Lone Star Orthopaedic Institute

Patient Registration

Patient Information

Patient's Legal Name: _____ Date of Birth: _____

Social Security Number: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Email Address: _____

I consent to receive the following (check all that apply): ☐ Voicemails ☐ Text Messages ☐ Emails

Gender**:** ◯ Female ◯ Male ◯ Other, not listed: _____

Are you Hispanic or Latino?
(Circle One)
☐ YES or ☐ NO

Race**:** ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American

☐ White ☐ Hispanic or Latino ☐ Choose not to disclose ☐ Other, not listed: _____

Preferred Language: ◯ English ◯ Spanish ◯ Other (Specify): _____

Pharmacy: _____ Phone: _____

Address: _____ City, State, Zip: _____

Primary Care Provider: _____ Phone: _____

Referring Physician: _____ Phone: _____

Responsible Party Information

Responsible Party: ☐ Self ☐ Guarantor

Responsible Party Name: _____ Date of Birth: _____

Gender: ◯ Female ◯ Male Social Security Number: _____ Phone: _____

Address: _____ City, State, Zip: _____

Emergency Contact Information

Emergency Contact Name: _____ Relationship: _____

Phone Number: _____ Do you have a living will? ☐ Yes ☐ No

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Consent for Treatment

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical exams, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature, even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist) and other health care providers or the designees care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

Consent for Financial Communications

I acknowledge that as a courtesy, Lone Star Orthopaedic Institute may bill my insurance company for services provided to me. I agree to pay for services that are not covered, or covered charges not paid in full, including, but not limited to and co-payment, co-insurance, and/or deductible, any charges not covered by insurance. I understand there is a fee for returned checks.

I acknowledge Lone Star Orthopaedic Institute may use the services of a third party business associate, or affiliated entity as an extended business office (EBO Servicer) for medical account billing and servicing.

I hereby assign Lone Star Orthopaedic Institute any insurance or third party benefits available for health care services provided to me. I understand Lone Orthopaedic Institute has the right to refuse or accept such benefits. If these benefits are not assigned to Lone Star Orthopaedic Institute, I agree to forward all health insurance or third party payments that I receive for services rendered to me immediately upon receipt.

I certify that any information I provide, if any, in applying for payment under Title XVII (Medicare) or Title XIX (Medicaid) of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to Lone Star Orthopaedic Institute by the Medicare or Medicaid program.

I agree that, in order for Lone Star Orthopaedic Institute or Extended Business Office (EBO) servicers and collection agents, to service my account or to collect any amounts I may owe. I expressly agree and consent that Lone Star Orthopaedic Institute or EBO servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or Lone Star Orthopaedic Institute or EBO servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

A photocopy of this consent shall be considered as valid as the original.

Signature of Patient or Representative: _____ Date: _____

Printed Patient Name: _____ Relationship to Patient: _____

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Patient HIPAA Acknowledgement and Consent Form

I acknowledge that I have received the Notice of Privacy Practice, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the provider and/or the providers business associates. To the extent permitted by law, I consent to the use of my information for the purposes described in the Notice of Privacy Practice.
I hereby permit Lone Star Orthopaedic Institute and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.
Healthcare information regarding a prior service(s) at other HCA affiliated providers may be made available to subsequent HCA affiliated providers to coordinate care. Healthcare information may be released to any person or entity liable for payment on the patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under Worker's Compensation.
If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, lab reports, operative reports, physician progress notes, nurse notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
Federal and State laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions, and/or infectious diseases, including but not limited to, blood borne diseases, such as HIV and AIDS.

I authorize the following friends or family members to access my Protected Health information for the purposes of communicating results, findings and care decisions.

Please ✓ whether or not this individual is authorized to also pick up prescriptions on your behalf.

Name: _____ Relationship: _____ ☐ Yes ☐ No

Name: _____ Relationship: _____ ☐ Yes ☐ No

Name: _____ Relationship: _____ ☐ Yes ☐ No

I certify that I have read and fully understand the above statements from all pages and consent fully and voluntarily to its contents.

Signature of Patient or Representative: _____ Date: _____

Printed Patient Name: _____ Relationship to Patient: _____