PATIENT INFORMATION

DATE:_____ SS#:_____

NAME:_____
LAST FIRST MIDDLE

ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE_____

DOB:_____/_____/_____ AGE:_____ MARITAL STATUS: M S D W SEP

Primary contact #: ( )_____ Is this: ☐Home ☐Cell ☐Work ☐Other:_____
May we leave a detailed message at this number? ☐Yes ☐No

Secondary contact #: ( )_____ Is this: ☐Home ☐Cell ☐Work ☐Other:_____
May we leave a detailed message at this number? ☐Yes ☐No

Email address: _____

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED:_____

PHONE:_____RELATIONSHIP:_____

PATIENT EMPLOYER INFORMATION

PATIENT EMPLOYED BY:_____

OCCUPATION:_____

PLEASE LIST REFERRAL NAME/LOCATION:_____

I understand that I am responsible for all fees. I understand the office of Philip J. Straka, M.D. is not currently accepting new insurance patients and will not file any insurance claims or submit any insurance pre-approval letters on my behalf. I understand that all surgical fees are due prior to surgery being performed.

_____ DATE: _____
Patient Signature

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- ♦Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment either directly or indirectly.
- ♦obtain payment from third-party payers
- ♦conduct normal healthcare operations such as quality assessments and physician certifications.
- ♦if there are financial matters in dispute after the fact, I waive my right to privacy under the HIPAA Act of 1996

I have been informed of the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the opportunity review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

_____ DATE: _____

Patient signature

Please list those people with whom we may discuss/release medical information to:

_____

_____

<u>Electronic Signature Agreement</u>:

The parties, Dr. Philip Straka, patients and/or other personal representatives agree that all forms provided by this office, to include patient information, health history and surgical scheduling policy, may be signed electronically. The parties agree that the electronic signature appearing on these forms are the same as handwritten signatures for the purposes of validity, enforceability and admissibility.

Patient signature:_____