Parkcrest Orthopedics
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OPEN AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

PATIENT NAME: ____

HOME ADDRESS: ____

DATE OF BIRTH: ____

I, hereby authorize Parkcrest Orthopedics to release any and all protected health information maintained in my medical records to the following individuals, concerning my status as a patient, treatment or payment of services provided by Parkcrest Orthopedics.

NAME	RELATIONSHIP TO PATIENT

This authorization is given freely with the understanding that this authorization is valid until revoked by me. I may revoke this authorization at any time, except where information has already been released. Individuals not listed on this form will be unable to receive any information. Parkcrest Orthopedics and its workforce are hereby released from any legal responsibility or liability for disclosure of any of my Protected Health Information as indicated and authorized herein.

____

PATIENT'S NAME **DATE**

____

PATIENT'S SIGNATURE (OR PARENT OR LEGAL GAURDIAN IF A MINOR)

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been offered, and if wanted, received a summary of Parkcrest Orthopedics' notice of privacy practices and consent to the use or disclosure of my protected health information by Parkcrest Orthopedics for the purpose of diagnosing or providing treatment to me, obtaining payment for health care bills, to conduct health care operations of Parkcrest Orthopedics, and as required by law.

I also acknowledge that I was offered the entire notice and that I understand that I may obtain a full version of this notice at any time. I understand my rights as a patient of this practice concerning my protected health information, as it is outlined in this notice. I am aware Parkcrest Orthopedics reserves the right to change the privacy practices that are described in this notice. I may obtain a revised notice by contacting the office and requesting a copy be sent in the mail or asking for one at the time of my next appointment.

____

Patient Signature (Or Parent or Legal Guardian if a Minor) **DATE**

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I authorize payment of benefits, as determined by the Company, directly to : Surgeon/ Physician ( ) Yes ( ) No.
I understand that unless I have checked Yes above, I may still be responsible for any amounts not paid by my Insurance Company in the event that the charges made are not reasonable and customary.

We ask that all patients give at least a 24 hours notice that they will be unable to keep their appointment.

____

Patient Signature (Or Parent or Legal Guardian if a Minor) **DATE**

Name : ___________________________________ Date: _____/_____/_____________
Date of Birth :_____/_____/___________ Age: ______ Height:______ Weight:_______
Family Doctor:____________________________ Referred by: _____________________

PLEASE FILL IN CIRCLES COMPLETELY. Please do not √ check or × in circles.

What are you being seen for today ?

	R	L		R	L			R	L
O Shoulder	O	O	O Knee	O	O	O Back	O Ankle	O	O
O Elbow	O	O	O Hip	O	O	O Neck	O Foot	O	O
O Wrist	O	O	O Hand	O	O	O Finger	O Toe	O	O
O Tib/Fib	O	O	O Calf	O	O				

When did your pain/ problem start? _____/_____/_____________

How did your pain/ problem start?
O Injury O Spontaneous O Chronic

Were you hurt at work?
O Yes O No

Are you currently on :
O Full duty O Light duty O Off work O N/A

Please describe your pain/ problem :

____
____
____
____

What treatments have you had so far?

O None
O Narcotic Medication
O Braces
O Cortisone injection
O Physical Therapy
O Massage or Ultrasound
O Manipulation/ chiropractic
O Anti-inflammatory Medication
O Surgery
O Traction
O Visco supplementation

What tests have you had to evaluate your problem ?

O X-rays
O CT scan
O Blood Work
O Bone scan
O EMG/ Nerve Conduction
O Other ____
O Venous Doppler Study
O MRI scan

Please list all your Current Medications and Dosage:

____
____
____
____
____