OrthoElPaso

Today's Date:_____

☐ Male ☐ Female **Social Security #**:_____

Full Name:_____ **Date of Birth**:_____

Address: _____

City/State/Zip:_____

Primary Phone:_____ **Secondary Phone**: _____

Email Address: _____

Referring Physician: _____ **Primary Physician**: _____

Pharmacy: _____

Primary Insurance: _____

Policy/Member ID #: _____ **Group #:** _____

Policy Holder's Name: _____

Date of Birth of Policy Holder: ____ / ____ / _____

Relationship to Patient: ☐ **Self** ☐ **Spouse** ☐ **Parent** ☐ **Other:** _____

Patients Employment Status: ☐ Employed ☐ Unemployed ☐ Student ☐ Disabled ☐ Retired

Employer:_____ **Occupation**:_____

Is patient a student athlete: ☐ Yes ☐ No

If yes, what school: _____

Is this a Worker's Comp Claim: ☐ Yes ☐ No

If yes, Claim number #:_____

Emergency Contact:

Name: _____ **Phone Number**: _____

MISSED APPOINTMENT POLICY

Effective immediately, Ortho El Paso & Precision Hand Surgery, PA have a new cancellation / no show policy on all patients. We ask that you please call to notify us 24 hours in advance if you are unable to keep your appointment. Failing to do so will results in a **$50.00** cancellation / no show fee. This policy will also apply to same day scheduled appointments.

Patient's signature: _____ **Date**: _____

LATE ARRIVAL POLICY

We value your time and strive to stay on schedule for all our patients. Please be aware that our office allows a **15-minute grace period** for late arrivals. If you arrive more than 15 minutes past your scheduled appointment time, we may need to **reschedule your visit**.

By signing below, you acknowledge and agree to this policy.

Patient Signature: _____ **Date:** _____

Patient Financial Responsibility

I understand that I am responsible for all copayments, deductibles, coinsurance, and any non-covered services as determined by my insurance plan. Copayments are due at the time of service. Deductibles and coinsurance will be billed to me once my insurance company has processed the claim.

I agree to provide updated and accurate insurance information at each visit. If my insurance plan requires a referral or authorization, I understand it is my responsibility to obtain this prior to my appointment.

Any outstanding balance is my responsibility and must be paid promptly upon receipt of a statement. Failure to pay may result in late fees, collections activity, or rescheduling of future appointments until balances are resolved.

By signing below, I acknowledge that I have read and understand my financial responsibility for services rendered.

Patient Signature: _____ **Date:** _____

Jason Vourazeris, M.D. / Justin S Mitchell, D.O. reserve the right to modify the privacy practice outlined in the notice.

I have received a copy of the Notice of Privacy Practice for Ortho El Paso / Precision Hand Surgery Center.

Name of Patient (Print or Type) **DOB**

AUTHORIZATION:
I hear by consent to any necessary medical treatment for myself or the minor child named above for whom I am legally responsible.
ASSIGNMENT:
I permit payment directly to Ortho El Paso and Jason Vourazeris, M.D. or Justin S. Mitchell, D.O., for any benefit due for services rendered. I understand that I am responsible for all charges, whether or not covered by my insurance company.
MEDICAL RECORDS:
Authorization is hereby granted for release of any information required to process insurance claims. A copy of this authorization is a valid as the original. We cannot accept responsibility for collecting your insurance claims or for negotiating a settlement in a disputed claim.

Signature of Patient

Signature of Patient Representative
(Required if the patient is a minor or adult who is unable to sign the form)

Relationship of Patient Representative to patient

Date

Ortho El Paso / Precision Hand Surgery

HIPAA Consent Form – Authorization for Use and Disclosure of Health Information

Patient Name: _____**Phone Number:**_____
Date of Birth: _____

Consent for Use and Disclosure of Information

I, the undersigned, hereby authorize Ortho El Paso / Precision Hand Surgery to use and disclose my protected health information (PHI) as follows:

Treatment: For providing, coordinating, or managing my healthcare and related services.

Payment: For obtaining payment for healthcare services provided to me.

Healthcare Operations: For administrative, quality improvement, and business activities related to running Ortho El Paso / Precision Hand Surgery.

Optional Authorizations

I also authorize Ortho El Paso / Precision Hand Surgery to disclose my PHI to the following individuals:

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____

Acknowledgment of Notice of Privacy Practices

☐ I have received and reviewed a copy of Ortho El Paso / Precision Hand Surgery *Notice of Privacy Practices.*

☐ I decline a copy at this time but understand it is available upon request.

Patient Rights

I understand that:

I may revoke this consent in writing at any time, except where action has already been taken. I have the right to request restrictions on how my information is used or disclosed, and Ortho El Paso / Precision Hand Surgery is not required to agree to these restrictions. Refusing to sign this form may affect my ability to receive treatment if the use of PHI is essential for treatment purposes.

Signature of Patient or Legal Representative: _____**Date:**_____

Relationship to Patient:_____

Staff Witness: _____ **Date:** _____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of **Jason Vourazeris, M.D or Justin Mitchell, D.O.** For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders. Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition .. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:
• The right to request restrictions on the use and disclosure of your protected health information
• The right to receive confidential communications concerning your medical condition and treatment
• The right to inspect and copy your protected health information
• The right to amend or submit corrections to your protected health information
• The right to receive an accounting of how and to whom your protected health Information has been disclosed
• The right to receive a printed copy of this notice

Jason Vourazeris, M.D & Justin Mitchell, D.O. Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting **Intake Personnel or HIPAA Official**. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

HIPAA Official:
Jason Vourazeris, M.D., Ortho El Paso, 12770 Edgemere Blvd, Bldg F, El Paso, TX 79938
Justin Mitchell, D.O., Precision Hand Surgery, 12770 Edgemere Blvd, Bldg F, El Paso, TX 79938

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person

The name and address of the person you can contact for further information concerning our privacy practices is:

HIPAA Official:
Jason Vourazeris, M.D., Ortho El Paso, 12770 Edgemere Blvd, Bldg F, El Paso, TX 79938
Justin Mitchell, D.O., Precision Hand Surgery, 12770 Edgemere Blvd, Bldg F, El Paso, TX 79938

Effective Date: This Notice is effective on or after August lst, 2015