Jewett Orthopaedic Clinic, LLC

Patient Registration Information

PATIENT INFORMATION

First Name	M.I.	Last Name	Date Of Birth	Age

Street Address	Additional Address	City	State	Zip code

Social Security Number	E-mail	Preferred Phone Number	Secondary Phone Number

Gender	Marital Status	Race	Ethnicity	Preferred Language

CURRENT EMPLOYER

Employer	Phone

Street Address	City	State	Zip code

GUARANTOR INFORMATION

First Name	Last Name	Date Of Birth	Gender

Street Address	Additional Address	City	State	Zip code

SSN	Employer Information

EMERGENCY CONTACT

Name	Phone

PRIMARY INSURANCE INFORMATION

Insurance Name	Address	City	State	Zip code

ID/Certificate Number	Group ID/Number

Policy Holder (Subscriber) Name	Relation To Patient	Date Of Birth	Gender

SECONDARY INSURANCE INFORMATION

Insurance Name	Address	City	State	Zip code

ID/Certificate Number	Group ID/Number

Policy Holder (Subscriber) Name	Relation To Patient	Date Of Birth	Gender

ACCIDENT INSURANCE INFORMATION

Employment	☐ Yes ☐ No	Employer is different than above	City & State	Zip	Injury Date
Auto	☐ Yes ☐ No	Address	City & State	Zip	Injury Date
Other	☐ Yes ☐ No	Address	City & State	Zip	Injury Date

REFERRED TO THIS PRACTICE BY

Primary Care Physician	Phone Number

Who Referred you to our office?

I hereby give lifetime authorization for payment of insurance benefits to be made directly to **Jewett Orthopaedic Clinic,** and any assisting physicians for services rendered. I authorize treatment of the above listed patient by a provider at Jewett Orthopaedic Clinic. I agree that a photocopy of this agreement shall be valid as the original.

I understand that I may be seeing a Physician Assistant (PA) for my orthopaedic problem and that I have the choice of seeing a Physican at another time when an appointment is available. **Please initial if your appointment has been made with a PA_____**

Date: _____ Signature: _____

Name: _____

DOB: _____

Chart: _____

JEWETT ORTHOPAEDIC CLINIC, LLC
Notice of Privacy Practices Acknowlegement Form
Consent to Use or Disclose Protected Health Information

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information ("PHI") about you. You have the right to review our Notice before signing this form. Your signature below acknowledges that you have received a copy of our Notice of Privacy Practices. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting any Jewett Orthopaedic Clinic Supervisor. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of PHI about you for treatment, payment and health care operations as described in our Notice. These disclosures may be by phone, mail, fax or electronic transmission. **Unless you indicate otherwise in writing (by completing the form: Request for Restrictions on Use and Disclosure of Protected Health Information), if you allow a third party other than one of the practice's physicians or staff to be in the exam room while one of our physicians or staff is examining you or discussing your care, treatment or medical condition with you, by signing this Consent Form you are consenting to the disclosure of your PHI to that third party.** You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. If you refuse to sign this consent or revoke this consent, Jewett Orthopaedic Clinic may refuse treatment or provide further treatment as of the time of the revocation, except to the extent that treatment is required by law.

I am consenting to the disclosure of my protected health information ("PHI") to the following individuals:

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

I have read and understand the information in this acknowledgment. I am the patient or am authorized to act on behalf of the patient to sign this document. By signing below, I acknowledge and agree to the above conditions.

_____ _____ _____

Print name of patient (or authorized representative) | Signature of patient (or authorized representative) | Date

_____

Reason patient is unable to sign and representative's relationship to patient or authority to sign on behalf of patient

Name: _____

DOB: _____

Chart: _____

JEWETT ORTHOPAEDIC CLINIC
Consent for Electronic Prescribing

Jewett Orthopaedic Clinic, LLC. is enrolled in an electronic prescribing program. This program is meant to help our providers with understanding what medications our patients are currently using and to give them the best possible treatment.

By signing this form, you consent to the Jewett Orthopaedic Clinic retreiving electronic prescribing information from other providers through the Surescripts database.

This consent will only be valid for one year. A new consent will be required at that time.

I agree that Jewett Orthopaedic Clinic may request and use my prescribing medication history from other healthcare providers.

Print name of patient (or authorized representative)	Signature of patient (or authorized representative)	Date

Reason patient is unable to sign and representative's relationship to patient or authority to sign on behalf of patient

Please provide your preferred pharmacy information:

Pharmacy Name: _____

Address: _____

Phone Number: _____

For healthcare updates, how would you like to be contacted? (Please choose one)

_____ Primary phone

_____ E-mail

_____ Mail

Name: _____

DOB: _____

Chart: _____

JEWETT ORTHOPAEDIC CLINIC, LLC
Assignment of Benefits and Direction for Payment

Primary Ins. Co. _____ Secondary Ins Co. _____

I hereby instruct and direct the above named insurance company to pay by check made payable to:

Jewett Orthopaedic Clinic, P.A.
Post Office Box 8885
Winter Park, Florida 32790-8885

for the medical and diagnostic expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the Services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY**. This payment will not exceed my indebtedness to Jewett Orthopaedic Clinic, P.A. and I have agreed to pay, in a current manner, any balance of said service charges over and above this insurance payment except to the extent my liability for any such balance is limited by agreement or law applicable to the Jewett Orthopaedic Clinic, P.A.

A photocopy of this assignment shall be considered as effective and as valid as the original. I also authorize the release of any information acquired in the course of my treatment to any insurance company, adjuster or attorney involved in this case.

_____ _____ _____

Print name of patient (or authorized representative) | Signature of patient (or authorized representative) | Date

_____

Reason patient is unable to sign and representative's relationship to patient or authority to sign on behalf of patient

TELEPHONE CONSUMER PROTECTION ACT
PRIOR EXPRESS CONSENT

Jewett Orthopaedic Clinic
1285 Orange Avenue, Winter Park, Florida 32789
407-647-2287

Name: Account #:

The Telephone Consumer Protection Act (TCPA) prohibits a person or company from making any call using any automatic telephone dialing system or an artificial or prerecorded voice to any wireless telephone number unless the call is made for an emergency purpose or the call is made with the prior express consent of the called party.

Through this Prior Express Consent, I consent to allow Jewett Orthopaedic Clinic to contact me through automated technology at my mobile or home phone number. My best contact number is: _____

I agree to allow Jewett Orthopaedic Clinic to contact me regarding my appointments.

I understand that my medical care is not conditioned on my acceptance of this Prior Express Consent.

_____ _____
Patient Date

_____ _____
Witness Date

Name: _____

DOB: _____

Chart: _____

JEWETT ORTHOPAEDIC CLINIC, LLC
Assignment and Lein for Medical Services Rendered

If I, _____, receive or become entitled to receive any monies from any source whatsoever for my injuries, either through a lawsuit, settlement of a lawsuit or claim, award by a court or arbitrator(s), jury verdict, judgment or payment of insurance proceeds, I hereby assign and agree to pay said funds to:

Jewett Orthopaedic Clinic, P.A.
Post Office Box 8885
Winter Park, Florida 32790-8885

to the extent of any outstanding amounts then owed by me to the Jewett Orthopaedic Clinic, P.A. for medical services before any other fees, costs, or expenses are disbursed from any said funds. I further agree and acknowledge that the fee for the services to be performed by the Jewett Orthopaedic Clinic, P.A. depends on the treatment rendered and that any amount that I owe to the Jewett Orthopaedic Clinic, P.A. shall constitute a lien on any claim or lawsuit I may have as a result of my injuries and any settlement, judgment, jury verdict, or insurance proceeds that I receive or become entitled to receive.

This Assignment and Lien shall be placed in my chart and a copy thereof shall constitute actual notice to my attorney, or any other person, that my medical bills to the Jewett Orthopaedic Clinic, P.A. shall be paid first from the proceeds of any such settlement, judgment, jury verdict, insurance proceeds or otherwise. This authorization cannot be modified unless it is in writing and signed by both parties.

I hereby appoint the Jewett Orthopaedic Clinic, P.A. or its designee as my attorney-in-fact to sign my name to and file a financing statement under the Uniform Commercial Code to evidence this lien.

I understand that I remain personally responsible for the payment of all fees owed by me to the Jewett Orthopaedic Clinic, P.A. and that notwithstanding this Assignment and Lien, the Jewett Orthopaedic Clinic, P.A. is not required to look to any other person or entity for payment.

I hereby instruct my attorney to pay directly the Jewett Orthopaedic Clinic, P.A. such sums as may be due and owing for medical services rendered to me, and to withhold such sums from any settlement, judgment, jury verdict, or insurance proceeds as may be necessary to adequately protect the Jewett Orthopaedic Clinic, P.A. These instructions are irrevocable and may not be changed without the written agreement of the Jewett Orthopaedic Clinic, P.A. I have given authorization to the Jewett Orthopaedic Clinic, P.A. to forward this document to my attorney. My attorney hereby acknowledges that in the event I recover money through settlement, judgment, jury verdict, or insurance proceeds from any person or entity in which the law firm and/or attorney is an additional named payee, my attorney agrees to withhold and pay sufficient funds to the Jewett Orthopaedic Clinic, P.A. for any outstanding expenses owed to the Jewett Orthopaedic Clinic, P.A. in connection with medical services rendered as a result of my injuries.

Print name of patient (or authorized representative)	Signature of patient (or authorized representative)	Date

Reason patient is unable to sign and representative's relationship to patient or authority to sign on behalf of patient

Signature of Attorney	Print name of Attorney	Date