

ORTHOPEDIC ASSOCIATES OF HAWAII, LLP

FOR OFFICE USE ONLY			
Account No	Type	Dr. #	Date

LAST NAME		FIRST NAME		MIDDLE NAME	
SEX <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH	SOCIAL SECURITY #	MARITAL STATUS <input type="checkbox"/> Divorced		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed
PATIENT'S ADDRESS (INCLUDE CITY, STATE AND ZIP CODE)				HOME PHONE	
GUARANTOR'S NAME & ADDRESS, IF DIFFERENT (INCLUDE CITY, STATE AND ZIP CODE)				CELL/PAGER	
EMPLOYER NAME/ADDRESS			OCCUPATION		BUSINESS PHONE
SPOUSE'S NAME		SPOUSE'S EMPLOYER			BUSINESS PHONE
EMERGENCY CONTACT NAME/ADDRESS (someone not living with you)			RELATIONSHIP		PHONE
REFERRING DOCTOR / PRIMARY CARE DOCTOR		PHONE NUMBER	E-MAIL ADDRESS		

If patient is a CHILD, please complete the following:

PARENT/GUARDIAN'S NAME		RELATIONSHIP TO PT	MARITAL STATUS <input type="checkbox"/> Divorced		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed
HOME PHONE	BUSINESS PHONE		CELL/PAGER		CHILD'S SCHOOL
PERSON(S) WHO MAY AUTHORIZE TREATMENT FOR CHILD				RELATIONSHIP TO PATIENT	

INSURANCE INFORMATION

PRIVATE INSURANCE WORKERS' COMPENSATION NO-FAULT TPL

PRIMARY INSURANCE NAME & ADDRESS Phone: _____ Fax: _____	SUBSCRIBER NAME		SEX <input type="checkbox"/> M <input type="checkbox"/> F	BIRTHDATE
	SOCIAL SECURITY #	EMPLOYER		EFF DATE
	MEMBERSHIP# / POLICY# / CLAIM #		GROUP #	COVG CODE
SECONDARY INSURANCE NAME & ADDRESS Phone: _____ Fax: _____	SUBSCRIBER NAME		SEX <input type="checkbox"/> M <input type="checkbox"/> F	BIRTHDATE
	SOCIAL SECURITY #	EMPLOYER		EFF DATE
	MEMBERSHIP# / POLICY# / CLAIM #		GROUP #	COVG CODE
TERTIARY INSURANCE NAME & ADDRESS Phone: _____ Fax: _____	SUBSCRIBER NAME		SEX <input type="checkbox"/> M <input type="checkbox"/> F	BIRTHDATE
	SOCIAL SECURITY #	EMPLOYER		EFF DATE
	MEMBERSHIP# / POLICY# / CLAIM #		GROUP #	COVG CODE

INJURY INFORMATION

DATE OF INJURY/ONSET	CONDITION(S) WE ARE TREATING YOU FOR TODAY
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FOR OFFICE USE ONLY:

AUTHORIZATION TO RELEASE MEDICAL INFORMATION and ASSIGNMENT OF INSURANCE BENEFITS:

I authorize Orthopedic Associates of Hawaii, LLP, or its representative, to release to my insurance company or its representative any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical or surgical care. I hereby authorize that payments for these services be made directly to my physician or supplier.

FINANCIAL AGREEMENT: I understand that I am financially responsible for all charges whether or not paid by said insurance.

These include deductible, co-payment, cost-share, and/or non-covered benefits. I also agree to pay a late payment fee of 1% a month on any unpaid balance over 90 days old together with reasonable attorney's fees and collection expenses should the account be referred to an attorney or collection agency. I agree to pay a \$10.00 processing fee for each returned check.

I certify that the insurance information I have provided is correct. I permit a copy of this authorization to be used in place of the original. This authorization is valid until revoked by me in writing.

Patient/Parent/Guardian Signature

Relationship to Patient

Date

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF USES AND DISCLOSURES
OF PROTECTED HEALTH INFORMATION
FOR

ORTHOPEDIC ASSOCIATES OF HAWAII, LLP

I hereby acknowledge that I received from Orthopedic Associates of Hawaii, LLP a copy of their Notice of Uses and Disclosures of Protected Health Information that details their Privacy Policy as required by the Health Information Portability and Accountability Act (“HIPAA”).

Print Your Name

Signed

Relationship to Patient

Date: _____

ORTHOPEDIC *OA* ASSOCIATES
of Hawaii LLP

Orthopedic Associates of Hawaii is in the process of implementing ePrescribing in each of our offices.

ePrescribing is a federally mandated initiative that requires all physicians prescribe in this manner by 2011.

ePrescribing software sends prescriptions over the internet to your pharmacy in a safe, secure way, through the same technology used by credit card companies. This helps protect the privacy of your personal information.

ePrescribing software also lets your doctor see important information – like drug interactions and your prescription history.

The benefit to you:

- Less confusion over handwritten prescriptions or unclear phone calls
- Reduced possibility of medical errors
- Less chance of adverse drug reactions
- Fewer trips to drop off at the pharmacy
- A safer, faster, easier way to get your prescriptions filled

Patient Consent

I agree that Orthopedic Associates of Hawaii may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

Patient Signature

Date