The Centers for Advanced Orthopaedics
Potomac Valley Orthopaedic Associates

PATIENT INFORMATION (Please Print)

Office Use Only Patient Account # _____ Employee Initials _____

Patient's Name (Last, First, Middle Initial) _____
Responsible Party (if minor) _____
Address _____ City _____ State _____ Zip _____
Home Phone No. ( )_____ Business Phone No. ( ) _____
Cellular Phone No. ( )_____ Email Address _____
Date of Birth _____ Age _____ Sex: M ☐ F ☐ Social Security No. _____
Employed: Y ☐ N ☐ Occupation _____ Full Time Student: Y ☐ N ☐
Patient's / Parent's Employer _____
Emergency Contact & Relationship:_____/_____ Phone No. ( ) _____
Primary Care Physician: _____ Phone No. ( ) _____
Referring Physician: _____ Phone No. ( ) _____
Pharmacy Name: _____ Phone No. ( ) _____
Language:_____ Race:_____ Ethnicity:_____

I would like to complete the Confidential Communication form allowing a family member/specific individual(s) access to my protected health information: Y ☐ N ☐

PRIMARY INSURANCE COMPANY _____
Policy/ID No. _____ Group No. _____ Effective Date _____
Policy Holder's Name _____ Date of Birth _____ Relation to Patient _____
Policy Holder's Employer _____

SECONDARY INSURANCE COMPANY _____
Policy/ID No. _____ Group No. _____ Effective Date _____
Policy Holder's Name _____ Date of Birth _____ Relation to Patient _____
Policy Holder's Employer _____

CONSENT FOR USE AND DISCLOSURE OF INFORMATION (Please Read and Sign Below)

By signing below, you consent to our use and disclosure of your protected health information for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent. I hereby give my consent for The Centers for Advanced Orthopaedics Potomac Valley Orthopaedic Associates and Sports Medicine & Rehabilitation Center division to furnish information to insurance carriers concerning my physical condition and treatments, and I hereby assign to the Physicians all payments for Medical Services rendered to myself or my dependents.
I understand that I am responsible for all fees and finance charges for the above named patient, regardless of Insurance coverage. If, after default, this account is placed in the hands of a collection agency, the undersigned agrees to pay 30% of the unpaid balance as a reasonable collector's fee, together with the additional costs and expenses of collection to the extent permitted by law.

Signature _____ **Date** _____

ACKNOWLEDGEMENT OF NOTIFICATION OF PRIVACY PRACTICES (Please Read and Sign Below)

By signing below, you acknowledge the availability of our Notice of Privacy Practices pamphlet, which provides information about how we may use and disclose your protected health information, and is compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). We reserve the right to change the terms described, and should we do this we will post the changes in all of our offices. You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree with your restrictions; but if we do, we are bound by our agreement with you. **OSHA**: The state of Maryland requires that a patient be tested in the event of a health care exposure, by signing the patient is agreeing to be tested.
** Please Note: Exposure testing will include rapid HIV, rapid Hepatitis C antibody, and Hepatitis B surface antigen. In accordance with Maryland law, we may destroy patient charts 6 years after the last documented record. In the case of a minor, records must be retained until the patient reaches the age of 18 plus 3 years, or for 5 years after the record was made, whichever is later.**

Signature _____ **Date** _____