Family Orthopedics and Rehabilitation ____ ***Dr. Wong*** ____***Dr. Huynh***

PATIENT INFORMATION FORM

Date completed ___________________ Referring physician ________________________________
Reason for visit ____
Name: Last _____________________ First: _____________________ Middle: _______________
Social Security #: ____________________________ M_______ F_______
Date of Birth _________________________ Student: _________________
Address: Street ____
City _______________________ State __________ Zip Code ________________
Phone Number: Home # _______________________ Work # ___________________________
Cell # ________________________
Patient's employer: ____
Address: ____
Phone: ________________________ Contact: ___________________________________
Emergency contact/ nearest relative: ___________________ Phone: ________________________

Guarantor name ___________________________ Relationship to patient____________________
Address______________________________ Phone______________ Work phone____________
Guarantor employer and address ____

MEDICAL CONSENT

Permission is hereby granted to the attending physician and supervised assistant to administer such medical and surgical examinations, treatments, and procedures as are deemed necessary for myself and/or the patient named or minor (<18 yr.). __________Initial __________Date

RELEASE OF INFORMATION

I authorize **Family Orthopedics and Rehabilitation** to furnish information to insurance carriers, Health Care Financing Administration/ Medicare/ Medicaid, Workman's comp, case manager, physicians, attorney and other related entities concerning the illness or medical treatment of my dependent or myself via telephone, fax, or in writing, in order to determine benefits, request payments and provide medical care. __________Initial __________Date

CONFIRMATION OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I have received **Family Orthopedics and Rehabilitation** Notice of Privacy Practice.

____________________________ ________________

Signature of Patient for Medical Consent, Release of Information, HIPPA — Date

FINANCIAL RESPONSIBILITY

I hereby assign authorized Medicare, Medicaid and Medigap benefits and all insurance payments to **Family Orthopedics and Rehabilitation** for any services (medical, surgical, therapy) furnished to my dependent or myself. This assignment will remain in effect until revoked by me in writing.

I recognize and accept responsibility for payment of all medical fees regardless of any insurance I may have to assist me in this responsibility. If for any reason my account should become delinquent, I agree to pay for all court costs, collection, finance charges & legal fees.

____________________________________ ______________

Signature of Patient or Responsible Party — Date