PREMIER ORTHOPEDIC
SPECIALISTS OF TULSA

NAME_____ ADDRESS _____

CITY_____STATE_____ZIP_____MARITAL STATUS: M / S / W / D

BIRTHDATE_____AGE _____ SSN: _____SEX: M F

PRIMARY PHONE_____CELL PHONE_____EMAIL_____

EMERGENCY CONTACT _____ PHONE _____

REFERRING DOCTOR _____PHONE #_____

PRIMARY CARE DOCTOR_____ PHONE #_____

HOW DID YOU HEAR ABOUT PREMIER ORTHOPEDIC _____

*PRIMARY INSURANCE NAME_____PHONE #_____

MEMBER ID#_____ GROUP_____

POLICY HOLDER NAME _____ DOB:_____

SOCIAL SECURITY NUMBER_____-_____-_____

EMPLOYER_____ PHONE #_____

*SECONDARY INSURANCE NAME_____PHONE #_____

MEMBER ID#_____ GROUP_____

POLICY HOLDER NAME _____ DOB:_____

SOCIAL SECURITY NUMBER_____-_____-_____

EMPLOYER_____ PHONE #_____

FINANCIAL RESPONSIBILITY, AUTHORIZATION TO RELEASE INFORMATION & FINANCIAL DISCLOSURE: I assign **Premier Orthopedic Specialists of Tulsa**, all health insurance benefits and other public and private benefits covering the medical treatment provided to me, and I direct that all payments for such services be made directly to Premier Orthopedic Specialists of Tulsa. I understand that I am financially responsible for all insurance deductibles, coinsurance payments and for the cost of all medical treatment that is not covered by insurance or for which there are no other benefits available.

Work compensation:
I hereby give Premier Orthopedic Specialists of Tulsa consent to release to _____, my employer, their insurance carrier or other representative, any information regarding my medical condition or treatment.
Per 63 O.S. § 1-502.2, all request for medical records must contain the following language: **I understand that my medical records may contain information that indicates that I have a communicable or non-communicable disease. I further understand that my medical information may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.**

Premier Orthopedic Specialists of Tulsa physicians have an ownership interest in Oklahoma Surgical Hospital, LLC. and your physician may refer you to this facility for medical treatment. Please let your physician know if you have any questions about the medical facility. By signing below, you acknowledge the disclosure of your physician's ownership interest in the medical facility, and you consent to treatment at the facilities.

Deline to Consent to Release of Medical Records: In the event you, the patient, **do not consent to the release of your medical records** by POST to your referring physician or your insurance company, you will be solely and individually responsible for picking up and delivering your records to all physicians or insurance companies requesting them, and for payment of such serviced that are denied to insufficient records. If you wish to be responsible for this action, please initial here_____. If you wish for POST to release all records on your behalf, you do not have to initial.

I consent to the disclosure of my Protected Health Information to my health insurance provider, and to all other public and private providers of benefits, if any, for my medical treatment. I additionally consent to the disclosure of my Protected Health Information to all medical providers that are necessary for my medical treatment.

_____ _____
Patient Signature Date