

AVENTURA ORTHOPEDICS  
Patient Registration Form (eCW)

PATIENT INFORMATION

(Please Print)

Dr.  Miss  Mr.  Mrs.  Ms.  Sir

Patient's Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_ Previous Name \_\_\_\_\_

Address Line 1 \_\_\_\_\_

City, State \_\_\_\_\_ ZIP \_\_\_\_\_ Pharmacy \_\_\_\_\_ Pharmacy Phone \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell No. \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_

Primary Care Provider (PCP) \_\_\_\_\_ Referring Provider \_\_\_\_\_

Rendering Provider Name (this practice) \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Date of Birth MM \_\_\_\_/DD \_\_\_\_/YYYY \_\_\_\_ Sex  F - Female  M - Male  Transgender

Race  American Indian or Alaska Native  Asian  Native Hawaiian or Other Pacific Islander  Black or African American  White  Declined

Ethnicity  Hispanic or Latino  Not Hispanic or Latino  Declined

Language  English  Spanish  Indian  Japanese  Chinese  Korean  French  German  Russian  Other \_\_\_\_\_

Marital Status  Married  Single  Divorced  Widowed  Legally Separated  Partner

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Employer Name \_\_\_\_\_

Employment Status  1 - Full-Time  2 - Part-Time  3 - Not Employed  4 - Self-Employed  5 - Retired  6 - Active Military

Student Status  F - Full-Time Student  P - Part-Time Student  N - Not a Student

Emergency Contact Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Phone Number \_\_\_\_\_ Do you have a living will?  Yes  No

Emergency Contact Relationship to Patient \_\_\_\_\_  Guardian

Address Line 1 \_\_\_\_\_

City, State \_\_\_\_\_ ZIP \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_

Referring Provider Name \_\_\_\_\_

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Responsible Party  Another Patient  Guarantor  Self Check here if information is same as patient

Responsible Party Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

Guarantor Account Number \_\_\_\_\_ Date of Birth MM \_\_\_\_/DD \_\_\_\_/YYYY \_\_\_\_

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Telephone \_\_\_\_\_

E-Mail Address \_\_\_\_\_ Sex  F - Female  M - Male

Address Line 1 \_\_\_\_\_

City, State \_\_\_\_\_ ZIP \_\_\_\_\_

Employer \_\_\_\_\_ Employer Phone Number \_\_\_\_\_

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

Name of Insured \_\_\_\_\_ Patient Relationship to Insured \_\_\_\_\_

Subscriber ID (Policy Number) \_\_\_\_\_ Group ID \_\_\_\_\_ Copay Amount \_\_\_\_\_

Effective Date \_\_\_\_\_ Termination Date \_\_\_\_\_ Date of Birth MM \_\_\_\_/DD \_\_\_\_/YYYY \_\_\_\_

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

Name of Insured \_\_\_\_\_ Patient Relationship to Insured \_\_\_\_\_

Subscriber ID (Policy Number) \_\_\_\_\_ Group ID \_\_\_\_\_ Copay Amount \_\_\_\_\_

Effective Date \_\_\_\_\_ Termination Date \_\_\_\_\_ Date of Birth MM \_\_\_\_/DD \_\_\_\_/YYYY \_\_\_\_

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature \_\_\_\_\_ Date \_\_\_\_\_



## CONSENT FOR EVALUATION OR TREATMENT

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The undersigned hereby consents to evaluation or treatment the assigned healthcare provider may deem necessary to the patient name above.

\_\_\_\_\_  
PATIENT, PARENT, LEGAL GUARDIAN OR AUTHORIZED REPRESENTATIVE      DATE

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## INSURANCE ASSIGNMENT

I hereby authorize my insurance benefits to be paid directly to Parkview Internal Medicine. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.

\_\_\_\_\_  
PATIENT SIGNATURE      DATE

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## FOR MEDICARE PATIENTS ONLY MEDICARE PART B SIGNATURE AUTHORIZATION – LIFETIME

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration 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. I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

\_\_\_\_\_  
PATIENT NAME

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
MEDICARE B#

\_\_\_\_\_  
DATE

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## ADVANCE DIRECTIVE

I understand that the terms of any Advance Directive that I have executed will be followed by the health care facility and my care givers to the extent permitted by law. Please check one of the following statements:

- I HAVE executed an Advance Directive.  
(Living Will, Durable Power of Attorney, Designation of a Health Care Surrogate.)
- I HAVE NOT executed an Advance Directive.  
(Living Will, Durable Power of Attorney, Designation of a Health Care Surrogate)

Signature: \_\_\_\_\_

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

**Aventura Orthopedics Patient HIPAA Acknowledgment and Consent Form**

Patient Name: \_\_\_\_\_

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

\_\_\_\_\_ (Patient initials) **Notice of Privacy Practices.** I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

\_\_\_\_\_ (Patient initials) **Release of Information.** I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior admission(s) at other HCA affiliated facilities may be made available to subsequent HCA-affiliated admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

**Disclosures to Friends and/or Family Members**

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

**Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:**

**Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.**

If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

\_\_\_\_ (Patient initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is \_\_\_\_\_.

The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is \_\_\_\_\_.

*The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).*

**Revocation**

***I hereby revoke my request for future communications via email and/or text.***

*\_\_\_\_ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via text messages.*

*\_\_\_\_ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email.*

**NOTE:** *This revocation only applies to communications from this Practice.*

*Patient Name:* \_\_\_\_\_

*Patient/Patient Representative Signature:* \_\_\_\_\_

*Date:* \_\_\_\_\_ *Time:* \_\_\_\_\_

**Consent for Photographing or Other Recording for Security and/or Health Care Operations**

\_\_\_\_ (Patient Initials) I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment or health care operations purposes or otherwise permitted or required by law.

**Prescription Order Pick-up.** There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

\_\_\_\_ (Patient initials) I wish to designate the following family member / friend to pick up an order on my behalf:

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

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

\_\_\_\_ (Patient initials) I do not want to designate anyone to pick-up my prescription order.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_