HOUSTON Methodist℠
ORTHOPEDICS & SPORTS MEDICINE

PATIENT INFORMATION FORM

PATIENT DATA:

_____ _____-_____-_____ _____
PATIENT NAME (LAST, FIRST, MIDDLE) SOCIAL SECURITY # SEX

_____ (_____)_____-_____ (_____)_____-_____
ADDRESS HOME PHONE NUMBER MOBILE PHONE NUMBER

_____ _____ _____ _____
CITY STATE ZIP CODE OCCUPATION

_____/_____/_____ _____ _____
DATE OF BIRTH (MM/DD/YYYY) MARITAL STATUS **REFERRED BY**

_____ (_____)_____-_____
EMPLOYER NAME & ADDRESS WORK PHONE NUMBER

_____ _____ (_____)_____-_____
IN CASE OF EMERGENCY: NAME RELATIONSHIP EMERGENCY PHONE NUMBER

GUARANTOR INFORMATION:

_____ _____-_____-_____ _____/_____/_____
POLICY HOLDER NAME GUARANTOR SOCIAL SECURITY # DATE OF BIRTH (MM/DD/YYYY)

_____ _____ _____ _____
ADDRESS CITY STATE ZIP CODE

_____ (_____)_____-_____
EMPLOYER NAME & ADDRESS BUSINESS PHONE NUMBER

IS THIS VISIT DUE TO A: PERSONAL INJURY AUTOMOBILE ACCIDENT WORK RELATED INJURY

PRIMARY INSURANCE INFORMATION:

_____ (_____)_____-_____
NAME OF PRIMARY INSURANCE VERIFICATION PHONE #

_____ _____ _____ _____
CLAIMS ADDRESS CITY STATE ZIP CODE

_____ _____
MEMBER ID/SUBSCRIBER ID GROUP NUMBER/POLICY NUMBER

SECONDARY INSURANCE INFORMATION:

_____ (_____)_____-_____
NAME OF SECONDARY INSURANCE VERIFICATION PHONE #

_____ _____ _____ _____
CLAIMS ADDRESS CITY STATE ZIP CODE

_____ _____
MEMBER ID/SUBSCRIBER ID GROUP NUMBER/POLICY NUMBER

PAYMENT IS REQUIRED AT THE TIME SERVICES ARE RENDERED.
THANK YOU!

HOUSTON Methodist ORTHOPEDICS & SPORTS MEDICINE

Acknowledgment for Receipt of Notice of Privacy Practices

I have been given a copy of the Notice of Privacy Practices for Houston Methodist Physician Organization and its Physicians. This Notice describes my legal rights regarding my health information and informs me of the legal duties and privacy practices of Houston Methodist Physician Organization and its Physicians with respect to health information created for services generated by Houston Methodist Physician Organization and its Physicians.

_____ _____

Signature of Patient or Patient's Qualified Personal Representative* Date

* In the event the patient is legally unable to sign, please print the name of the patient's Qualified Personal Representative and the individual's legal authority to act on behalf of the patient.

Printed Name of Qualified Personal Representative: _____

Legal Authority to Act on Behalf of the Patient _____

CONSENT TO TREAT

I voluntarily consent to the physicians and other clinical personnel of The Methodist Hospital, Department of Orthopedics, for the evaluation and treatment of the conditions for which I present myself to this office.

I acknowledge that I am legally responsible for all reasonable charges in connection with the medical care and treatment provided by representatives of The Methodist Hospital, Department of Orthopedics and promise to pay whatever charges are not paid by my health plan or insurance in return for the medical care and services that are provided to the patient.

I understand that this consent form will be valid and remain in effect as long as I receive my medical care at The Methodist Hospital, Department of Orthopedics. I understand that this consent may be revoked in writing at any time.

_____ _____

Printed Patient Name Patient Date of Birth

_____ _____

Signature of Patient or Guarantor, if minor Date Signed

ASSIGNMENT OF BENEFITS

YOUR SIGNATURE IS NECESSARY FOR US TO PROCESS ANY INSURANCE CLAIMS AND TO ENSURE PAYMENT OF SERVICES RENDERED.

I hereby authorize my insurance benefits to be paid directly to The Methodist Hospital, Department of Orthopedics, realizing I am responsible to pay non-covered services. I certify that the information given by me to The Methodist Hospital, Department of Orthopedics, in applying for payment under insurance coverage or other protection is correct and complete. I authorize any holder of medical information about me, to release to the insurance company or its agents, any information needed to determine the benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ AND UNDERSTAND THIS INFORMATION.

_____

Printed Patient Name

_____ _____

Signature of Patient or Guarantor, if minor Date Signed

HOUSTON Methodist ORTHOPEDICS & SPORTS MEDICINE

PERMISSION TO DISCLOSE RELEVANT HEALTH INFORMATION TO INDIVIDUALS INVOLVED IN MY HEALTH CARE

❑ I GIVE PERMISSION for **Houston Methodist Orthopedics and Sports Medicine** to disclose relevant health information (my health status, treatment, and payment arrangements) to my family members and to the individual(s) I have listed below who are involved in my health care:

Name: _____ **Name:** _____

Relationship: _____ **Relationship:** _____

Name: _____ **Name:** _____

Relationship: _____ **Relationship:** _____

❑ I DO **NOT** GIVE PERMISSION for **Houston Methodist Orthopedics and Sports Medicine** to disclose relevant health information (my health status, treatment, and payment arrangements) to family members and other individuals involved in my health care.

❑ I GIVE PERMISSION for any **surgery centers or hospitals associated with Houston Methodist Orthopedics and Sports Medicine** to disclose relevant health information (my health status, treatment, and payment arrangements) to my family members and to the individual(s) I have listed below who are involved in my health care:

Name: _____ **Name:** _____

Relationship: _____ **Relationship:** _____

Name: _____ **Name:** _____

Relationship: _____ **Relationship:** _____

❑ I DO **NOT** GIVE PERMISSION for any **surgery centers or hospitals associated with Houston Methodist Orthopedics and Sports Medicine** to disclose relevant health information (my health status, treatment, and payment arrangements) to family members and other individuals involved in my health care.

*** Patient's Signature:** _____ **Date:** _____

Patient's Printed Name: _____

Signature of Witness: _____ **Date:** _____

* Patient is a minor (___ years of age) *OR is unable to give permission because: _____

_____

Signature of Individual Signing on Behalf of Patient: _____**Date:** _____

Legal authority to act on the patient's behalf: _____

HOUSTON Methodist ORTHOPEDICS & SPORTS MEDICINE

Preferred Method of Telephone Contact

If we need to contact you regarding test results, referrals, appointments, or other medical or billing information, please indicate below how you wish to be called. **Please check all that apply and indicate below** whether we may discuss your medical and billing information with family members or other individuals.

Home Telephone _____

Cell Phone Number _____

- ❑ Leave **only a call-back name and telephone number** on my answering machine or with any person who answers the telephone.
- ❑ Leave a **detailed message** on my answering machine.
- ❑ **Do not** leave any type of message or call-back information if I am not there.

Work Telephone _____

- ❑ Leave only a **call-back name and telephone number** on my voice mail or with any person who answers the telephone.
- ❑ Leave a **detailed message** on my voice mail or answering machine.
- ❑ **Do not** leave any type of message or call-back information if I am not there.

Discussion of Medical and Billing Information with Family Members and Other

❑ You may also discuss my medical and billing information with my family members and with other individuals I have listed below.

Name	Relationship	Telephone Number (s)

_____ _____

Signature of Patient or Patient's Qualified Personal Representative* Date

* In the event the patient is legally unable to sign, please print the name of the patient's Qualified Personal Representative and the individual's legal authority to act on behalf of the patient.

Printed Name of Qualified Personal Representative: _____

Legal Authority to Act on Behalf of the Patient _____