PREMIER ORTHOPEDIC SURGERY AND SPORTS MEDICINE
PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history it is important for you to fill this out as completely and accurately as possible. The information will then be entered in your electronic chart and become part of your record

Last name: _____ First name: _____

DOB: ____/____/____Height: ft ____ in _____ Weight: _____lbs.

Name of Primary Care Physician: _____

Reason for today's visit: _____

Please list medications you are currently taking:

Medication/Dosage: _____
Medication/Dosage: _____
Medication/Dosage: _____
Medication/Dosage: _____
Medication/Dosage: _____
Medication/Dosage: _____
Medication/Dosage: _____

Medication Allergies __ Yes___ No... If yes please see below

Medication/Reaction: _____

Medication/Reaction: _____

Medication/Reaction: _____

Non-Medication Allergies ____Yes___No....If yes please see below

Allergy/Reaction: _____

Allergy/Reaction: _____

Allergy/Reaction: _____

PREMIER ORTHOPEDIC SURGERY AND SPORTS MEDICINE
PATIENT HEALTH HISTORY

Last name: _____ First name: _____

Past Medical History:

1. _____

2. _____

3. _____

4. _____

Surgeries and Hospitalizations:

Have you ever had any surgeries_____yes_____no?
If yes please list: _____
_____
Have you ever had any problems with anesthesia_____yes_____no?
If yes please describe reaction: _____
Have you been hospitalized for any non surgical reasons?_____yes_____no?
If yes please list reason for hospitalizations: _____

Most-recent occupation: _____

Premier Orthopedic Surgery & Sports Medicine, PLLC

PATIENT FINANCIAL RESPONSIBILITY/AUTHORIZATION FORM

Patient Name: _____ Date: _____

1. **FINANCIAL RESPONSIBILITY**: We are pleased to assist with your insurance. I understand that with the exceptions explained below, I am personally responsible for any medical fees I will incur with Premier Orthopedic Surgery & Sports Medicine, PLLC. I also understand **that I will be responsible for any charges incurred by not providing the most current & correct insurance including an HMO referral if required to Premier Orthopedic Surgery & Sports Medicine, PLLC.** Exceptions to this policy are those patients with a current authorization with an HMO, a State or Federally funded program, or PPO in which Premier Orthopedic Surgery & Sports Medicine, PLLC is currently a contracted provider.

_____

******Signature of Patient or Legal Guardian***

2. **AUTHORIZATION TO RELEASE INFORMATION/MEDICATION SEARCH: I HERBY AUTHORIZE** Premier Orthopedic Surgery & Sports Medicine, PLLC to release medical information acquired in the course of my examination or treatment, to my insurance company, or other physicians required to participate in my care. I authorize Premier Orthopedic Surgery & Sports Medicine, PLLC to do a medication search prior to giving me a prescription for a controlled substance.

_____

******Signature of Patient or Legal Guardian***

3. **AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN**: I hereby authorize payment for medical services provided directly to Premier Orthopedic Surgery & Sports Medicine, PLLC physicians.

_____

******Signature of Patient or Legal Guardian***

4. **ACKNOWLEDGE OF RECEIPT OF PRIVACY POLICY**: I acknowledge that I have received a copy of Premier Orthopedic Surgery & Sports Medicine, PLLC Privacy Policy.

_____

Date *****Signature of Patient or Legal Guardian**

PREMIER ORTHOPEDIC SURGERY AND SPORTS MEDICINE, PLLC

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby consent to Premier Orthopedic Surgery and Sports Medicine, PLLC (the "Practice") using and disclosing my protected health information (PHI) to carry out treatment, payment and healthcare operations (TPO). I hereby acknowledge that I have had the right to review the Practice's Privacy Policy prior to signing this consent, which provided me a more complete description of potential uses and disclosures of my PHI. I am aware that the Practice reserves the right to revise its Privacy Policy at anytime. I am also aware that a revised Privacy Policy may be obtained by my forwarding a written request for same to the Practice.

Consent to Calls/Mail/Email

I hereby consent to the Practice calling my home, cell phone or other designated location and leaving a message on my voicemail or in-person in reference to any items that assist the Practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results and other matters incident to my treatment. You may leave information with:_____

I hereby consent to the Practice mailing to my home or other designated location any items that assist the Practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I hereby consent to the Practice e-mailing me any items or communications that assist the Practice in carrying out TPO, such as appointment reminder cards and patient statements.

I understand that I have the right to request that the Practice restrict how it uses or discloses my PHI 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 the Practice's use and disclosure of my PHI as specified in the Privacy Policy and this Patient Consent for Use and Disclosure of Protected Health Information.

I understand that 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, I understand that the Practice may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Date

_____ _____
Phone Number(s) (Cell/Home/Work) Email Address

PREMIER ORTHOPEDIC SURGERY AND SPORTS MEDICINE, PLLC

PATIENT SIGNATURE ON FILE

I understand that I am financially responsible for my bill for services rendered in this office. I understand that this bill will be sent to my insurance company for payment, however, I still remain obligated to pay the entire balance of what my insurance company states is **patient responsibility**, no matter what my insurance company pays. I understand that the insurance company may not cover certain services and there may be certain charges such as deductible, co-payments and co-insurance which will be my responsibility. The insurance company may also determine that certain charges were "unnecessary." This does not mean that they were medically unnecessary, but that it was unnecessary for the insurance company to pay for them. If any sums due and owing cannot be obtained through the authorized credit card, I understand that I will be responsible for any and all costs, fees and attorney's fees associated with collection thereof.

I authorize Premier Orthopedic Surgery and Sports Medicine, PLLC to keep my signature on file and to charge the credit card selected below for all visits for the following year.

Check one: { } Visa { } American Express { } PulseCard (healthcare credit card)

{ } MasterCard { } Discover

I assign my insurance benefits to the provider listed above. I understand this form is valid for one year unless I cancel the authorization through written notice to the healthcare provider.

Patient Name: _____

Cardholder Name: _____

Cardholder Address: _____

City: _____ State: _____ Zip: _____

Credit Card #: _____ Exp. Date: _____

Cardholder Signature: _____ Date: _____