Patient Demographics & Insurance

NuHeight
Minimally Invasive Limb Lengthening

Acct #

Patient Information

Patient Last Name	First Name	Middle Name	Alias Name
Address (Street or Box)	City	State	Zip
Home Phone ❑ Primary Number	WorkPhone ❑ Primary Number	Mobile Phone ❑ Primary Number ☐ Yes, you can communicate information via SMS text for appointment reminders.	
E-mail (Allows us to send you important messages.)		Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed	
Social Security Number		Sex ☐ Male ☐ Female	Date of Birth
Employer Name		Employer Address	
Primary Care Physician Name	Phone #	Referring Physician Name	Phone #

How did you hear about the physician you are seeing today? ☐ Billboard ☐ Community Event/Health Fair ☐ Digital/Web Advertising ☐ FriendorFamily ☐ Mailer ☐ Postcard ☐ News Story/Broadcast ☐ Newspaper/Magazine Ad ☐ Physician Referral ☐ Radio Commercial ☐ TV Commercial

Responsible Party

Complete this section only if the patient above is a minor

Responsible Party Last Name	First Name	Middle Name	Alias Name
Address (Street or Box)	City	State	Zip
Home Phone	Work Phone	Mobile Phone	
E-mail (Allows us to send you important messages.)		Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed	
Social Security Number		Sex ☐ Male ☐ Female	Date of Birth

Insurance & Subscriber Information

Primary Insurance Company	Effective Date	**Secondary** Insurance Company	Effective Date
Claims Mailing Address (Street or Box)		Claims Mailing Address (Street or Box)	
City / State / Zip		City / State / Zip	
Policy ID Number	Group ID Number	Policy ID Number	Group ID Number
Subscriber Name (policy holder)	Date of Birth	Subscriber Name (policy holder)	Date of Birth
Subscriber Social Security #	Relationship to Patient	Subscriber Social Security #	Relationship to Patient
Subscriber Employer	Work Phone #	Subscriber Employer	Work Phone #
Subscriber Employer Address (Street or Box)		Subscriber Employer Address (Street or Box)	
City / State / Zip		City / State / Zip	

Consent to Treat & Financial Responsibility

Acct #

NuHeight
Minimally Invasive Limb Lengthening

Consent to Treat

I hereby authorize employees and agents of *Nu*Height (including physicians, physician assistants and nurse practitioners and other employees and staff members) to render medical evaluations and care to the patient indicated below. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

_____

Patient Name (please print)

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**

Complete this section ONLY if the patient is a minor

I consent for _____ to authorize evaluation and treatment for the patient identified above when I am not available. I understand that this authorizes the foregoing person(s) to consent to medical and surgical procedures and immunizations for the patient. The duration of this consent is indefinite and continues until revoked in writing.

_____ _____

Signature of Parent or Legal Guardian **Date**

Financial Responsibility

I hereby authorize payment of medical benefits directly to *Nu*Height and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in the patient's medical record to the patient's medical insurance company (or its employees or agents) as may be necessary to process and complete the patient's medical insurance claim. I understand that this authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). I understand that I am financially responsible for the total charges for services rendered which may include services not covered by the patient's insurance companies. I agree that all amounts are due upon request and are payable to *Nu*Height. I further understand that should my account become delinquent, I shall pay the reasonable attorney fees or collection expenses of *Nu*Height, if any.

The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before the services are rendered.

_____

Patient Name (please print)

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**

Acknowledgement of The Receipt of *Nu*Height Notice of Health Information Practices

NuHeight
Minimally Invasive Limb Lengthening

Acct #

Acknowledgement of Receipt

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care.

*Nu*Height is furnishing you with the attached notice, which provides information about how *Nu*Height and its physicians[1] may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. **By signing this form, you acknowledge that you have received a copy of *Nu*Height's Notice of Health Information Practices.**

_____
Patient Name (please print)

_____ _____
Signature of Patient, Parent, or Legal Guardian **Date**

Effective Date of this Notice: **7-17-23**

Race, Ethnicity & Language

Acct #

NuHeight
Minimally Invasive Limb Lengthening

***Nu*Height** is implementing a systematic method of collecting data on race, ethnicity, and communication needs directly from patients or their caregivers. The purpose of collecting this information is to ensure that all patients receive high-quality care.

We would like for you to provide us with your race and ethnic background. We will only use this information to review the treatment patients receive and make sure everyone gets the highest quality of care.

Race

Which category best describes your race?

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White or Caucasian
- ☐ Some Other Race
- ☐ Unknown
- ☐ Patient Declined

Race Definitions: American Indian or Alaska Native: A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment. **Black or African American:** A person having origins in any of the black racial groups of Africa. **White or Caucasian:** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa. **Asian:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. **Native Hawaiian or Other Pacific Islander:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

Ethnicity

Which category best describes your ethnicity?

- ☐ Not Hispanic or Latino
- ☐ Hispanic or Latino
- ☐ Unknown
- ☐ Patient Declined

Language

What language do you feel most comfortable speaking with your doctor or nurse?

- ☐ English
- ☐ Spanish
- ☐ Vietnamese
- ☐ Chinese
- ☐ Dutch
- ☐ Hindi
- ☐ Other_____

_____ **Patient Name (please print)**

_____ **Date**

Patient Preferences Regarding Communication of PHI. (Patient Health Information)

NuHeight
Minimally Invasive Limb Lengthening

Acct #

Preferred Method of Communication

My preferred method of communication regarding my **medical conditions** is indicated below **(check one):**

- ☐ Home Phone
- ☐ Work Phone
- ☐ Cell Phone
- ☐ Mailed Letter
- ☐ Guardian

If the above method of communication is by phone, please check the appropriate box below **(check one):**

- ☐ Leave a message with detailed information.
- ☐ Leave a message with a call-back number only.

Please note that you are responsible for any charges incurred in receiving our communications. For example, if you provide a cell phone number as a method of contact, then you are responsible for any charges imposed by your mobile carrier for receiving calls or text messages from the clinic.

Please let our office know if you have any special directions or requests regarding our communication with you. For example, please let us know if you would like for us to call you at a different phone number for a particular test result or if you do not want to be called at all.

Approved HIPAA Contacts

Keeping our patient's information private is important to us and by default we will only disclose information related to the patient's **Billing Account** and **Medical Conditions** to the **patient** or **legal guardian**.

If you would like to add additional contacts (other than the patient or legal guardian) that OINT is allowed to disclose this type of information to, please complete the fields below and select the appropriate checkboxes based on your approval for each person you list. In addition, please choose the person you would like *Nu*Height to list as your **Emergency Contact** in the event an emergency situation was to take place at our office.

1. Contact Name _____ Relationship to Patient _____ Contact Phone Number _____
   - ☐ **Billing Account Information**
   - ☐ **Medical Condition Information**
   - ☐ **Emergency Contact**

2. Contact Name _____ Relationship to Patient _____ Contact Phone Number _____
   - ☐ **Billing Account Information**
   - ☐ **Medical Condition Information**
   - ☐ **Emergency Contact**

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for health information from persons not listed on this form will require my specific authorization prior to the disclosure of any health information.

_____
Patient Name (please print)

_____ _____
Signature of Patient, Parent, or Legal Guardian **Date**