Coastal Orthopaedic & Sports Medicine Center

UPDATE PATIENT REGISTRATION

Date of Visit: _____/_____/_____ **Office Use Only**: Account #:_____

Full Name: _____ **Date of Birth**: _____/_____/_____

Social Security #:_____-_____-_____ **Gender**: ☐ Male ☐ Female **Hand Dominance**: ☐ Left ☐ Right

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Life Partner

Race: ☐ African American ☐ Asian ☐ Caucasian
☐ American Indian or Alaska Native ☐ Native Hawaiian or other Pacific Islander
☐ Other:_____

Ethnicity: ☐ Hispanic ☐ Not Hispanic or Latino ☐ Other: _____

Employer: _____ **Occupation**: _____

Primary Care Physician: _____
Who referred you to us? ☐ Physician _____

INSURANCE INFORMATION

Primary Insurance: _____

Secondary Insurance: _____

CONTACT INFORMATION

Mailing Address: _____ City: _____ State: _____ Zip Code:_____

Primary Contact Phone: _____ Secondary Contact Phone: _____

E-Mail:_____

Preferred Method of Contact: ☐ Patient Portal ☐ E-Mail ☐ Mail ☐ Mobile ☐ Phone

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Phone#:_____ Mobile #:_____

***Information below must be filled out completely and accurately in order for qualified RXs to be prescribed:**

Pharmacy Name: _____ Phone #:_____
Address (If phone # is not supplied):_____

INJURY QUESTIONNAIRE

Patient Name: _____ **Insurance Company**:_____

If your visit is related to an injury, please complete the below questions. Please answer all questions in detail if possible. Enter "N/A" if not applicable, and sign.

☐ Worker's Compensation: Date of injury: ☐ Auto Accident: Date of injury: ☐ Not an Accident

Please answer the following questions in order to provide your insurance company information to process claims for benefit for all types of accidents. If this form is not completely filled out, you may be responsible for any accrued balances.

1. **Brief description of accident:** (Please be specific as to the exact date, time and place if possible.)

_____

_____

_____

_____ Date: _____

Patient's Signature (Legal Guardian if patient is a minor)

Office Use Only: Receptionist Initials: _____

DO YOU HAVE AN ADVANCED DIRECTIVE? ____ YES ____NO
DO YOU WANT TO PROVIDE A COPY OF THE ADVANCED DIRECTIVE? ____YES ____NO
DO YOU WANT TO DISCUSS YOUR ADVANCED DIRECTIVE? ____YES ____NO
WHO IS YOUR POWER OF ATTORNEY? NAME _____ PHONE #_____

HIPAA: Permission to share health information with others:

I have **received a copy** of Coastal Orthopaedic & Sports Medicine Center's "Notice of Privacy Practices" on this day (posted in office). I hereby **authorize** Coastal Orthopaedic & Sports Medicine Center to disclose my health information to the following person(s):

NAME **RELATIONSHIP TO PATIENT**

_____

_____

_____

_____

By my signature below, I affirm the above information.

_____

Patient's Signature

_____

Date

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by Coastal Orthopaedic and Sports Medicine Center, Inc. (herein after referred to as the "practice") for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct health care operations.
I understand diagnosis or treatment of me by my treating physician may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my health information is used or disclosed to carry out treatment, payment for healthcare operations of the practice. The practice agrees to a restriction that I request, the restriction is binding on Coastal Orthopaedic and Sports Medicine Center, Inc. and My Treating Physician.

I have the right to revoke this consent, in writing, at any time, except to the extent that My Treating Physician and Coastal Orthopaedic and Sports Medicine Center, Inc. have taken action in reliance on this consent.

My "protected health information" means health information including demographic information, collected from me and created or received by physician, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present or future physical or mental health condition and identifies me, or if there is a reasonable basis to believe that information may identify me.

I understand I have a right to review the practices Notice of Privacy Practices prior to signing this document. By signing this document, I acknowledge that the practices Notice of Privacy Practices has been provided to me and that I have had the opportunity to read, ask questions, get answers and get a copy to take with me if I so desire. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of healthcare operations of the practice. The Notice of Privacy Practices also describes my right and the practice duties with respect to my protected health information.

I understand that the Physical Therapy performed at Coastal Orthopaedic and Sports Medicine Center, Inc. is generally performed in an open room. If I find the openness uncomfortable, the practice is happy to accommodate my request to be treated in a curtained area.

The practice reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a copy to be sent by mail or given at my next appointment.

I understand the above terms of the Office Policy and consent to use or disclose information of my protected health information.

Patient Name:

Signature of Patient or Parent (if Minor):_____

ASSIGNMENT OF BENEFITS

I authorize *Coastal Orthopaedic and Sports Medicine Center, Inc.* to endorse checks and/or to sign any piece of paper which will enhance or expedite payment to providers for services rendered, including, but not limited to a release of medical records and assignment of benefits/authorization to pay.

I, (Name of Insured/Patient) Hereby Authorize Primary Insurance Company: (Name of Auto or Health Ins.Carrier)

to make medical benefits payments otherwise payable to me for services rendered by *Coastal Orthopaedic and Sports Medicine Center, Inc.* but not to exceed the charges of those services, payable to and mailed directly to:

COASTAL ORTHOPAEDIC & SPORTS MEDICINE CENTER
7710 S. US HIGHWAY ONE
PORT ST. LUCIE, FL 34952

I understand and agree that (regardless of my insurance status); I am ultimately responsible for the balance of my account for any professional services rendered. I understand that payment of charges incurred is due at the time of service unless financial agreements have been made prior to treatment***. I also authorize Coastal Orthopaedic and Sports Medicine Center, Inc. to charge my account $25.00 if co-payments, deductibles, etc. are not paid on the same day services are rendered.*** I agree to pay for all reasonable attorney fees and reasonable collection cost in the event of default payment for services rendered. I further authorize and request that insurance payments be made directly to *Coastal Orthopaedic and Sports Medicine Center, Inc.* I understand that the office files to my insurance carrier/s for insurance reimbursement as a courtesy, and failure on the part of the insurer to make payment shall not relieve me of my obligation to pay any balance due to *Coastal Orthopaedic and Sports Medicine Center, Inc.*

I have read and fully understand the above financial responsibility and insurance authorization. I have read all the information on this sheet. I certify that all the information in this packet is true and correct to the best of my knowledge. I will notify you of any changes in my status or information given.

Patient Name: _____

Parent or Guardian Signature (if Minor): _____

Office use only:

Front Office: _____