PATIENT REGISTRATION & AUTHORIZATION

All professional services are the patient's responsibility. We will be happy to expedite the insurance carrier payment by filing the claim for you. However, the patient is responsible for all fees regardless of insurance coverage. We advise you to check with your insurance carrier for benefit coverage. Payment is due at the time of service unless arrangements are made.

Legal Name:_____ Preferred Name:_____DOB:_____

Address:_____ Social Security #:_____

City:_____State:_____ Zip:_____ Sex:_____ Age:_____Email:_____

Single_____Married_____Divorced_____Widowed_____ **RACE_____ LANGUAGE_____ETHNICITY_____**

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Emergency Contact: _____ Phone #:_____

Pharmacy & Address:_____ Employer & Phone:_____

Primary Care Physician:_____ PCP'S Phone #:_____

- **I give my consent for Coastal Orthopedics to discuss my health information with:**

Name(s):_____ Phone Number(s):_____

Relationship(s) to patient:_____

- ***If this is a Workers Compensation injury, please include the required information:***

*Workers Comp Claim #:*_____ *Date of Injury:*_____

*Employer responsible for injury:*_____

*(If BIW employee, please include Badge #:*_____ *Department #:*_____

- **Required Billing information if the person responsible is someone other than the patient:**

Name:_____ Social Security#:_____

Address:_____ Sex:_____ DOB:_____

City:_____ State:_____ Zip:_____ Employer/Occupation:_____

Home Phone:_____ Work Phone:_____ Employer Address:_____

****If you are a managed care patient, a referral number is required at the time of the visit. If you do not have a referral number, you may choose to reschedule or sign a waiver stating you may be responsible for the bill if your insurance does not pay.****

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Coastal Orthopedics to furnish information to insurance carriers concerning my treatment and hereby assign to the physician all payment for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance. For worker's compensation claims, I further authorize Coastal Orthopedics to release information regarding my examination or treatment to my employer or their insurance carrier. Please send the office notes to my family physician.

Signature:_____ **Date**:_____

PATIENT PARTNERSHIP PLAN

Welcome to our practice! We intend to provide you with the care and service that you expect and deserve. Achieving your best possible orthopedic outcome requires a "partnership" between you and your doctor. As our "partner in health," we ask you to help us in the following ways:

Schedule visits as recommended by your doctor – I understand that my doctor will explain to me my treatment plan in detail. I will schedule the visits pertaining to diagnostic tests, treatments and other physician specialists as recommended by my doctor. I understand that by following the treatment plan as outlined, it will enable me to obtain the highest level possible of functionality and overall outcome.

Keep follow-up appointments and reschedule missed appointments – I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to complete my treatment as outlined. This may put my overall outcome at risk, as well as preventing detection and treatment of a serious health condition. I will make every effort to reschedule missed appointments as soon as possible. I understand that I may be charged a fee for an appointment missed without a 24 hour advance notice. I understand that multiple missed appointments could result in my dismissal from the practice.

Inform my doctor if I decide not to follow their recommended treatment plan – I understand that after examining me, my doctor may make certain recommendations based on what they feel are best for my orthopedic condition. This might include but is not limited to prescribing medication, referring me to a specialist, ordering labs and tests, recommending surgical intervention, or even asking me to return to the office within a certain period of time. I understand that not following my treatment plan can have serious negative effects on my overall outcome. I will let my doctor know whenever I decide not to follow their recommendations so that they can fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, at any time, to ask questions, report symptoms, or discuss any concerns that you may have. If you need more information about your health or condition, please ask.

ACKNOWLEDGEMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES:

Please sign below and return this form to the receptionist so that we know you have received our Notice of Privacy Practices.

I acknowledge receipt of the Notice of Privacy Practices prepared by COASTAL ORTHOPEDICS & SPORTS MEDICINE, P.A. Also I acknowledge that I have had an opportunity to ask questions about the practice's Notice of Privacy Practices if needed.

_____	_____	_____
Patient Name	DOB	**Patient Signature**

Name of Patient/Legal Guardian (Please print): _____

Physicians signature:_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment of this Notice of Privacy Practices, but was unable to do so as documented below:

Date:_____ Initials:_____ Reason:_____