



# Orthopaedic Associates, L.L.P.

Orthopaedic Sports Medicine  
Arthroscopic Surgery of  
Knee and Shoulder  
Joint Replacement Surgery

Stephen D. Ryyle, M.D.  
Steven J. Wilson, M.D.  
Brandon A. Perez, M.D.

## PATIENT REGISTRATION INFORMATION

Please print and complete all sections below

**PATIENT'S INFORMATION:** Marital Status:  Single  Married  Divorced  Widowed Sex:  Male  Female

Race:  White  African American  Asian  American Indian  Native Hawaiian  Other: \_\_\_\_\_  Refuse to report

Ethnicity:  Hispanic or Latino  Not Hispanic or Latino  Refuse to report Pharmacy: \_\_\_\_\_

Preferred Language:  English  Spanish  Other School Attending (If Student): \_\_\_\_\_

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_ Email Address: \_\_\_\_\_

Home #:(\_\_\_\_) \_\_\_\_\_ Cell #:(\_\_\_\_) \_\_\_\_\_ Work #:(\_\_\_\_) \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Area Injured: \_\_\_\_\_ Work Related: Y / N

**RESPONSIBLE PARTY INFORMATION:** Relationship to Patient:  Self  Spouse  Child  Parent  Other: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Home Phone:(\_\_\_\_) \_\_\_\_\_ Cell Phone:(\_\_\_\_) \_\_\_\_\_ Work Phone:(\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Work Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**INSURANCE INFORMATION:** Please present insurance cards to personnel.

Primary Insurance Name: \_\_\_\_\_

Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_ Subscriber's Date of Birth: \_\_\_\_\_

Name of Subscriber: \_\_\_\_\_ SS#: \_\_\_\_\_

Relationship to Patient:  Self  Spouse  Child  Parent  Other: \_\_\_\_\_

Secondary Insurance Name: \_\_\_\_\_

Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_ Subscriber's Date of Birth: \_\_\_\_\_

Name of Subscriber: \_\_\_\_\_ SS#: \_\_\_\_\_

Relationship to Patient:  Self  Spouse  Child  Parent  Other: \_\_\_\_\_

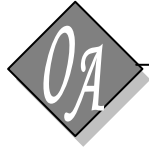
**EMERGENCY CONTACT:** Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**WHAT MADE YOU CHOOSE OSTC FOR YOUR CARE?** Check all that apply:  Phonebook  Website  Friend  Doctor  
 Physical Therapist/Athletic Trainer  Prior treatment at OSTC

Have you ever had an interaction with a staff member of OSTC that made you want to choose OSTC?  Yes  No

Patient/Responsible Party signature: \_\_\_\_\_ Date: \_\_\_\_\_



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## PRIVACY PRACTICE

I have reviewed the Privacy Practices of this office which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

*Orthopaedic Associates, LLP / OSTC* may release information to the following people:

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relation: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relation: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relation: \_\_\_\_\_

Patient Name (PRINT): \_\_\_\_\_

Signature of Patient or Responsible Party: \_\_\_\_\_

Date: \_\_\_\_\_

**PLEASE READ AND SIGN**

**RELEASE OF INFORMATION**

I authorize *Orthopaedic Associates (OA), LLP/OSTC*, to release any medical information requested by other physicians or representatives of local, state, or federal agencies; insurance companies; or other organizations or entities as may be required by said representatives for treatment or payment of claims arising out of this treatment/hospitalization as are due *Orthopaedic Associates, LLP/OSTC*.

**RELEASE OF PRESCRIPTION HISTORY**

I understand this information is used in our electronic health records to avoid drug interactions. I authorize *Orthopaedic Associates (OA), LLP/OSTC* to collect this information.

**PRIVATE PAY PATIENTS (PHYSICIAN PATIENT’S ONLY)**

I understand that due to not having health insurance, I am responsible for \$400.00 deposit prior to being seen by a physician. I understand this is only a deposit and may not cover all charges for this visit.

**FINANCIAL RESPONSIBILITY**

I understand that regardless of my assigned insurance benefits, I am responsible for the total charges for services rendered plus any late charges or interest accrued on delinquent payments and I further agree that all amounts are due upon request and are payable to *Orthopaedic Associates, LLP/OSTC*, Wichita Falls, Texas. When the outstanding balance reaches thirty days past due (payment is due on day of service), interest is accrued at 10% APR. This will authorize and direct my lawyer to withhold from any recovery or settlement as a result of injuries, which I may have sustained, the amount of any reasonable professional fee due *OA, LLP/OSTC*, for services rendered to me and to remit said amount to the said *OA/LLP/OSTC*. If you have a liability injury, such as a motor vehicle accident or other such injury where there is or will be a liability claim, if we file your insurance for you, then you will be responsible for repaying the insurance company.

**INSURANCE ASSIGNMENT**

In consideration of services rendered or to be rendered, I hereby assign and transfer to *Orthopaedic Associates, LLP/OSTC* any benefits payable to or for my benefit under hospitalization, sickness, or accident insurance, and any other insurance coverage; to include major medical or payment of such service rendered. I agree to cooperate, aid, and assist *Orthopaedic Associates, LLP/OSTC* in procuring all possible insurance benefits including initiation and fulfillment of all policy provisions such insurance companies may require for payment. I further assign and transfer to said *Orthopaedic Associates, LLP/OSTC* an interest in any cause of action I may be arising out of injuries directly or indirectly resulting in this period of treatment.

**NOTICE OF PRIVACY PRACTICES**

I acknowledge that the Notice of Privacy Practices of *Orthopaedic Associates, LLP/OSTC* was made available for me to read.

**KELL WEST HOSPITAL (PHYSICIAN PATIENT’S ONLY)**

I acknowledge that Kell West Hospital is a physician-owned hospital and that the physicians of *Orthopaedic Associates, LLP* are minor shareholders.

Patient Name(PRINT) \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Responsible Party  
Name (PRINT) \_\_\_\_\_ Signature \_\_\_\_\_

