Winchester Orthopaedic Associates, Ltd. ***REGISTRATION & AUTHORIZATION***

PATIENT INFORMATION

Patient's Name: ______________________________ Suffix (Jr/Sr/III)____Date of Birth: ____________ Age: ______

Home Address: ____

Mailing Address (if different from above): ____

Home Phone: ____________________ Cell Phone: ____________________ E-mail: ____________________

Soc. Sec. #: ____________________ ☐Male ☐Female Preferred Language: ☐English ☐Spanish ☐______________

Occupation: ________________________Employer: ________________________________

Employer's Address: ____Work Phone____________________

Race: ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐Caucasian ☐Greek ☐Hispanic ☐Indian ☐Multi-Racial ☐Native Hawaiian/Other Pacific Islander ☐Spanish American ☐Other Race ☐Prefer Not to Answer

Ethnicity: ☐Not Hispanic/Latino ☐Hispanic/Latino ☐Prefer Not to Answer

Spouse's Name: ____________________________DOB: ____________Soc. Sec. #: ____________________

Phone: ________________ Employer: ________________________________Work Phone:________________

Emergency Contact: ________________________ Relationship: ____________Phone #:________________

PARENT / GUARDIAN INFORMATION IF PATIENT IS A MINOR

Father's/Guardian's Name ________________________ DOB ____________ Soc. Sec. # ____________________

Address (if different from patient) ____

Home Phone: ________________________________ Cell Phone: ____________________________

Employer ________________________________ Work Phone: ____________________________

Mother's/Guardian's Name ________________________ DOB ____________ Soc. Sec. # ____________________

Address (if different from patient) ____

Home Phone: ________________________________ Cell Phone: ____________________________

Employer ________________________________ Work Phone: ____________________________

HEALTH INSURANCE – *PLEASE PRESENT YOUR CARD(S) TO RECEPTIONIST*

Primary Insurance ____________________________ Policy ID#________________ Group # ________________

Effective Date: ____________ Subscriber's Name ________________________Relationship to Patient: ______________

Subscriber's Soc. Sec. # ________________________DOB ______________ Sex: ☐Male ☐Female

Address (if different from patient): ____________________________________ Phone:____________________

Secondary Insurance ____________________________ Policy ID#________________ Group # ________________

Effective Date: ____________ Subscriber's Name ________________________Relationship to Patient: ______________

Subscriber's Soc. Sec. # ________________________DOB ______________ Sex: ☐Male ☐Female

Address (if different from patient): ____________________________________ Phone:____________________

*__MEDICARE PATIENTS__: Are you currently in a Skilled Nursing Facility or receiving Home Health services?

☐Yes ☐No Facility/Agency Name: ____________________________________

ACCIDENT INFORMATION (IF APPLICABLE)

Date of Accident:________________ ☐Worker's Compensation; or ☐ Auto Accident; or ☐Other State: ____________

Part of body injured______________ Describe how you were injured: ________________________________

Employer (at the time of accident) ________________________________ Phone ____________________

Insurance Carrier ____ Phone ____________________

Claim / Policy # ________________________ Name of Adjuster ________________________________

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ASSIGNMENT AND RELEASE OF INFORMATION / CONSENT TO TREAT

Assignment and Release of Information: I hereby authorize Winchester Orthopaedic Associates, Ltd., to release any information acquired in the course of my examination and treatment to the insurance company. I also authorize payment directly to the physician. I understand that in the event that my account is referred to a collection agency, I will be responsible for the balance plus an additional charge of 33.3% and any associated attorney fees, if applicable. ***By signing below, I recognize and accept responsibility for any balance remaining after payment of benefits.***
Consent to Treat: I also hereby request and consent to treatment and services reasonable and proper by today's standards provided by a practitioner of Winchester Orthopaedic Associates, Ltd., and any employee acting under the practitioner's orders.

______________________________ ______________________________ ______________
Signature of Patient/Responsible Party Relationship to Patient Date

HIPAA / PRIVACY AUTHORIZATION AND ACKNOWLEDGMENT

Winchester Orthopaedic Associates is very concerned about the protection of your health information. Federal law requires us to have a signed privacy statement on file for every patient. This law is intended to protect the privacy of your medical records. In order to serve you, we must have an existing Privacy Acknowledgement on file.

I have been given the opportunity to review the HIPAA Privacy Notice. **Patient/Guardian Initials:** ___________

____ **I do;** ____ **I do NOT** - give permission to leave detailed messages on my answering machine regarding instructions for surgery, test results, billing and/or insurance issues or other pertinent information from Winchester Orthopaedic Associates, Ltd.

Patient/Guardian Initials: ___________

____ **I do;** ____ **I do NOT** - give permission to leave detailed messages on my answering machine regarding appointment reminders.

Patient/Guardian Initials: ___________

Preferred contact method for appointment reminders: ☐Home # ☐Cell # ☐Work #

Please list any persons you would like to authorize to have access to your billing, appointment, or health information:

Name	*Relationship*	*Phone #*	*Date of Birth*

Patient Name: ______________________________ Date of Birth:______________________

Name of Legal Guardian if patient is a minor: ______________________________

Signature of Patient or Legal Guardian:______________________________ **Date:** _____________

PRESCRIPTION MONITORING PROGRAM NOTICE

Winchester Orthopaedic Associates, Ltd., participates in the Prescription/Controlled Substances Monitoring Program regulated by the states of Virginia and West Virginia. These programs collect data on controlled prescription drugs dispensed in Virginia and West Virginia to promote appropriate use of controlled substances.

Patient/Guardian Initials: ____________

FOR OFFICE USE ONLY:

For use by WOA personnel if unable to obtain a written acknowledgement of receipt of the HIPAA Privacy Notice:
I have made a good faith effort to obtain a written acknowledgment of receipt of the HIPAA Privacy Notice from the above named patient, but was unable to for the following reason:
__Language Barrier __Patient cannot read __Patient objects __Unable to sign __Other:_________________

Employee Name: ______________________________ Date: ______________________________