CNOS Patient Information Sheet

Patient Name:		**Acct #:**	**Sex:**	**Date of Birth:**	**Age:**
Marital Status:	**Primary Care Physician:**				
Address:		**City:**		**St:**	**Zip:**
Soc. Sec.#:	**Primary Ph.:**	**Cell:**		**Other Ph:**	
Email Address:		**Primary Language:**			

Race: ***(If not already indicated, please check box)*** «AdditField1»
☐ American Indian / Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian
☐ Other Pacific Islander ☐ White ☐ More Than One Race ☐ Refused To Report

Ethnicity: ***(If not already indicated, please check box)*** «AdditField2»
☐ Hispanic / Latin American ☐ Non-Hispanic / Latin American ☐ Refused To Report

Responsible Party:		**Sex:**	**Date of Birth:**	
Address:		**City:**	**St:**	**Zip:**
Soc. Sec.#:	**Home Ph.:**	**Cell:**	**Work:**	
Emergency Contact Name: (Outside the household) :				
Home Ph.:	**Cell Ph.:**	**Relationship:**		

Is this Accident Related: ☐ No ☐ Yes **Date of Injury:** ☐ Auto ☐ Work ☐ Other

PRIMARY INSURANCE	**SECONDARY INSURANCE**
Carrier Name:	**Carrier Name:**
Subscriber Name:	**Subscriber Name:**
Date of Birth:	**Date of Birth:**
Subscriber SS#:	**Subscriber SS#:**
Subscriber Employer:	**Subscriber Employer:**

Authorization To Release Information/Assignment of Benefits: I authorize payment of benefits to CNOS, including insurance payments, settlements from any lawsuit or workers' compensation proceedings, special cases or lump sum settlements of which my attorney will pay upon receipt of any funds for services rendered by CNOS. I authorize CNOS to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim. Initials_____

Disclosure of Physician Ownership: A majority of CNOS physicians, including your treating physician, may be owners of Dunes Surgical Hospital. Physical Therapy, Occupational Therapy and Durable Medical Equipmen tas well as MRI equipment are owned by and operated under the supervision of the physicians of CNOS. These services are utilized in cooperation with your physician's expertise to treat, improve and/or return you to a higher level of functionality.

- You have the right to choose the provider of your healthcare services. Initials_____
- You have the option to use a healthcare facility other than the Dunes Surgical Hospital.
- You are free to use other options for your Physical and Occupational Therapy, Durable Medical Equipment & MRI Screening.

You will not be treated differently by your physician if you choose to obtain healthcare services at a facility other than the Dunes Surgical Hospital for ambulatory surgery and related service prescribed by your physician. In the event that you choose to have your surgery performed at the Dunes Surgical Hospital any anticipated or unanticipated Durable Medical Equipment needs following surgery will be furnished through CNOS. If you have any questions concerning this notice, please feel free to speak with your physician, or any representative of CNOS or the Dunes Surgical Hospital.

Notice of Privacy Practices: A copy of the CNOS Notice of Privacy Practices was made available to me. Updated copies are posted in the reception area or on the CNOS web site at www.cnos.net. Copies are available upon request at each visit. Initials_____

Contact Authorization: I may be contacted at the phone numbers provided above. Initials_____

By signing this form, I acknowledge that I have read and understand the four individual statements above.

Signature: _____ _____

Patient or Legal Guardian if patient under 18 years old Date