ASSIGNMENT OF BENEFITS, DIRECTION TO PAY, & RELEASE OF INFORMATION:

ASSIGNMENT OF BENEFITS: The undersigned patient assigns the benefits of insurance and any overdue interest payments under the No-fault Policy of Automobile Insurance, also known as Personal Injury Protection (P.I.P.), or Medicare Payments Policy of Insurance with my insurance carrier or the responsible insurer to **SOUTHWEST ORTHOPEDIC GROUP, L.L.P./STEPHEN ESSES, M.D.** for services rendered. The medical provider agrees to accept the irrevocable assignment of benefits rendered to the patient. This assignment applies to both past and future medical expenses. A photocopy of this assignment is to be considered as valid and original. The undersigned patient agrees to pay any applicable deductible, co-payments, or any and all other services not covered by the insurance policy. **DIRECTION TO PAY:** The undersigned patient further directs the insurer to pay **SOUTHWEST ORTHOPEDIC GROUP, L.L.P./STEPHEN ESSES, M.D.** directly for the services rendered. **RELEASE OF INFORMATION:** I hereby authorize **SOUTHWEST ORTHOPEDIC GROUP, L.L.P./STEPHEN ESSES, M.D.** to furnish my insurance company or companies, or their representatives with any and all information that may be contained in their medical records.

X_____ Date: _____
(Patient's signature or parent's signature if patient is a minor)

LIFETIME MEDICARE PART B SIGNATURE AUTHORIZATION: I authorize my holder of medical or other information about me to release to the Social Security Administration, its intermediaries, carriers, or the billing agent of **SOUTHWEST ORTHOPEDIC GROUP, L.L.P./STEPHEN ESSES, M.D.** any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits be made to the holder of this assignment on my behalf. I understand that I am responsible for any health deductibles and insurance.

X_____Date:_____Medicare#:_____
(Medicare signature only)

IF PATIENT IS UNDER 18:

I hereby give my permission for _____to be treated by Dr. _____.

X_____Date:_____

Patient unable to sign due to _____.

Witness X_____Date:_____

SOUTHWEST ORTHOPEDIC GROUP, L.L.P.

COMMUNICATION for TEST RESULTS

NOTICE TO PATIENT:

In order for our practice to respond promptly and accurately to your needs, use this form to make a request of how you would like to receive TEST RESULTS. Check one:

- o I will receive my results in person at your facility.
- o You may call me at the following number: _____
- o You may leave a voicemail stating for me to call your facility (Results will NOT be left on voicemail).
- o You may mail the results to: _____

  _____

  _____
- o Other: _____

Please list any person(s) whom you would like to have access to your medical information:

_____

_____

_____

For certain test results, our physicians may request that you return to the facility for a second visit and follow-up care.

PRINT NAME: _____

SIGNATURE: _____DATE: _____

Stephen Esses, M.D.

PLEASE COMPLETE ALL BLANKS BELOW. IF ANY INFORMATION IS INCORRECT, PLEASE CROSS IT OUT AND WRITE THE CORRECT INFORMATION. PLEASE SIGN AND DATE AT THE BOTTOM OF THE FORM.

PATIENT DEMOGRAPHIC INFORMATION

LAST NAME _____ FIRST NAME _____ MIDDLE _____ PATIENT ID _____

DATE OF BIRTH _____ AGE _____ GENDER _____ SOCIAL SECURITY NO. _____

HOME ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

MEDICATION ALLERGIES & PHARMACY INFORMATION

ALLERGIES: _____ **HEIGHT** _____ **WEIGHT** _____

PHARMACY NAME: _____ **PHONE #:** _____ **Fax #:** _____

LIST CURRENT MEDICATIONS YOU ARE TAKING

MEDICATION NAME AND STRENGTH

EXAMPLE: ASPIRIN 81 MG. ONCE A DAY

SMOKING STATUS

_____ Daily Smoker _____ Social Smoker

_____ Former Smoker _____ Never Smoked

MEDICAL HISTORY

_____ Hypertension _____ Diabetes

_____ Back Pain _____ Cholesterol

_____ Other _____

Patient Signature: _____ **DATE:** _____