

RESPONSIBILITY STATEMENT

I hereby authorize payment directly to _____ for surgical and/or medical benefits otherwise payable to me for services rendered. I further understand that Torrance Orthopaedics contracts with PPO insurances only and that my policy may not cover all charges incurred. I will verify my insurance plan coverage and be responsible for all non covered services, supplies, deductibles and co-payments.

NOTE: Torrance Orthopaedics does not accept any HMO products or Medicare HMO.

Patient name _____
(please print)

Signature of patient (parent if minor) (date)

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I have received *Torrance Orthopaedic and Sports Medicine Group Notice of Privacy Policies* that provides a more complete description of information uses and disclosures. I understand that it may become necessary to disclose my protected health information to another entity as part of my medical treatment, payment of my account, or other health care operations as defined in the *Notice of Privacy Policies*. I consent to such disclosures for these permitted uses to include electronic interchange, telephone, facsimile and mail.

I understand that I may request restrictions regarding the use of my health information or revoke this consent by following the procedures outlined in the *Notice of Privacy Policies*. However, Torrance Orthopaedic is not required to agree with any restrictions I request and may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I fully understand the terms of this consent.

Signature of patient (parent if minor) (date)

Medical Disclosure

I acknowledge and accept that _____ (surgeon) may have a financial interest in a surgery center, or in companies that produce medical devices he/she chooses to utilize for surgery. My surgeon may also have an interest in bracing, medical imaging or physical therapy services. I also recognize my right to choose another surgeon or request other medical devices or services be used.

Signature of patient (parent if minor) (date)

Please list the names of any doctor's that you see for medical treatment.

General Medical:

- Diabetes yes ___ no ___
High Blood Pressure yes ___ no ___
Hepatitis yes ___ no ___
Jaundice/Liver
Problems yes ___ no ___
Asthma yes ___ no ___
Hay fever yes ___ no ___
Tuberculosis yes ___ no ___
Epilepsy yes ___ no ___
Cancer yes ___ no ___
Polio yes ___ no ___
Stroke yes ___ no ___
Heart disease yes ___ no ___
Heart attack yes ___ no ___
Thyroid disease yes ___ no ___
Pneumonia yes ___ no ___
Ulcers yes ___ no ___
Urinary or kidney
Problems yes ___ no ___
Arthritis yes ___ no ___
Broken bones yes ___ no ___
Serious head injury yes ___ no ___
Prolonged bleeding yes ___ no ___
Bruise easily yes ___ no ___
Taken cortisone
or other steroids yes ___ no ___
Taken blood
thinners yes ___ no ___
Seizures yes ___ no ___
Psychiatric treatmt. yes ___ no ___

Please give us details on any yes answers.

Allergies:

List allergies to medications:

Medications:

List of current medications:

Past Surgical History:

List previous surgeries and dates:

Do you smoke now, or have you ever smoked in the past? Yes ___ No ___
(if yes, how much)

_____ (if no longer smoking when did you stop?) _____

Do you drink alcohol?

Never Occasionally
Moderately Heavily

Could you be pregnant? _____

Are you under a doctor's care for any medical condition, not previously mentioned?
