Capitol Orthopaedics and Rehabilitation, LLC

PATIENT REGISTRATION

Legacy Patient ID:_____

Is today's visit the result of an accident? □ Yes □ No

If yes, was the accident the result of □ Auto Accident □ Worker's Comp or

□ Other_____

First Name: _____MI:____ Last Name:_____

Address: _____PO Box/Apt. # _____

City: _____State: _____ Zip code: _____

Home Telephone:_____ Cell Telephone:_____Work Telephone:_____

Email Address:_____

Preferred Method of Contact: □ H □ W □ C □ Email

Patient Date of Birth:_____Sex: □ M □ F Marital Status: □ M □ S □ D □W

Social Security Number: _____

Patient's Occupation/Student Status: _____

Name of Employer: _____

Primary Care Physician: _____ PCP Phone#: _____

Referring Physician: _____ Phone #: _____

Emergency Contact Name: _____ Phone #: _____

If patient is under 18, legal guardian/guarantor's name: _____

□ Demographic information for legal guardian/guarantor is the same as above

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□ I give permission to release and/or discuss my medical treatment, test results, billing questions/issues with:

_____ _____

Name (Printed) Relationship To Patient

□ I do **NOT** want any information released

_____

Best Contact Number for person listed above

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Ethnicity: □ Hispanic Origin □ Non-Hispanic Origin □ Declined ethnicity

Language: □ English □ Chinese □ French □ Hebrew □ Italian □ Japanese □ Korean □ Russian □ Spanish

□ Other _____ □ Declined Language

Race: □ American Indian or Alaskan Native □ Asian □ Black or African American

□ Native Hawaiian or Other Pacific Islander □ White □ Declined race

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Preferred Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Telephone: _____

I agree that Capitol Orthopaedics and Rehabilitation, LLC may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.

_____ (Please Initial)

PRIMARY INSURANCE

Insurance Name: _____

Policyholder's Name: _____

Relationship: □ Self □ Spouse □ Child

□ Other _____

Policyholder's Date of Birth: _____

Policy Number: _____

Group Number: _____

SECONDARY INSURANCE

Insurance Name: _____

Policyholder's Name: _____

Relationship: □ Self □ Spouse □ Child

□ Other _____

Policyholder's Date of Birth: _____

Policy Number: _____

Group Number: _____

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I certify that the information I have reported with regard to my insurance coverage is correct, and I further authorize the release of any information, including medical information, for this or any related claim to my insurance company. I permit a copy of this authorization to be used in place of the original.

I, _____, hereby authorize CAPITOL ORTHOPAEDICS & REHABILITATION, LLC, to apply for benefits on my behalf for covered services rendered by Neil Barkin, MD, Stephen Rockower, MD, or Victor Wowk, MD or their employees from my insurance company, and promise to pay all reasonable amounts and copays as determined by my insurance company. I further agree to pay all reasonable interest charges, collection fees and attorney fees in relation to the collection of these amounts.

Patient Signature _____ Date _____

Acknowledgment of notification

The educational pamphlet entitled “Notice of Privacy Practices" provides information about how Capitol Orthopedics & Rehabilitation may use and disclose protected health information about you, and is compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our Notice Of Privacy Practices states that we reserve the right to change the terms described. Should this happen, you will be notified on your next visit to our office.

You have the right to request restrictions on how your protected information may be used or disclosed for treatment, payment, or healthcare operations. We are not required to agree to your restrictions, but if we do, we are bound by our agreement with you.

By signing below you acknowledge the receipt of our Notice Of Privacy Practices.

Patient's Signature: _____ Date _____

Consent for Use in Disclosure of Information

By signing below, you consent to our use and disclosure of protected health information about you for treatment , payment, and healthcare operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

Patient's Signature: _____ Date _____

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MEDICARE LIFETIME AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to CAPITOL ORTHOPEDICS AND REHABILITATION, LLC for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the payments payable for related services.

Patient's Signature: _____ Date _____

Medicare ID Number_____