PLEASE BRING YOUR INSURANCE CARDS AND THIS COMPLETED FORM TO YOUR FIRST APPOINTMENT

JORDAN-YOUNG INSTITUTE
ORTHOPEDIC SURGERY & SPORTS MEDICINE

PATIENT INFORMATION

PATIENT: **ACCOUNT #:** _____

NAME: _____ MAIDEN/OTHER NAME: _____

ADDRESS _____

AGE: _____ DATE OF BIRTH: ___/___/___ □ MALE □ FEMALE MARITAL STATUS _____

HOME TELEPHONE # _____ SOCIAL SECURITY NUMBER: _____

CELL # _____ OCCUPATION: _____

EMPLOYER: _____ EMPLOYER TELEPHONE # _____

PRIMARY CARE PHYSICIAN: _____

REFERRING PHYSICIAN: _____

SPOUSE OR RESPONSIBLE PARTY:

NAME: _____ MAIDEN/OTHER NAME: _____

ADDRESS _____

AGE: _____ DATE OF BIRTH: ___/___/___ □ MALE □ FEMALE MARITAL STATUS _____

HOME TELEPHONE # _____ SOCIAL SECURITY NUMBER: _____

CELL # _____ OCCUPATION: _____

EMPLOYER: _____ EMPLOYER TELEPHONE # _____

PRIMARY HEALTH INSURANCE INFORMATION:

COMPANY NAME _____ EFFECTIVE DATE _____

POLICY HOLDER NAME _____ POLICY # _____

POLICY HOLDER DATE OF BIRTH _____ SOCIAL SECURITY # _____

PATIENT'S RELATIONSHIP TO POLICY HOLDER □ SELF □ SPOUSE □ CHILD □ OTHER GROUP # _____

SECONDARY HEALTH INSURANCE INFORMATION:

COMPANY NAME _____ EFFECTIVE DATE _____

POLICY HOLDER NAME _____ POLICY # _____

POLICY HOLDER DATE OF BIRTH _____ SOCIAL SECURITY # _____

PATIENT'S RELATIONSHIP TO POLICY HOLDER □ SELF □ SPOUSE □ CHILD □ OTHER GROUP # _____

EMERGENCY CONTACT INFORMATION:

NAME OF CONTACT _____

TELEPHONE # _____ RELATIONSHIP _____

I HEREBY CONSENT TO TREATMENT by Jordan Young Institute physicians, their associates, and/or assistants and accept responsibility for fees for such medical services. I understand that treatment may include x-rays, injections, medical appliances and/or other procedures as deemed necessary.

DEEMED CONSENT

I understand that, in accordance with Section 32.1-45.1 of the Code of Virginia, 1905, as amended, if a Jordan-Young Institute, P.C. healthcare provider is exposed to my blood or other bodily fluids in a manner which may transmit disease, I may be tested for infection with Human Immunodeficiency Virus (HIV), the virus which causes Acquired Immune Deficiency Syndrome (AIDS) or Hepatitis B or C viruses. I further understand that the results of any such test will be shared with me and the exposed healthcare provider; that the Virginia Department of Health will be notified; and that appropriate counseling shall be provided if the results are positive.

DISABILITY FORM INFORMATION

Jordan-Young Institute, P.C. staff will complete all disability and/or FMLA forms that you require, within two weeks of the date requested. We are unable to complete forms while you wait. We require all requests for completing and copying disability forms, medical records or x-rays to be pre-paid.

PATIENT AUTHORIZATION

I authorize Jordan-Young Institute, P.C. to release medical information necessary to submit my health insurance or Worker's Compensation Claims. I request that my health insurance or Worker's Compensation claims be paid directly to Jordan-Young Institute, P.C. In consideration of the services rendered, I/we agree and understand that each person(s) signing this document jointly and severable agrees to pay for all services rendered by Jordan-Young Institute, P.C. If this account is referred to an outside collection agency or attorney, then the undersigned person(s) agree and promise to pay all collection costs including attorney fees of 33 1/3 % of the principal amount due and owing when turned over for collection and do further agree to pay interest on the unpaid balance at the legal rate from the date services were last rendered. I authorize photocopies of this form to be valid as the original.

POLICY FOR FORMS COMPLETION AND THE COPYING OF NOTES AND X-RAYS

I have had the opportunity to read the Jordan-Young Institute, P.C. POLICY FOR FORMS COMPLETION AND THE COPYING OF NOTES AND X-RAYS and I understand that I may ask questions regarding this policy.

PRESCRIPTION REFILL POLICY

To request a prescription refill, please call us Monday through Friday, from 9:00a.m. to 4:00 p.m.. Please allow 24 hours for us to process your prescription refill request. Prescriptions for narcotics cannot be ordered after hours or on weekends. Please remember to call us in advance so that we can assist you in a timely manner.

CLINICAL RESEARCH ACTIVITY

The physicians of Jordan-Young Institute are involved in clinical research studies and trials and work closely with Jordan Research Foundation. The companies sponsoring these studies and trials provide financial support for research staff as well as for activities the physicians perform outside of clinical practice. These activities may include consulting, advisory boards, giving speeches and/or presentations, or writing reports. If you would like more information please ask to speak with the Jordan Research Foundation's Research Coordinator.

Patient Signature: _____ Date: _____

Patient or Guardian's Signature: _____ Date: _____

Relationship to patient: _____