Arizona Orthopedic and Fracture Surgeons

Dr. Charles M Creasman MD

Patient Name: _____ Birth Date: _____

Would you like a copy of the Notice of Privacy Practices? ☐ Declined ☐ Accepted

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Acknowledgement of Notice of Privacy Practices:

I have been offered a copy of the Notice of Privacy Practices. I understand that Arizona Orthopedic and Fracture Surgeons has the right to change its Notice of Privacy Practices from time to time and that I may contract Arizona Orthopedic and Fracture Surgeons at any time to obtain a current copy.

**Signature: _____ Date: _____

I may be contacted in the following manner (circle all that apply):

Ok to leave message with detailed information: Home Work Cell No

Ok to leave call back number only: Home Work Cell No

Ok to email to: _____

Authorization of Release of Health Information:

I authorize the following individual(s) to have access to my personal health information.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

**Signature: _____ Date: _____

Workman's Compensation, if applicable

Insurance Carrier: _____ Claim#_____Date of Injury: _____

Address: _____ City: _____ State: _____ Zip: _____

Adjuster: _____ Phone: _____ Fax: _____

Nurse Case Manager: _____ Phone: _____ Fax: _____
