

BLACK MOUNTAIN ORTHOPAEDICS
Patient Registration Information

Please PRINT and complete ALL sections below

PATIENT'S PERSONAL INFORMATION

Marital Status: Single Married Divorced Widowed **Sex:** Male Female

Name: _____
last name first name initial

Date of Birth: ____ / ____ / ____ Social Security #: ____ - ____ - ____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Address: _____ Apt. #: ____ City: _____ State: ____ Zip: _____

PATIENT'S / RESPONSIBLE PARTY INFORMATION

Relationship to Patient: Self Spouse Child Other: _____

Name: _____
last name first name initial

Date of Birth: ____ / ____ / ____ Social Security #: ____ - ____ - ____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Address: _____ Apt. #: ____ City: _____ State: ____ Zip: _____

PATIENT'S INSURANCE INFORMATION

Please present insurance cards to receptionist.

PRIMARY Insurance Name: _____

Address: _____ City: _____ State: ____ Zip: _____
 Self Spouse
 Child Other

Name of insured: _____ Date of Birth: ____ Relationship to insured: _____

Policy #: _____ Group #: _____ Copay: \$ _____

SECONDARY Insurance Name: _____

Address: _____ City: _____ State: ____ Zip: _____
 Self Spouse
 Child Other

Name of insured: _____ Date of Birth: ____ Relationship to insured: _____

Policy #: _____ Group #: _____ Copay: \$ _____

PATIENT'S REFERRAL INFORMATION

Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: (____) _____ Fax: (____) _____

PHARMACY INFORMATION

Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: (____) _____ Fax: (____) _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Assignment of Benefits • Financial Agreement

I herby give lifetime authorization for payment of insurance benefits to be made directly to BLACK MOUNTAIN ORTHOPAEDICS, and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Date: _____ Signature: _____

Notice of Privacy Practices

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Options. Your health information may be used as necessary to support the day-to-day activities and management of **Black Mountain Orthopaedics**. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandate reporting.

Public Health Reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment Reminders. Your health information will be used by our staff to send you appointment reminders.

Information about Treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights

You have certain rights under the Federal Privacy Standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Black Mountain Orthopaedics – Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting **Michael S. Ravitch, M.D. and/or Roger A. Fontes, M.D.** or the **Office Manager**. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Black Mountain Orthopaedics
1681 West Horizon Ridge Parkway
Henderson, NV 89012

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person

The name and address of the person you can contact for further information concerning our privacy practices is:

Teresa Day, Office Manager
Black Mountain Orthopaedics
1681 West Horizon Ridge Parkway
Henderson, NV 89012
Phone: (702) 564-1234

Effective Date

This Notice is effective on or after April 14, 2003.

BLACK MOUNTAIN ORTHOPAEDICS
Acknowledgement of Receipt of Notice of Privacy Practices

Black Mountain Orthopaedics reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the Notice of Privacy Practices for **Black Mountain Orthopaedics**.

Name of Patient (Please Print)

Signature of Patient

Date

Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient

**PATIENT CONSENT FOR USE AND DISCLOSURE OF
PROTECTED HEALTH INFORMATION**

With my consent, **Black Mountain Orthopaedics**, may use and disclose protected health information (PHI) about me to carry out treatment payment and healthcare options (TPO). Please refer to the Notice of Privacy Practice for a more complete description for such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Black Mountain Orthopaedics**, reserves the right to revise its Notice of Privacy at anytime. A revised notice may be obtained by forwarding a written request to **Black Mountain Orthopaedics**, 106 East Lake Mead Parkway, Suite 108, Henderson, NV 89015.

With my consent, **Black Mountain Orthopaedics**, and staff may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, referrals, insurance items, labs, X-rays, and other items.

With my consent, **Black Mountain Orthopaedics**, and staff may mail to my home or other designated location any items that assist in my treatment, such as appointment cards, patient statements, etc., as long as they are marked "personal and confidential."

With my consent, **Black Mountain Orthopaedics**, may email to my home or other designated location any information that may assist the practice in carrying out TPO, as listed above.

By signing this form, I am consenting **Black Mountain Orthopaedics**, to use and disclose my PHI to carry out TPO.

Signature of Patient/ or Guardian

Date

Patient's Name (please print)

ILLNESS/INJURY FORM

Please complete the following information. If this information does not apply to you, please fill in "N/A" after each question and sign below. Thank you.

Appointment Date: _____

1. When did the illness or injury occur (list date mm/dd/yy)?:

2. Where did the illness or injury occur?:

3. How did the illness or injury occur?:

4. Is this illness or injury someone else's fault? Yes No

If yes, please explain: _____

5. Is your illness or injury work related? Yes No
(If yes, please continue to questions 6 & 7)

6. Did you report the condition to your employer? Yes No

7. Do you expect to receive or have you been provided
with worker's compensation benefits? Yes No

Patient Signature: _____

Print Name: _____