



Emile C. Li MD, PLC
Kristina A. Johnson PA-C

C. Mark Race MD, PLC
Matthew N. Mortiz PA-C

Today's Date:

PLEASE PRINT INFORMATION TO BECOME PART OF YOUR CONFIDENTIAL MEDICAL RECORD

PATIENT	Name (First, Middle, Last)			Home Phone (000) 000-0000	Work Phone (000) 000-0000	Cell Phone (000) 000-0000
	Street Address			City, State, Zip Code		
	Age	Date of Birth (mm/dd/yy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		Social Security # 000-00-0000
	<input type="checkbox"/> Employed <input type="checkbox"/> Not Employed <input type="checkbox"/> Student <input type="checkbox"/> Retired <input type="checkbox"/> Disabled					
	Employer			Employer's Address		

Responsible Party Information (If other than patient)						
Name (First, Middle, Last)			Home Phone (000) 000-0000	Work Phone (000) 000-0000	Cell Phone (000) 000-0000	
Street Address			City, State, Zip Code			
Date of Birth	Relationship to Patient	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		Social Security # 000-00-0000	
<input type="checkbox"/> Employed <input type="checkbox"/> Not Employed <input type="checkbox"/> Student <input type="checkbox"/> Retired <input type="checkbox"/> Disabled						
Employer			Employer's Address			

Insurance Information						
Primary Insurance (BCBS, Medicare, etc)			Cardholder's Full Name		Relationship to Patient	
Employer (i.e. 'ABC Company')			Identification Number		Group Number	
Cardholder			Date of Birth		Social Security # 000-00-0000	
Secondary Insurance (BCBS, Medicare, etc)			Cardholder's Full Name		Relationship to Patient	
Employer (i.e. 'ABC Company')			Identification Number		Group Number	
Cardholder			Date of Birth		Social Security # 000-00-0000	

Emergency Contact Information						
Full Name of Emergency Contact (not living with you)			Relationship to Patient		Home Phone (000) 000-0000	Cell Phone (000) 000-0000

Nature of Illness or Injury						
Brief Description of Orthopaedic Illness or Injury. Please Indicate Location (Left / Right / Both)						
Check Those That Apply: <input type="checkbox"/> Work Injury <input type="checkbox"/> Liability Accident <input type="checkbox"/> Motor Vehicle Accident	Date of Injury: (mm/dd/yy)		If this is a work injury, has medical treatment been authorized by your employer? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Name and Address of Company and/or Representative (i.e. claims adjuster) to Contact for Verification				Phone Number	
					Claim Number	
Work Comp Insurance Co. Name			Address		Phone	Fax
Contact Person						
Family Physician				Referring Physician		

How did you learn about our practice? ___ Family Member ___ Friend ___ Primary Care Physician ___ Education Seminar
 ___ Newspaper ad ___ Web Page ___ Radio ___ Bill Board ___ Other _____

OVER PLEASE

OVER PLEASE

This authorization is for Orthopaedic & Sports Medicine Specialists LLC,
Emile C. Li MD, PLC and C. Mark Race MD, PLC hereafter referred to as OSMS.

READ CAREFULLY AND SIGN NAME BELOW

AUTHORIZATION TO RELEASE MEDICAL INFORMATION:

I authorize release of medical information necessary to process this (these) insurance claim(s) and permit the following to be used in place of this original document for all federal, state, commercial, compensation, or liability insurance claims:

- (1) a photocopy of other facsimile reproduction of this authorization, or
- (2) use of a computer to indicate my signature is on file at clinic, and/or
- (3) use of a computer to electronically transmit my claim for processing.

AUTHORIZATION TO ASSIGN MEDICAL BENEFITS TO CLINIC:

I certify that information provided relative to injury, illness, and insurance coverage is both true and correct. I authorize payment of insurance benefits or proceeds from any liability claim and legal/court settlement to be assigned to the physicians of this Clinic to the extent that their charges are paid in full.

ACKNOWLEDGEMENT OF INSURANCE LIMITATIONS:

Many insurance carriers require a written referral from a primary care physician (PCP) in advance of service (office visits, surgery, and diagnostic tests– MRI). Patients, parents, or the guardians are responsible for (1) obtaining physician referrals and (2) contacting their insurance carrier to verify benefits in advance of service. Patients are also responsible for non-covered services, deductibles, co-insurance, and any penalties imposed by their insurance company on our physician for seeing patients out-of-network. Co-payments are due at time of service.

ACKNOWLEDGEMENT OF PAYMENT RESPONSIBILITY:

Payment for medical services is between the Clinic (physician) and the patient. Payment is due in full according to the terms of this Clinic's credit policy. Therefore, I understand that this Clinic cannot accept responsibility for collecting or negotiating settlement on any disputed (1) health insurance claim, (2) worker's compensation claim, (3) accidental injury/illness liability claim, (4) claim where patient is/will be represented by an attorney, and/or (5) claim to be settled in a court of law.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES:

I understand I have a right to review Orthopaedic & Sports Medicine Specialists (OSMS) Notice of Privacy Practices prior to signing this document. OSMS's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment payment of my bills or in the performance of health care operations of OSMS. The Notice of Privacy Practices for OSMS is also provided in the clinic registration area and on OSMS's website at www.orthosportsmedonline.com. This Notice of Privacy Practices also describes my rights and OSMS's duties with respect to my protected health information.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand OSMS will use or disclose my protected health information for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of OSMS.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. OSMS is not required to agree to the restrictions that I may request. However, if OSMS agrees to a restriction that I request, the restriction is binding on OSMS and its providers.

OSMS reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing OSMS's website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative _____ Date _____

Description of Personal Representative's Authority / Relationship to Patient _____

THIS CLINIC ACCEPTS VISA, DISCOVER, MASTERCARD, PERSONAL CHECKS AND CASH.

CO-PAYMENTS ARE DUE AT TIME OF SERVICE.

Other Information: