

ORTHO KC

sports medicine and joint reconstruction

8919 Parallel Parkway, Suite 270, Kansas City, KS 66112
www.orthokc.com | p: 913.788.7111 | f: 913.788.3702

PATIENT REGISTRATION

Date: _____

PATIENT INFORMATION

Patient Legal Name: _____ **Account Number:** _____
Date of Birth: _____ **Home Phone:** _____
SSN: _____ **Work Phone:** _____
Home Address: _____ **Cell Phone:** _____
City/State/Zip: _____ **Primary Care Physician:** _____
Who referred you to OrthoKC? _____

GUARANTOR INFORMATION

Same as patient

I authorize my physician or designee to disclose Billing and/or Treatment information to the following individual:

Contact Name: _____ **Home Phone:** _____
Address: _____

EMERGENCY CONTACT INFORMATION

Same as guarantor

I authorize my physician or designee to disclose Billing and/or Treatment information to the following individual in case of emergency:

Contact Name: _____
Contact Phone: _____

PRIMARY INSURANCE SUBSCRIBER INFORMATION

Insurance Name: _____ **Subscriber Address:** _____
Subscriber Name: _____ **Subscriber City/State/Zip:** _____
Subscriber Date of Birth: _____ **Subscriber Phone:** _____
Subscriber Social Security Number: _____
Relationship to Patient: _____

SECONDARY INSURANCE SUBSCRIBER INFORMATION

Insurance Name: _____ **Relationship to Patient:** _____
Subscriber Name: _____ **Subscriber Address:** _____
Subscriber Date of Birth: _____ **Subscriber City/State/Zip:** _____
Subscriber Social Security Number: _____ **Subscriber Phone:** _____

BUSINESS OFFICE NOTES

HIPAA Date: _____

HIPAA NOTICE

I have received a copy of OrthoKC Professional Association NOTICE OF PRIVACY PRACTICES.*

Patient Signature (or Guardian)

Date

*You may refuse to sign this acknowledgement.

AUTHORIZATION TO LEAVE PATIENT INFORMATION ON VOICE MAIL

I authorize my physicians' staff to leave voice mails on phone numbers provided by me that include my name and my physician's name. I also authorize my physician to use an automated telephone system to use my name, address and phone number, name of my physician, time and place of my scheduled appointment(s), for the limited purpose of notifying me of a pending appointment. I also authorize my healthcare provider to disclose to third parties who answer my phone limited protected health information regarding the pending appointment and to leave a reminder message on my voice mail or answering machine.*

Patient Signature (or Guardian)

Date

To decline, please initial: _____

*You may refuse to sign this acknowledgement.

INSURANCE BILLING ACKNOWLEDGMENT

I understand that OrthoKC Professional Association can release any and all of my patient records to the insurance company listed on the first page of this registration form.

Patient Signature (or Guardian)

Date

AUTHORIZED BILLING AND TREATMENT CONTACTS

I authorize release of Billing and/or Treatment information to the following additional contacts:

«AdditField2»

Name/Relationship to Patient

CONSENT FOR TREATMENT

I hereby authorize my physician (or whomever she/he may designate) to administer such medical treatment, as is necessary for a patient in my condition:

Patient Signature (or Guardian)

Date

PATIENT'S FINANCIAL RESPONSIBILITY FOR HEALTHCARE CHARGES

I HAVE BEEN GIVEN ORTHOKC's FINANCIAL POLICY. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I authorize my insurance company to make payment directly to OrthoKC. I will make every effort to ensure that my insurance has all information needed for timely payment. I understand that if my insurance company does not pay, or I owe a co-payment, deductible, or co-insurance amount, that I will make prompt payment in full or setup a payment plan at an affordable monthly rate.

Patient Signature (or Guardian)

Date

OPPORTUNITY TO REVOKE CONSENT

This portion of this form is only applicable if you previously signed this form. Should you wish to revoke consent to use telephone numbers originally written on this form, please provide us with alternative communications options here. **Please ask a receptionist for assistance if you wish to use this section.**

I revoke consent to the following previously given telephone number(s) and/or address(es):

Please provide us with alternative means of communication here, along with instructions for use:

Patient Signature (or Guardian)

Date