

DR#

PLEASE PRINT

HIPAA

PATIENT INFORMATION

Patient Name Last First MI Social Security No. DOB

Age Single Married Widowed Divorced Separated Male Female

Home Address Street City State Zip

Home Telephone Cellular Number Work Telephone Ext.

Employer Full-time Part-time Unemployed Retired Occupation

Medical Doctor Referring Physician (if different)

Are you allergic to any drugs? No Yes If yes, please list:

INSURANCE INFORMATION

PRIMARY

Policy Holder ID# Group#

Insurance Company Address

SECONDARY

Policy Holder ID# Group#

Insurance Company Address

Accident related? No Yes If yes, please continue. Date of injury Auto Work Other

Explanation

SPOUSE INFORMATION OR PARENT (IF PATIENT IS A MINOR)

Parent/Spouse Name Cellular Number SS#

Employer Work Telephone Occupation DOB

EMERGENCY CONTACT

Name (person not living with you) Telephone No Relationship

AUTHORIZATION AND ASSIGNMENT

I hereby consent to GTVSA, dba Ohio Valley Surgical Specialists (the "Practice") using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me or to carry out the Practice's health care operations. I also consent to the Practice using or disclosing my protected health information for treatment activities provided by another health care provider, as well as the payment activities conducted by another health care provider or entity. I further consent to the disclosure of my protected health information in order for another provider or health care entity to conduct health care operations including quality assessment and reviewing the competence of health care professionals.

Specific Records Expressly Excluded: I expressly authorize release of the following information for the purposes of treatment, payment and health care operations, if it is part of my protected health information (CHECK ANY OR ALL YOU AGREE TO AUTHORIZE FOR RELEASE):

- Chemical Dependency/Substance Abuse Drugs Alcohol Sexually Transmitted Diseases

I further acknowledge the Practice has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information. I authorize other providers to release my protected health information to GTVSA for treatment purposes. I assign payment of all insurance benefits to GTVSA. I agree to be responsible for all attorney fees associated with the collection of my account. I have been given a copy of, and agree to abide by, the practice's financial policies.

Signature of Patient or Personal Representative

RESTRICTIONS:

Name of Patient or Personal Representative

Date

Note: The Practice only issues refund checks for amounts in excess of \$5.00