

DAVID D. DORE, MD
Director of Joint
Replacement Surgery

FAISSAL ZAHRAWI, MD,
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Director of The Spine Center at
Celebration Health

**CELEBRATION ORTHOPAEDIC
& SPORTS MEDICINE
INSTITUTE**

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(407) 764-4270 (Osceola County) • Fax (407) 764-4271
(407) 303-4270 (other areas) • Fax (407) 303-4271

BRAD HOMAN, DO
Director of Sports Medicine at
Celebration Health

STEPHEN A. KNYCH, MD,MBA
Joint Replacement, Sports Medicine
and Foot & Ankle

PATIENT INFORMATION

Who is responsible for Patient? Self Parent Employer Other _____

Patient's Last Name _____ First Name _____ Middle Initial _____

Patient's Social Security Number _____

Address _____ Apt # _____

City _____ State _____ Zip Code _____

Telephone #: Home () _____ Business: () _____

Date of Birth _____ Sex: Male Female

Do you have an alternate address? Yes No If yes, please print here _____

Marital Status (check one): Single Married Divorced Widowed Separated

Employment Status (check one): Full-Time Part-Time Retired Other _____

Employer: _____ Occupation: _____

Employer Address _____

Student? Yes No Full-Time Part-Time

Spouse/Parent Name: Last _____ First _____ Middle Initial _____

SSN: _____ Date of Birth: _____

Employer: _____

Employer Address: _____ Phone #: _____

Spouse/Parent Name: Last _____ First _____ Middle Initial _____

SSN: _____ Date of Birth: _____

Employer: _____

Employer Address: _____ Phone #: _____

Name of closest relative not living with you: _____

Relationship: _____ Phone #: _____

Referring Physician: _____

Address: _____ Phone #: _____

PLEASE FILL OUT REVERSE SIDE

INSURANCE INFORMATION
PLEASE PRINT

Primary Insurance Co: _____ Secondary Insurance: _____
Insured's Name _____ Insured's Name _____
Relationship to Patient: _____ Relationship to Patient: _____

ACCIDENT INFORMATION

EMPLOYER: _____ Date of Injury: _____
Place of Accident or Injury: _____ Was the Accident: Work-Related Auto-Related
Date & Time of Accident: _____ Other _____
Do you have notice of injury on file? Yes No W.C. Claim #: _____
Attorney Name: _____ Insurance Co: _____
Policy Holder: _____ Address: _____
I.D. #: _____ Zip: _____
Telephone #: _____ Were X-rays taken of this injury or problem? Yes No
If yes, where were X-rays taken? _____ Date X-rays taken: _____

PLEASE HAVE YOUR INSURANCE CARD AND DRIVER'S LICENSE READY FOR THE RECEPTIONIST.
PAYMENT FOR PROFESSIONAL SERVICES IS DUE AND PAYABLE WHEN SERVICE IS RENDERED.

OFFICE POLICY FOR PRESCRIPTION REFILL REQUESTS

We require a 48 hour notice for all prescription refill requests.
Please leave the following information on the Medical Assistant's voice mail:

- **Your Name & telephone number**
- **Your Physician's name**
- **Pharmacy telephone number**
- **Medication name & strength**

Please initial: _____

Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(to be filed in patient's medical record)

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Signed: _____ Date: _____

Relationship (if not signed by patient): _____

I wish to place the following restrictions on disclosure of my health information:

Internal Use Only - If patient/patient's representative refuses to sign acknowledgment, please document date and time notice was presented to patient and sign below.

Presented on (date and time): _____ By (name and title): _____

RELEASE OF MEDICAL RECORDS

I hereby authorize the release of medical, psychiatric, alcohol and HIV testing and/or drug abuse information for insurance carriers or for continuing patient care. I further agree to have my physician maintain my health information data for the purpose of education, research and publication in professional journals and medical books. However, any publication of these will exclude my name so as to protect my identity.

SIGNATURE OF PATIENT

DATE

SIGNATURE OF PARENT, GUARDIAN AND/OR RESPONSIBLE PARTY

DATE

CONSENT FOR EVALUATION OR TREATMENT

Undersigned hereby consents to whatever evaluation or treatment the assigned physician deems necessary to the above named patient.

SIGNATURE OF PARENT, GUARDIAN AND/OR RESPONSIBLE PARTY

DATE

INSURANCE ASSIGNMENT & RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to **Celebration Orthopaedics and Sports Medicine Institute** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named physician may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Patient Guardian or Personal Representative

Date

Please print name of Patient, Patient Guardian or Patient Representative

Relationship to patient

MEDICARE/MEDIGAP AUTHORIZATION

Patient Name: _____

Date of Birth: _____

Medicare #: _____

Patient I.D.#: _____

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to **Celebration Orthopaedic & Sports Medicine Institute**, for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, any Medigap insurer, and their agents any information needed to determine these benefits and related services.

Signature of Patient, Patient Guardian or Personal Representative

Date

Please print name of Patient, Patient Guardian or Patient Representative

Relationship to patient

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges for services or items provided to me, to my minor/child, or to the patient for whom I have legal responsibility. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

Signature of Patient, Patient Guardian or Personal Representative

Date

Please print name of Patient, Patient Guardian or Patient Representative

Relationship to patient