PATIENT REGISTRATION

PATIENT _____ **SEX** M F **D.O.B** _____

Marital Status: Single Married Divorced Widowed SS# _____

Address_____ City_____ State_____ Zip_____

Home Phone_____Cell Phone_____Work Phone_____Email_____

Employer_____Occupation_____

Address_____ City_____ State_____ Zip_____

ETHNICITY Hispanic/Latino Not Hispanic/Latino Patient Declined

RACE American Indian/Alaskan Native Asian Chinese Filipino Japanese Native Hawaiian Other Pacific Islander White Black/African American Patient Declined

Primary Language _____

NAME OF RESPONSIBLE PARTY _____ **D.O.B.** _____

Address_____ City_____ State_____ Zip_____

Home Phone_____Cell Phone_____Work Phone_____Email_____

Employer_____Occupation_____

Address_____ City_____ State_____ Zip_____

EMERGENCY CONTACT _____ **PHONE #** _____
Relationship to Patient_____

PRIMARY CARE PHYSICIAN _____ **OFFICE PHONE #**_____

REFERRING PHYSICIAN _____ **OFFICE PHONE #**_____
How were you referred to OrthoVirginia?
White/Yellow Pages Website Newspaper TV Radio Direct Mail Self Family/Friend

HEALTH INSURANCE COVERAGE

To be completed by ALL patients.

(In the case of workers' compensation, this information will only be used if your case is denied.)

	PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Company Name		
Policy Holder Name		
Policy Holder's Date of Birth		
Relationship to Patient		
Policy Holder's Employer		

WORKER'S COMPENSATION

Please complete this section if your illness/injury is work related.

Date of Injury_____ Claim #_____

Employer's Name _____

Employer's Address _____

Contact Person _____ Employer's Telephone _____

PATIENT AUTHORIZATION FOR TREATMENT, CLAIMS & PAYMENT

Thank you for selecting OrthoVirginia or its affiliates as your health care provider. We are committed to providing you with the best possible medical care. Following is an authorization for treatment, claims payment and review of policies which we require you to sign prior to any treatment.

Authorization for Medical Treatment: I authorize and consent to health care services or supplies including, but not limited to, diagnostic procedures, injections, therapy and medical treatment at and by OrthoVirginia or its affiliates. I acknowledge that no guarantees or promises have been made to me as to the result to be obtained from such services. I have the right to refuse treatment and/or medicines after my physician has given me adequate explanation.

Financial Agreement: In consideration of health care services provided to me by OrthoVirginia or its affiliates for this and all subsequent services, I agree to pay OrthoVirginia in accordance with its regular rates and terms of payment. I understand that the Surgical Suite charges do not include the fees of my treating physician(s), anesthesiologist, DME supplies or any pathology tests. By signing the line below, I authorize OrthoVirginia to treat me without my referral; and I accept full responsibility for payment of all services or treatment provided. For more financial information, please see "Patient Billing Practices" brochure.

I understand that I am financially responsible for the payment of medical fees to the physician(s) who render services through the Surgical Suite.

Advanced Directives: I understand that the Surgical Suite does not honor Advanced Directives. However, the Surgical Suite will accept a copy of my Advanced Directives, and information about Advanced Directives will be provided to me upon request. Should it become necessary, I understand that resuscitation efforts will be attempted, and a transfer will be made to an acute care facility where Advanced Directives may be followed.

Medicare Lifetime Signature Agreement (if applicable): I authorize any holder of medical or other information about me and their agents to release to the Social Security Administration and the Centers for Medicare and Medicaid Services or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original; and I request payment under Medicare be made to the physician, provider or other supplier of services or supplies furnished by the physician, provider or other supplier.

Assignment of Benefits: In consideration of healthcare services provided to me by OrthoVirginia or its affiliates for this and all subsequent services, I hereby assign to OrthoVirginia any and all rights, benefits and claims I may have under any policy of insurance (major medical, automobile, liability, worker's compensation and any other) and the proceeds from any claim that I may have for injuries. I permit a copy of this authorization and assignment to be used in place of the original. Such assignment hereby authorizes direct payment to OrthoVirginia under and/or from any such policy of insurance or proceeds.

Notice of "Deemed Consent" for HIV, HBV, and HCV Testing: As a health care provider, we are required by §32.1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice.

1. If one of our health care professionals, workers, or employees should be directly exposed to your blood or body fluids in a way that may transmit disease, your blood will be tested for infection with human immunodeficiency virus ("HIV", the "AIDS" virus) and for the presence of the hepatitis B and hepatitis C viruses. A physician or other health care provider will tell you and that person the results of the test and provide counseling, if necessary.
2. If you should be directly exposed to blood or body fluids of one of our health care professionals, workers, or employees in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus ("HIV", the "AIDS" virus) and for the presence of the hepatitis B and hepatitis C viruses. A physician or other health care provider will tell you and that person the results of the test and provide counseling, if necessary.

Financial and Ownership Interest of Physicians: I understand that my OrthoVirginia physician may refer me to another facility or entity for health-related services, appliances or devices, and that the physician may have a financial or ownership interest in that facility or entity. I have been advised that OrthoVirginia physicians have, or may have, a financial or ownership interest in: OrthoVirginia's surgical and therapy departments; Ortho On-Call. I further understand that such health-related services, appliances or devices may be available from other suppliers in the community and that I have the freedom to choose the facility or entity that I want to use.

Other:

I understand that family members, case managers or others will be allowed in the examination room with my consent and at the discretion of the treating physician.

I understand that OrthoVirginia may access the Virginia Prescription Monitoring Program (PMP) without specific patient consent.

Patient's Signature	**Date**
Signature of Legal Guardian or Power of Attorney	**Date**
Signature of Financially Responsible Party (if different from above)	**Date**
Witnessed by OrthoVirginia Representative	**Date**