Georgia Orthopedic Resources
Notice of Privacy Practices

Patient Information Check box ☐ if information has changed since last visit

Patient Name _____ _____ _____ Patient's DOB ____/____/____
First Middle Last

Home Address _____
Street City State Zip Code

Home Phone_____ Cell Phone _____ Height _____ Weight _____

Email _____ ☐ Male ☐ Female

Is the Patient Diabetic? ☐ Yes ☐ No Diabetic Doctor _____ Dr. Phone _____

SSN# _____ - _____ - _____ Referring Doctor _____ Dr. Phone _____

Have you ever been treated by a Physical or Occupational Therapist? ☐ Yes ☐ No If yes, who? _____

Appointment Location _____ Accident Date ____ /____ /____

Have you ever worn an orthotic device (brace) before? ☐ Yes ☐ No If yes, what kind? _____

Primary Insurance _____ ID # _____

Policy Holder's Name _____ DOB ____/____/____

Secondary Insurance _____ ID # _____

Secondary Policy Holder's Name _____ DOB ____/____/____

Name of the school the child attends _____ Phone number _____

Surgeries_____ Allergies_____

Medications _____

For minor Patients please provide information about the person responsible for payment

Name _____ Work Phone _____ Cell Phone _____

Address _____ SSN# _____ - _____ - _____

Relationship to Child _____ Email address _____

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I grant to Georgia Orthopedic Resources the rights to use pictures of _____ for marketing and training purposes.
Name of Patient

Signature: _____ Date: ____/____/____

By signing below, I authorize the release of any medical or other information to process the claim for services rendered by South GA Orthopedic Resources. I also request payment of benefits to South GA Orthopedic Resources for these Services. South GA Orthopedic Resources will attempt to verify insurance benefits before you leave the office. If we are unable to verify your insurance, we will attempt to bill your insurance. However, you understand that you will be responsible for any balance due to South GA Orthopedic Resources as a result of no coverage, partial payment, deductible or co-payment. We expect payment at the time services are rendered or a payment plan to be arranged.

Signature _____ Date ____/____/____

I certify that I was offered a copy of South GA Orthopedic Resources Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosure of my protected health information that might occur during my treatment, payment of my bills, or in the performance of South GA Orthopedic Resources health care operations. By signing this form, I consent to use or disclosure of my protected health information by South GA Orthopedic Resources for the purpose of providing treatment to me, obtaining payment for my healthcare bills or to conduct South GA Orthopedic Resources healthcare operations.

X _____ _____ Date ____/____/____
Signature of Patient or Personal Representative Name of Patient or Personal Representative