THE CHRIST HOSPITAL ORTHOPAEDIC ASSOCIATES

Date:		DOB:
First Name:		Last Name:
SSN:		Sex:
Address:		
Marital Status:		
	Primary Care Physician	
Name:		Phone #:
	Guarantor	
Name:		City/State:
Address:		Zip:
	Emergency Contact	
Name:		Phone #:
	Insurance	
Primary:		Secondary:
Address:		Address:

Patient Insurance Coverage Responsibility Disclaimer and Authorization

I understand that it is my responsibility to know if The Christ Hospital Orthopaedic Associates are an authorized provider according to my insurance contract. If for any reason my insurance contract is not valid or any fees are not covered by my insurance contract, I am responsible for payment of all charges. I also understand that The Christ Hospital Orthopaedic Associates are required by law and contract to collect from me ON THE DATE OF SERVICE, any present co-payment amount required by my insurance contract.

I understand that I am responsible to know which lab and outside facilities my insurance company utilizes for all lab work, diagnostic testing and specialists' appointments. If prior authorizations are required by my insurance contract for diagnostic testing and specialists' appointments, I realize that it is my responsibility to request a referral authorization from my primary care provider. Failure to do so may result in my insurance company denying payment for services and I will be responsible for the services performed.

I authorize my insurance company to pay all benefits directly to The Christ Hospital Orthopaedic Associates and thereby agree to the release of relevant medical information to insurance carriers.

Signature of Patient or Guarantor: ____

Authorization for Medical Treatment

This release and consent gives The Christ Hospital Orthopaedic Associates, permission to administer medical treatment to patient/or my child. I release The Christ Hospital Orthopaedic Associates and all medical providers from liability in acting on my behalf in this regard in rendering such medical treatment. I give permission to The Christ Hospital Orthopaedic Associates to obtain my medical records and permission to acquire my past medication records.

Signature of Patient / Parent / or Guardian: ____

Authorization for Use of Personal E-Mail Address

This release and consent gives The Christ Hospital Orthopaedic Associates permission to send messages, x-rays, etc., to my personal e-mail address.

Signature of Patient: ____ E-Mail Address: __________________________________

Acknowledgement of Notice of Privacy Practices

I acknowledge that I have read the Notice of Privacy Practices. I understand that The Christ Hospital Orthopaedic Associates may, at its discretion, change the terms and conditions of this notice. I understand the content of the Notice of Privacy Practices and will be provided with a copy upon my request. I give The Christ Hospital Orthopaedic Associates permission to leave a message on my answering machine or with the following family members regarding reports or blood work if I am not home when they call. I consent to general treatment, medical procedures, and medications prescribed by The Christ Hospital Orthopaedic Associates .

______ Copy given to patient _____ Patient declined copy

Signature of Patient or Personal Representative:

Family members to leave messages with:

____

____

____