Welcome to Orthopedic Associates of Port Huron

Thank you for choosing Orthopedic Associates for your musculoskeletal care. We have enclosed information to help you get acquainted with our facility. We have also included registration forms for you to complete prior to your office visit; this will expedite the registration process on the day of your appointment.

To help us serve you better, please bring the following items to your appointment:

☐ X-rays, including images and/or reports
☐ Test results, including MRI, CT scan, bone scan, etc.
☐ Insurance cards and Driver’s License
☐ Letters of referral and authorization
☐ Completed registration forms (enclosed)

Insurance mandates that all deductibles and co-pays are due at the time of your appointment. Orthopedic Associates does offer VISA, MasterCard, Discover, American Express, Care Credit, or automatic credit card withdrawal as methods of payment.

Your treatment is important to us. Feel free to contact the office should you have any questions prior to your appointment.

Sincerely,

Physicians and Staff
Orthopedic Associates of Port Huron, P.C.
ORTHOPEDIC ASSOCIATES OF PORT HURON, P.C.
PATIENT INFORMATION

Patient’s Name: ____________________________ Age: ______ Birth Date: __/__/____
Address: ____________________________ Phone #: (____) - _______ Cell # ____________
Sex: □ M □ F
City: ____________________________ State: ______ Zip: ____________
Social Security #: ____________________________ Primary Care Physician: ____________________________
Marital Status: □ M □ S □ D □ W □ Sep □ Email Address: ____________________________
Patient Employer: ____________________________
Employer’s Address: ____________________________ Business Phone #: (____) - _______
City: ____________________________ State: ______ Zip: ____________

Spouse’s Name: ____________________________ Spouse’s Birth Date: __/__/____
Social Security #: ____________________________ Spouse’s Employer Name: ____________________________
Email Address: ____________________________ Employer Address: ____________________________
City: ____________________________ State: ______ Zip: ____________

IF THE PATIENT IS A MINOR OR STUDENT

Mother’s Name: ____________________________ Birth Date: __/__/____
Social Security #: ____________________________ Address: ____________________________
City: ____________________________ State: ______ Zip: ________ Home Phone #: (____) - _______
Email Address: ____________________________ Employer: ____________________________
Business Phone #: (____) - _______ Employer Address: ____________________________

Father’s Name: ____________________________ Birth Date: __/__/____
Social Security #: ____________________________ Address: ____________________________
City: ____________________________ State: ______ Zip: ____________
Email Address: ____________________________ Employer: ____________________________
Business Phone #: (____) - _______ Employer Address: ____________________________

Authorization

I hereby authorize payment directly to ORTHOPEDIC ASSOCIATES OF PORT HURON, P.C. for the surgical and/or medical services as described. I understand that I am responsible for payment of my bills and that my insurance will be billed for any payable benefits as a service to me.

I authorize the release of information regarding my condition, as necessary, to process these and/or related claims. I permit a copy of this authorization to be used in place of the original.

Signature: ____________________________ Date: ____________________________
1. I hereby authorize ORTHOPEDIC ASSOCIATES OF PORT HURON, P.C., to release my medical information to the following individual(s):
   - Self
   - Spouse: ________________________________________
   - Parent(s): _______________________________________
   - Employer: _______________________________________ 
   - School: _________________________________________
   - Other: __________________________________________

2. Specific information to be disclosed (check all that apply):
   - Records of treatment including office notes and health history
   - Diagnostic testing
   - Digital X-ray films
   - Billing Statements
   - Other: __________________________________________

3. I am requesting this information to be released for the following purpose(s):
   - Continued Care
   - Insurance Claim
   - Personal Use
   - Other (Describe): __________________________________

4. I authorize all information which may be contained in my medical records at Orthopedic Associates of Port Huron, P.C. to be released unless otherwise specified here:
   ___________________________________________________
   ___________________________________________________
   ___________________________________________________

5. This authorization will automatically expire on: ____/____/____ (If no expiration date is listed this authorization will expire one year from the date of my signature.)

I give permission for this information to be released via telephone, mail, facsimile, and/or e-mail. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information.

I further understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to ORTHOPEDIC ASSOCIATES OF PORT HURON, P.C. I understand that the revocation will not apply to information that has already been released in response to this authorization. I also understand that the revocation will not apply to medical information that is released for purposes of treatment, payment, and/or healthcare operations as outlined in OAPH’s privacy notice.

_______________________________________________________  __________________________
Patient Name (Print)       Date of Birth

_______________________________________________________   __________________________
Signature of Patient or Legally Authorized Representative (Agent)   If Agent, Relationship to patient

________________________
Date