CORNERSTONE ORTHOPAEDIC
TRAUMA ASSOCIATES

Patient Information / HIPAA

Last Name: ______________________ First Name: ______________________ M.I. : _______

Date of Birth: ______ / ______ / __________ SSN: ______________________ Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow

Prefered Language: ☐ Unspecified ☐ English ☐ Spanish ☐ Other: ______________

Ethnicity: ☐ Unspecified ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Race: ☐ Unspecified ☐ American Indian/Alaska Native ☐ Asian ☐ Black or African American
☐ Native American or Pacific Islander ☐ White ☐ Other

Employer: ______________________ City/State: ______________________

Preferred Pharmacy: ______________________ Location: ______________________

Contact Information

Address: ____
Street *City* *State* *ZIP*

Primary Phone: ______________________ Type: ☐ Mobile ☐ Home ☐ Work ☐ Other

Alternate Phone: ______________________ Type: ☐ Mobile ☐ Home ☐ Work ☐ Other

Email Address: ______________________

Preferred Contact Method(s): ☐ Phone ☐ Email ☐ Letter/Mailing Address

Emergency Contact and/or Guarantor

Name: ______________________ Relationship: ______________________

Phone Number: ______________________ Type: ☐ Mobile ☐ Home ☐ Work ☐ Other

Billing Information

Primary Insurance: ______________________ Policy #: ______________________

Policy Holder: ______________________ Policy Holder's Date of Birth: _____ / _____ / _________

Secondary Insurance: ______________________ Policy #: ______________________

Policy Holder: ______________________ Policy Holder's Date of Birth: _____ / _____ / _________

Legal Proceedings

Are there currently any legal proceedings concerning the custody of the patient? ☐ Yes ☐ No ☐ N/A

If **YES**, please explain and/or provide court orders: ______________________

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HIPAA-PHI Release

Please mark all applicable options.

☐ Only release information to the patient or guardian.

☐ Permission to speak with Spouse/Significant other about patient medical care and test results.

Spouse/Significant Other's Name: ____ *Phone:* __________________________

☐ Permission to talk with other family and friends involved with patient's medical care.

Name: ____ *Name:* ____

Phone: ____ *Phone:* ____

Relationship: ____ *Relationship:* ____

Authorizations & Consent

Please read and initial each section.

Assignment of Benefits: I hereby assign all applicable insurance benefits and direct that payment be made directly to Cornerstone Orthopaedic Trauma Associates for all services provided during my visit. ____________

Release of Information: I authorize Cornerstone Orthopaedic Trauma Associates to furnish medical and other information necessary to process insurance claims on my behalf. This information may be released to my personal physician and, upon request, to any other healthcare provider who may need the information for continuity of care. ____________

Financial Responsibility: I understand and agree that I am responsible for payment on all charges including those not paid by my insurance at the time of service. If I fail to make payment in full for services that are rendered to me within 90 days of the date of service, my outstanding balance will be sent to a collection's agency. I will be responsible for the fees assessed by the collection's agency. These will be collected at a rate of 150% of my outstanding balance. ____________

I have read and understand the full financial policy. ___________

Appointments: I understand that if I do not notify Cornerstone Orthopaedic Trauma Associates of a cancellation of my appointment at least 24 hours prior to the scheduled appointment, on my second occurrence, I may be assessed a fee and/or dismissed from the practice for multiple occurrences. ____________

Treatment Authorization: I am willfully requesting treatment and consent to services provided by, or at the direction of the attending provider at Cornerstone Orthopaedic Trauma Associates. I authorize a copy of this document to be used in lieu of the original.

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_____________________________________	____	__________________________
Signature of Patient or Legal Guardian	*Name (Printed)*	*Date*

ASSISTANCE PROVIDED BY:

Name: ____ ☐ Interpreter ☐ Office Staff ☐ Other: ____________________

Signature and/or ID #: ____ Date/Time: ________________________________