KEMMLER
ORTHOPAEDIC
CENTER

JAMES E. KEMMLER, M.D.

123 Hamilton Street • Celina, Ohio 45822
Phone 419-586-5760 • Fax 419-586-7179

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

NAME: _____

BIRTHDATE: _____ SOCIAL SECURITY #: _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations, such as assessing care quality and reviewing the competence of the healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations, and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.
- To review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

I request the following restrictions to the use or disclosure of my health information: _____
_____

_____ _____ _____
Signature of patient or legal guardian Date Witness signature

The following person (s) may have access to my health records (i.e. spouse, family member, P.O.A., etc.)_____

OFFICE USE ONLY:

Accepted _____
Denied _____ Signature _____ Title _____ Date _____

KEMMLER ORTHOPAEDIC CENTER

Patient Legal Name _____ (Last) _____ (First) _____ (Middle)

Patient Address _____

City _____ State _____ Zip Code _____

Social Security # _____ Birthdate _____ Age _____ Marital Status _____

Home Ph.# _____ Work Ph.# _____ Cell Ph. # _____

Who referred you to our office? _____ Employer Name _____

Please send copy of records to family physician _____No _____Yes Physician Name _____

Emergency contacts:

Contact #1 _____ Relationship _____ Phone # _____

Contact #2 _____ Relationship _____ Phone # _____

Person responsible for payment _____ (MUST BE PARENT OR GURADIAN) (Last) (First) (Middle)

Address _____ Home Ph.# _____

City _____ State _____ Zip Code _____

Social Security # _____ Birthdate _____ Age _____ Marital Status _____

Employer Name _____ Check here if retired _____

Employer Address _____ Phone # _____

City _____ State _____ Zip Code _____

WE WILL BE GLAD TO FILE YOUR INSURANCE FOR YOU BUT IT IS YOUR RESPONSIBILITY TO SEE THAT THIS BILL IS PAID. PAYMENT IS EXPECTED AT THE TIME OF SERVICE.

Please state the reason and area of the body you are here for today _____

_____

Was this an injury? _____Yes _____ No If yes, give date of injury _____(be specific)

Work related? _____Yes _____ No If yes, has claim been filed?_____ WC# _____

*Primary Insurance Co. _____

Policy # _____ SSN _____ Group # _____

Name of person holding insurance _____ Birthdate _____

Address/Ph # if different than above _____

Relationship of patient to insured _____

*Secondary Insurance Co. _____

Policy # _____ SSN _____ Group #_____

Name of person holding insurance _____Birthdate _____

Address/Ph # if different from above _____

Relationship of patient to insured _____

Patient's authorization to release medical information and claim payment authorization:
I hereby authorize the above physician(s) to release any information regarding services rendered by him and allow a photo copy of my signature to be used for insurance purposes. I authorize the above information is correct and if any changes occur in names or addresses to let the office staff be aware. I also understand I am financially responsible for the fees for services rendered. I authorize payment of medical benefits to the undersigned physician or supplier for services below.

Date

Responsible Person/ Policy owner/ insured

Patient Name _____

Age _____ MALE or FEMALE Marital Status _____ Number of Children _____

Employer _____ Occupation _____

Do you see a cardiologist or other specialist? ____Yes ____ No Physician's Name _____

Surgeries and hospitalizations _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

What medications are you taking? (Please list name, dose and frequency) _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Preferred Pharmacy _____ City _____

Do you smoke? Yes No If yes, packs/day _____ Former Smoker: Yes No

What **medications** are you allergic to? _____

How much alcohol do you drink? _____ (cans/glasses/drinks) of (beer/wine/liquor) per (day/week/month)

Have you or any **immediate family member** (self, mother, father, grandmother, grandfather) ever had:

Lung disease? (asthma, emphysema, bronchitis, other _____) Who? _____

Heart disease? ..... Who? _____

Liver disease? ..... Who? _____

Kidney disease? ..... Who? _____

High blood pressure? ..... Who? _____

Stroke? ..... Who? _____

Arthritis? ..... Who? _____

Cancer?

Type _____ ..... Who? _____

Type _____ ..... Who? _____

Type _____ ..... Who? _____

Diabetes? ..... Who? _____

Tuberculosis? ..... Who? _____

Thyroid? ..... Who? _____

----OVER----

Have YOU ever had:

Recent vision changes or problems? ..... Yes No
Chronic or persistent headaches? ..... Yes No
Seizures? Passing out? ..... Yes No
Wear glasses or contact lenses? ..... Yes No
Difficulty hearing? ..... Yes No
Difficulty swallowing? ..... Yes No
Hoarseness? ..... Yes No
Repeated bloody nose? ..... Yes No
Difficulty smelling? ..... Yes No
Shortness of breath? ..... Yes No
To sleep on 2 or 3 pillows? ..... Yes No
Difficulty walking up stairs? ..... Yes No
Chest pain, tightness or pressure? ..... Yes No
Chronic nausea? ..... Yes No
Chronic heartburn? ..... Yes No
Chronic need for antacids? ..... Yes No
Chronic constipation? ..... Yes No
Blood in stools, either red or black? ..... Yes No
Chronic diarrhea? ..... Yes No
Hemorrhoids? ..... Yes No
Blood in urine? ..... Yes No
Uncontrolled loss of urine? ..... Yes No
Uncontrolled loss of bowel contents? ..... Yes No
Bladder infections? ..... Yes No
Prostate problems? ..... Yes No
Menstrual problems? ..... Yes No
Gout? ..... Yes No
Curvature of spine? ..... Yes No
Aids? ..... Yes No
Hepatitis? ..... Yes No
Anxiety? ..... Yes No
Depression? ..... Yes No
MRSA? ..... Yes No
Balance problems? ..... Yes No
Dizziness? ..... Yes No
Ringing in your ears? ..... Yes No
Any other health issues: _____

_____