care and treatment
- A means of communicating among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

Posted for my review is the **Notice of Information Practices.** I understand that the **Notice of Information Practices** provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to implementation. I also understand that I have the right to restrict as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the Practice has already taken action in reliance thereon.

With this consent, CCOA, may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the Practice in carrying out TPO (**T**reatment, **P**ayment, or **H**ealthcare **O**perations), such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, CCOA may mail to my home or other designated location any items that assist the Practice in carrying out TPO, such as appointment reminders and other correspondence. I have the right to request that CCOA restrict how it uses or discloses my Protected Health Information to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to CCOA to use and disclose my Protected Health Information to carry out my TPO.

I may revoke my consent in writing except to the extent that the Practice has already made disclosures in reliance upon my prior consent. **If I do not sign this consent, CCOA may decline to provide treatment to me.**

Print Patient Name: _____

Signature of Patient: _____, or

Signature of Legal Guardian: _____(if patient is under 18 years of age)

Date: _____