

Patient Enrollment

Robert J. Ziets, MD, FAAOS

Complete ENTIRE FORM. Fill in or circle ALL ITEMS and write "N/A" where not applicable.

Last Name _____ First Name _____ MI _____

Address _____ Apt. ____ City _____ State _____ Zip _____

Home Tel. # _____ Cell Tel. # _____ Work Tel. # _____

Birth Date _____ Age ____ Soc. Sec. # _____ Sex: M F Married? Y N

Employed? Y N Job Title _____ Employer's Name _____

Address _____ City _____ State _____ Zip _____

Primary Health Plan _____ ID # _____ Group # _____

Secondary Health Plan _____ ID # _____ Group # _____

Policyholder (if not self) Last Name _____ First Name _____ MI _____

Birth Date _____ Soc. Sec. # _____ Relationship _____

Referring Doctor's Name _____ or Other Referrer _____

Address _____ City _____ State _____ Zip _____

Primary Care Doctor's Name (if different) _____ Tel. # _____

Emergency Contact's Name _____ Tel. # _____ Relationship _____

Is your medical condition the result of a documented accident? Y* N

******** IF ANSWER IS YES, BACK OF THIS FORM MUST BE FULLY COMPLETED.********

Statements

1. To the best of my knowledge the information provided on this form is true and accurate.
2. I have the read the Notice of Privacy Practices for Protected Health Information (back of this form).
3. I request that direct payment of authorized medical benefits be made on my [patient's] behalf to Robert J. Ziets, MD, for services furnished to me [patient] by the provider.
4. I authorize any holder of medical information about me [patient] to release to the medical provider and its agents any information needed to determine these benefits or those payable for related services.
5. I assume responsibility to assure medical benefits eligibility and authorization for services and liability to pay all applicable co-insurance, deductibles and for all services not covered or denied by the insurer.

Signature (Patient or Guardian) _____ Date _____

Name (If Other Than Patient) _____ Relationship _____

Accident Information (If Applicable)

Is there a Workers' Compensation claim? Y* N Vehicle accident (no-fault) claim? Y* N

******* IF ANSWER TO EITHER IS YES, THE FOLLOWING MUST BE FULLY COMPLETED. *******

Injury Date _____ Injury Location: City _____ State _____

Employer's or Policyholder's Name _____

Address _____ City _____ State _____ Zip _____

Insurance Company's Name _____ Case/Claim # _____

Address _____ City _____ State _____ Zip _____

Claim Representative's Name _____ Tel. # _____

Is the case still open for medical treatment? Y N

Are you working? Y N If yes, are you on limited or restricted duty? Y N

If no, when was the last day you worked? _____

Notice of Privacy Practices For Protected Health Information

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. You are required to acknowledge in writing that you have received a copy of the Notice. If the terms of this notice change, a revised notice will be posted in this office, and paper copies will be made available upon written request.

Dr. Ziets and his staff are dedicated to protecting your privacy. Our office may use your medical information as part of rendering patient care, including treatment, payment or health care operations. Your information may also be disclosed in accordance with applicable federal and state laws

By law, your consent is not required for our office to discuss your medical information with other physicians or health care providers, facilities or payers. This allows us to send reports to your primary physician and insurance company, schedule surgery with the hospital and provide referrals and prescriptions, for example. Unless you object, we may also disclose your medical information to your relatives or friends relevant to their involvement in your care.

With few additional exceptions, your consent is required to release your medical information to other parties except by legal order, such as to your employer or to an attorney (other than one representing us). Once provided, you may revoke future authorization in writing at any time

By written request, you also have the right to inspect and copy your medical records created by our office. You may also request amendment, accounting of disclosures, restrictions or alternative communications of such medical information, subject to certain limitations. If you believe your privacy rights have been violated, you may file a written complaint with us and/or the Secretary of the Department of Health and Human Services.