



TRANSYLVANIA

HEALTH SYSTEM

Date _____ PHYSICIAN _____ Account Number _____

Patient's Name Mr./Mrs./Ms. _____
 Last First Middle

M ___ F ___ Age _____ Date of birth _____ Patient Social Security # _____

Parent or guardian Name (if patient under 18) _____ Driver's Licensee _____

Mailing address _____
 Street City State Zip code

Actual Street address if mailing address is a P.O. Box _____

Home Phone _____ Work Phone _____ Cell number _____

In case of an Emergency contact (name) _____ phone _____

Patient's Employer _____ Occupation _____

Employer's address _____
 Street City State Zip code

INSURANCE INFORMATION:

Subscriber name _____

Social Security number _____ Date of birth _____

Subscriber Employer _____ Phone number _____

Address _____

If work related accident name of person to contact _____

About X-rays: All x-rays taken are the property of Transylvania Physician Services, Inc.. X-rays are a part of your medical file and must be maintained as part of your medical record. The cost of x-rays includes taking the x-ray film, supplies, processing and interpretation.

Financial Responsibility/ Medical Records

I have read and fully understand the financial policy established by Transylvania Physician Services, Inc.. I agree that insurance payments are to be paid to Transylvania Physician Services, Inc. on my behalf. I understand that I am financially responsible for all charges not paid by insurance. In the case of a minor, the child's guarantor is responsible for the account. Patient portion of charges and co-pays are due at the time services are rendered.

Patient (Parent or Guardian if minor) signature _____
 Relationship to patient _____ SS# _____ Printed name _____



TRANSYLVANIA

HEALTH SYSTEM
Brevard Orthopaedics

Compound Authorization for Release of Information

Name of Patient _____

Date of Birth _____

Transylvania Physician Services, Inc. is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Check each person/entity that you approve to receive information and select what information can be released.

1	Voice Mail/Ans. Mach. Phone # _____	Fax # _____	E-mail _____
	<input type="checkbox"/> Results of lab tests/x-rays	<input type="checkbox"/> Appointment Information	
2	<input type="checkbox"/> Give information to employer	<input type="checkbox"/> Appointment Information	
3	<input type="checkbox"/> Give information to school	<input type="checkbox"/> Appointment Information	
Spouse _____			
	Name	Phone #	
4	<input type="checkbox"/> Results of lab tests/x-rays	<input type="checkbox"/> Appointment information	<input type="checkbox"/> Family billing information <input type="checkbox"/> Financial
Legal Guardian _____			
	Name	Phone #	
5	<input type="checkbox"/> Results of lab tests/x-rays	<input type="checkbox"/> Appointment information	<input type="checkbox"/> Family billing information <input type="checkbox"/> Financial
Other _____			
	Name	Phone #	
6	<input type="checkbox"/> Results of lab tests/x-rays	<input type="checkbox"/> Appointment information	<input type="checkbox"/> Family billing information <input type="checkbox"/> Financial
Please list any other information you would like released: _____			

Rights of the Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to the **Transylvania Physician Services, Inc** Privacy Officer. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority (attach necessary documentation)