Orthopaedic Associates, L.L.P.

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

Stephen D. Ruyle, 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***: O Single O Married O Divorced O Widowed ***Sex:*** O Male O Female

Race: O White O African American O Asian O American Indian O Native Hawaiian O Other:_____ O Refuse to report

Ethnicity: O Hispanic or Latino O Not Hispanic or Latino O Refuse to report ***Pharmacy:***_____

Preferred Language: O English O Spanish O 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:*** O Self O Spouse O Child O Parent O 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: O Self O Spouse O Child O Parent O Other:_____

Secondary Insurance Name:_____

Group #:_____***Policy #:***_____***Subscriber's Date of Birth:***_____

Name of Subscriber:_____***SS#:***_____

Relationship to Patient: O Self O Spouse O Child O Parent O Other:_____

EMERGENCY CONTACT: ***Name:***_____***Relationship:***_____

Home Phone:_____***Cell Phone:***_____***Work Phone:***_____

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

Have you ever had an interaction with a staff member of OSTC that made you want to choose OSTC? O Yes O 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:_____

#1 West Medical Court, Wichita Falls, TX 76310 ■ Phone: (940) 689-9664 Fax: (940) 689-9662

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 serves 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_____