THE STEADMAN CLINIC REGISTRATION

PATIENT INFORMATION Today's Date _____

Patient Name _____
Last First (Legal) Initial Nickname

Date of Birth _____ Age _____ SS# _____ Sex ☐ M ☐ F

Race _____ Ethnicity _____ Language _____

Cell Phone _____ Work Phone _____ Home Phone _____

Fax _____ E-mail Address _____

Permanent Mailing Address _____

City _____ State _____ Zip _____

Occupation _____ Retired? ☐ Y ☐ N

Marital Status ⋯_____ Spouse's Full Name _____

Spouse's Employer _____ Business Phone _____

Relative to Contact in Case of Emergency _____

(A relative not living with you)

Relationship _____ Phone _____

Primary Physician _____ Phone _____

Address _____ City _____ State _____ Zip _____

How were you referred to us? _____

INJURY INFORMATION

Date of Injury _____ Work Related: ☐ No ☐ Yes Auto Accident: ☐ No ☐ Yes

What is Injured? _____

Describe Injury _____

_____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY:

Carrier _____ Address _____

City _____ State _____ Zip _____ Phone _____

Policy ID Number _____ Group _____

Name of the Policy Holder _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Social Security Number _____ Sex ☐ M ☐ F

Employer _____ Occupation _____

SECONDARY INSURANCE COMPANY:

Carrier _____ Address _____

City _____ State _____ Zip _____ Phone _____

Policy ID Number _____ Group _____

Name of the Policy Holder _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Social Security Number _____ Sex ☐ M ☐ F

Employer _____ Occupation _____

WORKMAN'S COMPENSATION INSURANCE:

Carrier _____ Address _____

City _____ State _____ Zip _____ Phone _____

Claim Number _____ Case Worker's Name _____

Case Worker's Phone Number _____ Fax _____

Employer at Time of Injury _____

Address _____

ASSIGNMENT OF BENEFITS:

Your signature is necessary for us to process any insurance claims and to ensure payment of services rendered. I authorize release of all medical information necessary to process my insurance claims or that is pertinent to my medical care. I assign all medical and/or surgical benefits, including major medical benefits to which I am entitled to the above named physician or clinic. This agreement will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as the original.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

Patient _____ Date _____

Responsible Party _____ Date _____

Nondiscrimination

The Steadman Clinic complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

This information available in Spanish upon request. Solicite la versión en español de esta información.

THE STEADMAN CLINIC

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Location: 181 West Meadow Drive, Ste 400, Vail, Colorado 81657 | T 970.476.1100 | F 970.479.5835
Email: medicalrecords@thesteadmanclinic.com | **Hours of Operation:** 8 a.m. - 5 p.m. Monday - Friday

Patient Information:

Patient Name: _____ Date of Birth: _____/_____/_____

Phone: (_____) _____ Alias: _____ Email: _____

I direct and hereby authorize The Steadman Clinic to deliver or communicate the Protected Health Information specified in this authorization to myself and the party or parties specified in the following medium:

☐ Landline ☐ Message on Voicemail ☐ Cell Phone ☐ Message on Voicemail ☐ Text Message ☐ E-mail ☐ Fax ☐ Mail

I request my protected health information (PHI) to be used or disclosed to the following person, class of persons, or organization:

☐release of medical records ☐ verbal discussion ☐ no records sent at this time please keep

Name: _____

Address: _____
City: _____ State: _____ Zip: _____
Phone: (_____) _____ Fax: (____) _____ Email:_____

I request my protected health information (PHI) to be released from my medical record(s): (Please check all that apply or describe the information specifically).

☐ Discharge Summary ☐ Discharge Instructions ☐ History and Physical ☐ ER Record ☐ Medication Records ☐ Lab Report ☐ Treatment Plan ☐ Clinic Note ☐ Consultation ☐ Operative Report ☐ Pre-Operative ☐ Notes EKG / ECG ☐ CD of images

☐ Provider's Name: _____
☐ Other: _____
☐ Specific Date(s): _____ to _____ **or if no dates are specified, the last two (2) years will be released.**

I authorize the release of information in my health record which may include information related to:

☐ Behavioral or Mental Health Issues ☐ Sexually Transmitted Diseases ☐ Sexual Assault Nurse Examiner Reports
☐ Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus
☐ (HIV) Alcohol and Drug Treatment

Purpose for requesting information: (Please check one)

☐ Request of Patient ☐ Continuation of Care ☐ Other: _____

By signing this authorization, I understand that:

- The authorization form is in effect until revoked by me, or until any records retention period applicable to my records has expired, whichever is sooner.
- Electronic media and delivery methods such as e-mail, or text messages, pose certain risks to the privacy and security of my Protected Health Information that may be beyond the control of TSC/SPRI. I agree to assume such risks personally, and to hold TSC/SPRI harmless in the event my Protected Health Information is breached or compromised as a result of my directing and authorizing TSC/SPRI to transmit or deliver such information electronically.
- My refusal to sign this form will not adversely affect my ability to receive health services, reimbursement for services and an enrollment in a health plan or my eligibility for health benefits. However, information will not be released to the above indicated recipient without my signature. I acknowledge the information disclosed pursuant to this authorization may be subject to re-discloser by the recipient and no longer protected by Federal Law.
- I have the right to revoke this authorization by written notice to TSC/SPRI. I understand actions taken in reliance on the authorization cannot be reversed and my revocation will not affect those actions.
- There may be costs associated with this request in compliance with State copying laws.

Patient/Authorized Representative* Signature:_____ Date:_____

Printed Name of Authorized Representative:_____ Relationship to Patient:_____

* If signed by a patient's authorized representative, supporting legal documentation must accompany this authorization form.

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