

PATIENT REGISTRATION

PERSONAL INFORMATION

Patient's Name _____
FIRST NAME MIDDLE INITIAL LAST NAME

Address _____

City/Town _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell _____

Date of Birth _____ Social Security # _____ - _____ - _____ Sex: MALE FEMALE

Marital Status: SINGLE MARRIED DIVORCED WIDOWED

Employer's Name, Address & Phone # _____

FINANCIAL RESPONSIBILITY

Do you have medical insurance? YES NO If YES, please skip to INSURANCE section of this form.

If NO, how will you pay for your medical treatment? CASH CHECK CREDIT CARD, complete below

VISA MASTER CARD AMERICAN EXPRESS Account #: _____ Exp. _____

INSURANCE INFORMATION

Primary Carrier: _____	Secondary Carrier: _____
Address: _____	Address: _____
ID #: _____ Group #: _____	ID #: _____ Group #: _____
Phone #: _____	Phone #: _____
Name of Insured: _____	Name of Insured: _____
Insured's Date of Birth _____ SS # _____	Insured's Date of Birth _____ SS # _____

REFERRING/FAMILY PHYSICIAN

Referring Physician: _____	Family Physician: _____
Address: _____	Address: _____
Phone: _____	Phone: _____

EMERGENCY CONTACT

Who should we contact in case of emergency?

Name: _____ Relation to Patient: _____

Address: _____ Phone #: _____

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Ruggiero Orthopaedic Associates, Ltd. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of PAOC/Ruggiero Orthopaedic Associates, Ltd. I understand that diagnosis or treatment of me by Robert A. Ruggiero, M.D., Robert A. Ruggiero, Jr., M.D., Donald W. Mazur, M.D., Charles J. Odgers, IV, M.D., Michael S. Lee, M.D., Kevin Lutsky, M.D., Eric C. Zabat, M.D. or Jason Miller, D.P.M. may be conditioned upon my consent as evidenced by my signature on this document.

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. Ruggiero Orthopaedic Associates, Ltd. is not required to agree to the restrictions that I may request. However, if Ruggiero Orthopaedic Associates, Ltd. agrees to a restriction that I request, the restriction is binding on PAOC/Ruggiero Orthopaedic Associates, Ltd. and Robert A. Ruggiero, M.D., Robert A. Ruggiero, Jr., M.D., Donald W. Mazur, M.D., Charles J. Odgers, IV, M.D., Michael S. Lee, M.D., Kevin Lutsky, M.D., Eric C. Zabat, M.D. or Jason Miller, D.P.M.

I have the right to revoke this consent, in writing, at any time, except to the extent that Robert A. Ruggiero, M.D., Robert A. Ruggiero, Jr., M.D., Donald W. Mazur, M.D., Charles J. Odgers, IV, M.D., Michael S. Lee, M.D., Kevin Lutsky, M.D., Eric C. Zabat, M.D. or Jason Miller, D.P.M. or PAOC/Ruggiero Orthopaedic Associates, Ltd. has taken action in reliance on this consent.

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 I have a right to review PAOC/Ruggiero Orthopaedic Associates, Ltd.'s Notice of Privacy Practices prior to signing this document. The Ruggiero Orthopaedic Associates, Ltd.'s Notice of Privacy Practices is available to me at my request. 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 the PAOC/Ruggiero Orthopaedic Associates, Ltd. The Notice of Privacy Practices for PAOC/Ruggiero Orthopaedic Associates, Ltd. is also provided at the Barr Building, Suite 200, 266 Lancaster Avenue, Malvern, PA 19355. This Notice of Privacy Practices also describes my rights and the Ruggiero Orthopaedic Associates, Ltd.'s duties with respect to my protected health information.

PAOC/Ruggiero Orthopaedic Associates, Ltd. 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 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 / Parent / Guardian

Date

Name of Patient / Parent / Guardian

AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF PAYMENT

I HEREBY AUTHORIZE THE RELEASE OF ALL MEDICAL INFORMATION TO INSURANCE CARRIERS CONCERNING MY TREATMENT AND ASSIGN TO PAOC/RUGGIERO ORTHOPAEDIC ASSOCIATES, LTD. ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF AND/OR MY DEPENDENTS. I AUTHORIZE TRANSFER OF ALL UNPAID AMOUNTS TO MY CREDIT CARD AFTER 120 DAYS FROM THE DATE OF SERVICE. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE.

Signature of Patient / Parent / Guardian

Date

MEDICARE PATIENTS ONLY – MUST SIGN THE AUTHORIZATION BELOW:

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO PAOC/RUGGIERO ORTHOPAEDIC ASSOCIATE, LTD. FOR ANY SERVICES FURNISHED TO ME BY THAT PHYSICIAN OR SUPPLIER. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

Signature of Patient / Parent / Guardian

Date