



Orthopaedic Associates of Zanesville

2854 Bell Street Zanesville, Ohio 43701 P: 740-454-3273 F: 740-588-1081 www.orthozane.com

Patient Information

(Please print)

Patient's name: _____ Today's date _____
(First) (Middle) (Last)

Address: _____ Patient's Employer _____
(Street#) (Street) (Apt.#) Email address _____
Date of Birth: _____
Social Security #: _____
Sex: _____
Marital Status: M S W D
(City) (State) (Zip Code)

How did you hear about OAZ? _____

Telephone #: (Home) _____ (Work) _____ (Cell) _____

If child, parent's name: _____ If married, spouse's name: _____

Responsible party: _____ Their Social Security #: _____

Responsible party's address: (If different than above address) _____

Where are you or responsible party employed?: _____

Primary Care Physician: _____

Referring physician: _____ Reason? _____

Have you had x-rays taken (circle) Yes No Where? _____ When? _____

I, a patient of Orthopaedic Associates of Zanesville Inc., understand and accept and agree to following:

- A. The purpose of requesting examination and treatment is for medical purposes only and is not in connection with requiring my Physician to provide an option or testify at a deposition or Trial in a personal injury suit.
- B. Should litigation arise or be filed, I understand my treating Physician, and Orthopaedic Associates of Zanesville Inc., are not obligated to voluntarily participate in litigation except that:
 - a. They will provide true and accurate copies of medical records and x-rays in their possession and control if I sign an authorization and pay the usual copying charges, and
 - b. They may otherwise agree to participate by providing an opinion or testify at a deposition or trial, subject to, and at, their sole and absolute discretion.
- C. I understand the above and represent that I have not and will not schedule appointments for purposes of arranging for expert medical testimony in a pending or proposed legal matter.

Signature: _____ Date: _____
Patient or Legal Guardian

ORTHOPAEDIC ASSOCIATES OF ZANESVILLE INC.
Privacy Consent – For the Use and Disclosure of Protected Health Information

The consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

I hereby give my consent to Orthopaedic Associates of Zanesville Inc. (herein referred to as OAZ Inc.) to use and disclose my protected health information for the purposes of treatment, payment and operations of my health care and this practice.

Consent for treatment: I, with my signature, authorize OAZ Inc., and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but not limited to) preventive, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professional for care and treatment.

Consent for release of information for payment and operations: I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I further consent to the use for any practice operational needs as identified in the practice privacy notice.

Consent related to the Privacy Notice: I have had a chance to review the Practice Privacy Notice as part of this registration process. I understand the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health care information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on protected health information (PHI) use, it is bound by that agreement.

I understand that this practice may refuse me services if I refuse to sign this consent. I may revoke this consent at any time but the practice may refuse further services at that time. If I revoke this consent, the revocation does not take effect until that practice receives it.

Patient/Guardian: _____ Date: _____

Name printed: _____ If not patient, relationship: _____

Copy of Practice Privacy statement signed or initialed with patient/guardian on: _____

Patient unable to sign privacy statement due to: _____

Consent for assignment of benefits: I consent to assign all payments for these services to this practice. I understand that I am responsible for all co-payments, amounts applied to deductibles and other amounts that may be deemed by responsibility by the payment sources, as required by my contract with my insurance plan and state regulation. I further understand that my contract with my insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of the contract, I am aware that I am responsible for all charges that are incurred. I agree to be financially responsible for all charges not covered by insurances.

Patient/Responsible party signature: _____ Date: _____

SSN of person signing: _____
(required prior to treatment)

Revocation:

I hereby revoke the consent given above:

Patient/Guardian: _____ Date: _____

Name printed: _____ If not patient, relationship: _____