OVERTURF
ORTHOPEDICS

Steven Overturf MD
1300 N. Mound St
Nacogdoches, TX 75961
PH: 936-560-2990
Fax: 936-560-5734

Patient Information

Date _____

First Name _____ Middle Initial ____ Last Name _____

Date of Birth _____ Social Security Number _____

Address _____

City_____ State _____ ZIP Code _____

Main Phone _____ Work/Alternate Phone _____ (with answering machine/voice mail for lab results)

Sex: ___M ___F
Marital Status (Check One) __Married __Single __ Divorced __ Widowed

Email Address _____

Is this injury work related? __ Yes __ No *If yes, please complete employer information.*

Patient Employment Information

Employer _____ Occupation _____

Employment Status (Check One) __ Full Time __ Part Time __ Self __ Retired __ Military

Employer Address _____

Employer Phone _____ Ext _____

Worker's Comp Authorization

For on the job injuries which occurred on 01/01/1991 and after, state law requires medical providers to furnish reports of your medical care in regards to your on the job injury to the Texas Workers Compensation Commission, the insurance carrier and the employee (you). Medical information can be given to your employer only with your permission. so the physician(s) and staff of Overturf Orthopedics might better assist you and your employer during your treatment period, may we have your permission to release information to your employer? __ Yes __ No

_____ _____
Signature Date

OVERTURF
ORTHOPEDICS

Steven Overturf MD
1300 N. Mound St
Nacogdoches, TX 75961
PH: 936-560-2990
Fax: 936-560-5734

Parent/Guardian Information

If patient is a minor or is dependent on parents, please complete the following information.

Father's Name_____ Occupation _____

Employer _____ Phone _____ Ext _____

Mother's Name_____ Occupation _____

Employer _____ Phone _____ Ext _____

Parent's Home

Address_____

Parent's Home Phone _____

Insured's Information

Insured's Name _____ Relation to Patient _____

Insured's Date of Birth _____ Insured's Social Security # _____

Insured's Employment Status __ Full Time __ Part Time __ Retired

Insured's Employer

_____

I hereby authorize Overturf Orthopedics to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to Overturf Orthopedics all payments for medical services tendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. A photocopy of this authorization shall be considered as effective and valid as the original

_____ _____

Signature Date

OVERTURF
ORTHOPEDICS

Steven Overturf MD
1300 N. Mound St
Nacogdoches, TX 75961
PH: 936-560-2990
Fax: 936-560-5734

Notice of Privacy Practices Acknowledgement

I have been provided a copy of the practice's Notice of Privacy Practices and have reviewed it in detail. I have been given the opportunity to ask questions about the notice. I understand that my information may be used and disclosed according to the terms of the notice.

If changes are made to the current notice, I understand a revised notice will be given to me on my next office visit. The revised policies and practices will be applied to all protected health information maintained by this practice.

ASSIGNMENT AND RELEASE:

- **I hereby assign my insurance benefits to be paid directly to the physician.**
- **I understand that I am financially responsible for all non-covered services, copays, deductibles and/or coinsurance. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan.**
- **I authorize the physician to release any medical information required to process this claim.**
- **I authorize my provider's office to contact me by telephone to remind me of my appointments.**
- **A fee for no shows may apply.**

_____
Patient Name (Please Print)

_____
Date

_____
Signature of Patient/Personal Representative

_____
Witness Signature