CORNERSTONE ORTHOPAEDIC
TRAUMA ASSOCIATES

Patient Information

Last Name: _____ First Name: _____ M.I. : _____

Date of Birth: _____ / _____ / _____ SSN: _____ Sex: ☐ Male ☐ Female

Prefered Language: ☐ English ☐ Spanish ☐ Other: _____ Interpreter needed? ☐ Yes ☐ No

Employer: _____ City/State: _____

Are you currently residing at a skilled nursing/ rehabilitation facility? ☐ Yes ☐ No *If YES, facility name:_____

Is this injury a result of an accident involved with an auto or at work? ☐ Yes ☐ No * If YES, ☐ Auto OR ☐ Workers Comp

Contact Information

Address: _____
Street *City* *State* *ZIP*

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

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

Email Address: _____

I give Cornerstone Orthopaedic Trauma Associates permission to leave detailed text and/or voice messages regarding information about my appointments, medical treatment, and billing/insurance. ☐ Yes ☐ No

Emergency Contact

Name: _____ Relationship: _____

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

Billing Information
Please provide insurance information below OR present your insurance card(s) at the time of your appointment.

Primary Insurance: _____ Policy #: _____

Policy Holder (if other than patient): _____ Policy Holder's Date of Birth: ____ / ____ / _____

Secondary Insurance: _____ Policy #: _____

Policy Holder (if other than patient): _____ Policy Holder's Date of Birth: ____ / ____ / _____

Pharmacy Information

Preferred Pharmacy: _____ Address/Cross Streets: _____

Turn page over to complete ↩

HIPAA-PHI Release

Mark all that apply

☐ ONLY release information to the patient or guardian.

OR

☐ Add the above Emergency Contact for HIPAA-PHI privileges.

☐ Permission to share information with additional specific individuals involved with patient's medical care.

Name: _____ *Name:* _____

Phone: _____ *Phone:* _____

Relationship: _____ *Relationship:* _____

Authorizations & Consent

Please read and initial each section.

_____ **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.

_____ **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.

_____ **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.

_____ **Appointments:** I understand that failure to confirm, or notify Cornerstone Orthopaedic Trauma Associates of any needed changes to, my appointment at least TWO (2) BUSINESS DAYS prior to my appointment time will result in the automatic cancellation of my appointment. If an appointment is canceled for any reason, it is my responsibility to reschedule the appointment. Multiple missed appointments may result in dismissal from the practice.

COMPLETED BY:

_____ _____ _____

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

ASSISTANCE PROVIDED BY:

Name: _____ ☐ Interpreter ☐ Office Staff ☐ Other: _____

Signature: _____ Date: _____