Voytik Center *for* Orthopedic Care
PATIENT INFORMATION FORM

Gary J. Voytik, D.O.
Osteopathic Physician and Board-Certified Orthopedic Surgeon

Mariah Gibson PA-C
Certified Physician Assistant

Date: _____ ___ Male ___ Female Preferred Language _____

Patient's Full Name: _____ DOB _____ Age: _____SS#: _____

Address: _____ City:_____ State:_____ Zip_____

Phone Numbers: (Home)_____ (Cell)_____ (Alternate)_____
_____Please Initial: By providing any phone number, including cell numbers, I consent to receive calls for appointment reminders, test results, continuation of care, balance reminders and collection calls that could be prerecorded.

Email Address: _____ (**Please Print Clear**)
_____ Please Initial: By providing an email address, I consent to receive E-statements. If I choose not to provide an email, I am subject to a paper statement fee of $2.50. **As a service to our patients, we provide courtesy appointment reminder communication and possibly other important communication that may be placed using a prerecorded message or email content. By providing the above numbers and email address, you consent to receiving such communication from your healthcare provider.*

Patient Portal Our office now has a patient portal, as part of a healthcare regulation that requires practices to deliver health information to patients via secure portal. If you would like to have access to our patient portal, make sure your email address is listed above and initial here_____

NOTE: Electronic protected health information will be transmitted via above email address. I understand that if this email is not encrypted, that the transmission of this information is not considered secure and may be accessible by unauthorized individuals. I acknowledge that I am aware of these risks, and I give my permission to email my protected health information to the following individual:

Race: (circle one) Black / White / Asian / Native American / Native Hawaiian / Other **Ethnicity:** (circle one) Hispanic / Non-Hispanic / Other
__Single __ Widowed __Divorced __ Married/Spouse's Name: _____
Employer:_____ Occupation:_____

Primary Insurance _____ ID#: _____Group#_____
Secondary Insurance _____ ID#: _____Group#_____

--Responsible Party If Patient Is a Minor
Name:_____ Relationship: _____ SS#: _____ D.O.B_____
Address:_____ City:_____ State: _____ Zip_____
Best Contact Phone# (s):_____ Employer: _____

I _____ consent to the use or disclosure of my "protected health information: as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and this Consent by Voytik Center for Orthopedic Care, PC for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct the health care operations of Voytik Center for Orthopedic Care, PC. I understand that diagnosis or treatment of me by the provider(s) may be conditioned upon my consent as evidenced by my signature on this document.
My "protected health information" means health information, including but not limited to my demographic information, collected from me and created or received by my Physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe such information may identify me.
I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or the healthcare operations of Voytik Center for Orthopedic Care, PC. Voytik Center for Orthopedic Care, PC is not required to agree to any restriction that I may request. If, however, Voytik Center for Orthopedic Care, PC agrees to any restriction requested by me, such restriction shall be binding on Voytik Center for Orthopedic Care, PC and the provider(s). I further understand that I have the right to revoke this consent, in writing, at any time, except to the extent that the provider(s) or Voytik Center for Orthopedic Care, PC has taken action in reliance on this Consent.
Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services. We may use and disclose PHI to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you. I understand that appointment reminders are a service provided by my physician as a courtesy. I could be contact by a prerecorded message and by providing a cell phone number I consent to receive such calls.
I understand I have a right to Voytik Center for Orthopedic Care's **Notice of Privacy Practices** prior to signing this Consent. Voytik Center for Orthopedic Care's Notice of Privacy Practices has been provided to me and describes the types of uses and disclosures of my protected health information that may occur in my treatment, payment of my bills or in the performance of the health care operations of Voytik Center for Orthopedic Care, PC. This Notice of Privacy Practices also describes my rights and Voytik Center for Orthopedic Care's duties with respect to my protected health information.
Please also note that as provided in Voytik Center for Orthopedic Care's Notice of Privacy Practices, Voytik Center for Orthopedic Care, PC reserves the right to change the privacy practices that are described in such notice. I may obtain a revised notice of privacy practices by calling the office at (423) 479-3600 and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.
As required by privacy regulations, this practice may not use or disclose your protected health information except as provided in our notice of privacy practices without your authorization.
I hereby authorize the Voytik Center for Orthopedic Care to use or disclose my patient health information to the following person(s) Also known as **Emergency Contacts**.

1) Name:_____DOB: _____ Relationship to Patient: _____Phone#:_____

2) Name:_____DOB: _____ Relationship to Patient: _____Phone#:_____

--NOTICE:
Voytik Center for Orthopedic Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Voytik Center for Orthopedic Care does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Voytik Center for Orthopedic Care provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters. We provide free language services to people whose primary language is not English, including a qualified interpreter.

If you speak English, language assistance services, free of charge, are available to you. Si usted habla español, tiene a su disposición servicios de asistencia con el idioma sin costo alguno.
إذا كنت تتحدث باللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك مجانًا. 如果您讲汉语普通话，则可以免费向您提供语言协助服务。

--Medication Policy **Prescriptions will be called into your pharmacy ONLY in a emergency situation.**
*It is our office policy to list a primary pharmacy for your prescriptions to be called in to. ***PAIN MEDICATION** will not be called in after hours or on weekends. **NO EXCEPTIONS!**
*In addition, we will **NOT** call in early **prescription refills. NO EXCEPTIONS!** *If our office is notified that you are receiving pain medication from another physician, while under our care, we will **no longer** provide pain medication for you at any time. *Please address your need for prescription refills at the time of your appointment.
*Our office no longer accepts prescription request by phone.

_____ _____ _____
PRIMARY PHARMACY **STREET NAME** **PHONE NUMBER**

--Pain Management
*Are you currently under contract with a pain management physician? ____Yes ____No
If Yes, Physician's Name_____ Office Number_____

*Are you currently receiving monthly prescriptions of pain medication from your Primary Care Physician? ____Yes ____No

--CONSENT TO TREAT
The undersigned voluntarily consents to the medical and surgical care and treatment, as may be deemed necessary or advisable in the judgment of my physician or other provider, as well as by authorized members of Voytik Center for Orthopedic Care or their designees. This may include, but are not limited to, the rendering of such care, including diagnostic procedures, laboratory procedures, x-ray examination, medical or surgical treatment or procedures, anesthesia, or other services rendered the patient under the general and special instructions of the patient's physician, as may in their professional judgement be necessary.

--I acknowledge that I have read and understand the above information in its entirety. I understand that this information can be re-disclosed at any time.

Patient/Guardian Signature_____ Date _____