

Date: \_\_\_\_\_

Dr: \_\_\_\_\_

Chart #: \_\_\_\_\_



# WELCOME

Thank you for selecting our healthcare team! To help us meet your healthcare needs, please fill out this form completely.

How did you hear about us?  Friend/Family  Yellow Pages  TV/Advertisement

Referred by Dr. \_\_\_\_\_ from City \_\_\_\_\_ State \_\_\_\_\_

Your Primary Care Physician is: \_\_\_\_\_ City/State: \_\_\_\_\_

Patient's Name: First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_

Patient's Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

DOB: \_\_\_\_\_ SS# \_\_\_\_\_  Married  Single  Male  Female

Home # ( ) \_\_\_\_\_ Mobile # ( ) \_\_\_\_\_ Work # ( ) \_\_\_\_\_

Employer Name: \_\_\_\_\_ City: \_\_\_\_\_

Best time to reach you? Time: \_\_\_\_\_ Day of Week: \_\_\_\_\_

In the event of an emergency please contact:

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Mobile \_\_\_\_\_

Place of Injury  Work  Auto  Other \_\_\_\_\_

Current Problem (area of body) \_\_\_\_\_

Left side: \_\_\_\_\_ Right side: \_\_\_\_\_ State injury occurred in: \_\_\_\_\_

Is this visit related to an accident or a specific event?  Yes  No If Yes, date of injury \_\_\_\_\_

### Responsible Party IF DIFFERENT FROM PATIENT

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

DOB: \_\_\_\_\_ SS# \_\_\_\_\_  Male  Female

Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Mobile \_\_\_\_\_

Employer Name: \_\_\_\_\_ City: \_\_\_\_\_

**Primary Insurance (Please provide insurance card for us to copy)** Co-Pay Amount \$ \_\_\_\_\_

Name of Insured (as it appears on the card): \_\_\_\_\_ SS # \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ DOB: \_\_\_\_\_ Contract ID# \_\_\_\_\_

Employer Name: \_\_\_\_\_ City: \_\_\_\_\_

**Secondary Insurance (Please provide insurance card for us to copy)** Co-Pay Amount \$ \_\_\_\_\_

Name of Insured (as it appears on the card): \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ DOB: \_\_\_\_\_ Contract ID# \_\_\_\_\_

Employer Name: \_\_\_\_\_ City: \_\_\_\_\_



### GUARANTEE OF ACCOUNT

The Orthopaedic Center (TOC) requests payment for co-pays and deductibles at time of service. Your contract with your insurance carrier, depending on the type of insurance and the carrier, states that you are responsible for co-pays and deductibles at the time of service and TOC also has an agreement with your carrier to collect such fees at time of service. If your carrier has not paid your account with TOC within 60 days we ask that you pay the balance and seek settlement direct from your carrier.

If you are not covered by health insurance please ask the TOC personnel about a possible reduction in your fee for a cash payment at time of service.

If you have some other extenuating circumstance that leaves you unable to pay please ask the TOC personnel about possible resolution of debt.

I hereby authorize and assign payment directly to The Orthopaedic Center and each physician in the Group individually for any medical/surgical benefits, injury benefits due because of third party liability, or proceeds of all claims resulting from the liability of the third party until such time as the account is paid in full upon the completion of treatment.

By signing this form, I accept responsibility for reasonable costs incurred if my account becomes delinquent. I have read, understand and agree with the above.

X \_\_\_\_\_

Signature of Patient and/or Authorized Representative

\_\_\_\_\_ Date

### PATIENT SIGNATURE AUTHORIZATION / RELEASE OF INFORMATION

I hereby consent to and authorize TOC to furnish any insurance company, organization, hospital, physician or pharmacist any information requested with respect to any physical or mental condition and/or treatment of me or my child.

I understand the information obtained by this authorization will be used to determine eligibility for insurance and eligibility for benefits under my insurance coverage. Any information will not be released except to persons or organizations performing business or legal services in connection with the claim, or as may be otherwise lawfully required or as I may further authorize.

I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

X \_\_\_\_\_

Signature of Patient and/or Authorized Representative

\_\_\_\_\_ Date

### CONSENT FOR MEDICAL / EMERGENCY TREATMENT

I hereby consent to and authorize TOC personnel or its contractors to render usual and customary medical/emergency treatment to me. I understand the treatment provided will be in accordance with the standard of care at the time the care is provided, including but not limited to office visits, surgical procedures and interpretations of x-rays and MRIs.

X \_\_\_\_\_

Signature of Patient and/or Authorized Representative

\_\_\_\_\_ Date

\_\_\_\_\_ Witness





## Patient Financial Policy

### Financial Responsibility:

The following information outlines financial responsibilities related to payment for professional services as you, the patient, are ultimately responsible for all charges associated with your care regardless of insurance coverage.

Patients are expected to pay all co-pays, co-insurance, and deductibles at the time of service. Monthly statements are mailed to each patient with patient balance due expected within 30 days.

If you fail to pay the balance in full after two statements, fail to contact the collection department to make payment arrangements, or fail to pay after making agreed upon financial arrangements, your account may be sent to an outside collection agency. You will be responsible for the fees assessed by the collection agency. This outstanding debt may also be listed with local, regional, or national credit-reporting agencies and may have a negative effect on the granting of future credit.

### Financial Agreement:

The undersigned agrees that in consideration for the services to be rendered to the patient, he/she individually agrees to be totally responsible for all charges for services such as **DURABLE MEDICAL SUPPLIES, ORTHOVISC, SYNVISIC, SUPARTZ, SYNVISIC ONE, CASTING** and any other non-covered charges. The undersigned agrees to assign payment for the unpaid charges from services provided by specialist and by physicians for whom The Orthopaedic Center is authorized to bill. I, the undersigned, accept the fee(s) charged as a legal and lawful debt. I understand the fee(s) charged are due at the time of service. Should it become necessary to forward my account for collection, I agree to pay all monies due, including a 33% collection fee, attorney fees, and/or court costs, if such be necessary.

### Accepted Insurances:

Aetna	Medicaid
BCBS PMD	Medicaid/ Alacaid
BCBS of Alabama	Medicare
BCBS of Tennessee	NAMCI
Beech Street	PHCS (Private Health Care Services)
Choice Care	Principal
Cigna	Pro-America
Great West	United Healthcare
Mail Handlers	VIVA

Because these provider networks often add or delete insurance companies, we suggest that you contact your insurance company to verify their participation. Also, **be sure to bring a referral from your Primary Care doctor to each visit, if required by your insurance company.** Otherwise, they may not pay for the services provided and you will be responsible for payment or your appointment may be rescheduled.

### Separate Billing:

If you have a procedure or service outside of our office, you may receive bills from multiple parties. These may include but are not limited to The Orthopaedic Center, the surgical facility, radiology, anesthesiology, and durable medical equipment (DME).

### Medicare Policy:

As a courtesy to our patients, The Orthopaedic Center accepts Medicare assignment. We will file your claims to Medicare for you, and hold billing until after Medicare has responded to the claim. Medicare will pay 80% of their allowable, and the patient, or their secondary insurance, is responsible for the remaining 20%. Naturally, your Medicare deductible must be met first.

If you supply our office with the correct billing information, we will also file with your secondary insurance carrier on a one-time basis. If your secondary insurance carrier does not pay within 60 days, you will then be responsible for the balance.

**Worker's Compensation:**

Worker's compensation claims are not covered by your regular insurance. Our office requires written verification by your employer of a Worker's Compensation claim. This information must be received by our office before your scheduled appointment.

**Self-Pay:**

Patients who do not have health insurance are advised that they need to **be prepared to pay at minimum \$150** towards their initial visit. Likewise, any associated surgery will require a 50% prepayment or at minimum \$500 and the balance will be billed to the patient to be paid in full within 180 days.

For patients with no insurance, we offer an uninsured reduction to patients who pay in full at the time of service.

A healthcare credit plan (CareCredit) is available to qualified individuals. TOC will assist you in your application process. Once qualified, you will be able to pay for medical expenses immediately to take advantage of the uninsured reduction price.

**Treatment of a Minor:**

If the patient is a minor (under 19 years of age), the parent or guardian must sign below in addition to the authorization of treatment. The parent, guardian, or unaccompanied minor is responsible for any payment due at the time of service, and providing required referrals, insurance, and picture ID cards.

**Third Party Insurance & Auto Insurance:**

If your care is related to a motor vehicle accident, or third party liability, please note your medical insurance may not cover your care. We will file the insurance claim on your behalf, as well as any claims to a third party payer. **We do not accept liens.**

If third party funds are exhausted, we will automatically file claim on your behalf to your personal insurance (written letter of exhausted funds is required). If you do not have health insurance you will be responsible for the services rendered.

**High Deductible Plan:**

If you have a High Deductible Plan, be prepared to pay for your services in full as you incur them. If surgery is required you will be asked to pay in advance of booking a surgery time. There is no uninsured reduction offered to insured patients.

**Referral Requirement:**

If you have a PPO plan (e.g. Aetna Managed Care, BCBS Personal Choice, or Tricare) with which we are contracted or Medicaid, a referral authorization may be required from your primary care physician. **It is the patients responsibility to obtain this referral.** If we have not received an authorization prior to your arrival at the office, we have a telephone available for you to call your primary care physician to obtain it. If you are unable to obtain the referral at that time, you will be rescheduled. Please note, some of our physicians' practices are surgical based only and may require a physician referral even if your insurance carrier does not.

**Additional Charges:**

- Form - \$25 (each form)
- For returned checks - \$40
- X-ray film copies - \$10/ film
- Patient co-pays not paid at the time of service - \$15 rebill processing fee (*effective 1/1/11*)

The undersigned certifies that he/she has read and understands the foregoing, is the patient or is duly authorized by the patient to execute the above, and accepts the terms thereof.

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 Signature of Patient/ Responsible Party

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 Date

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 Relationship to Patient



Today's Date \_\_\_\_\_

Patient's Legal Name \_\_\_\_\_  
Last First Middle

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Male  Female  Occupation \_\_\_\_\_

Referred by \_\_\_\_\_ Family Physician \_\_\_\_\_

**PLEASE COMPLETE ALL AREAS INSIDE THIS BOX:**

- 1) Was this an accident:  Yes If an accident what Date: \_\_\_\_\_  No (if no, go to #3)
- 2) If an accident, please explain how it happened: \_\_\_\_\_  
\_\_\_\_\_
- 3) If not an accident, when was the onset of today's condition: \_\_\_\_\_  
\_\_\_\_\_
- 4) Specific location of injury or pain: Right \_\_\_\_\_ Left \_\_\_\_\_ Location \_\_\_\_\_
- 5) Is pain sharp / dull, constant / occasional? \_\_\_\_\_
- 6) What are your symptoms? \_\_\_\_\_  
\_\_\_\_\_
- 7) On a scale of 1 to 10, 10 being the worst, what is the severity of your pain? \_\_\_\_\_
- 8) What activities make the problem feel worse? \_\_\_\_\_  
or better? \_\_\_\_\_
- 9) How long have you experienced this problem? \_\_\_\_\_
- 10) If you have had an X-ray, MRI, PT or Injections in the last 60 days for this problem, please list those here: \_\_\_\_\_  
\_\_\_\_\_

List all medications that you are currently taking (prescription and non-prescription):  See attached medication list

Medication Name	Dosage	Times/Day	Medication Name	Dosage	Times/Day
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

ARE YOU ALLERGIC TO ANY MEDICATIONS?:  Yes  No Latex Allergy?:  Yes  No

List any medications that you are allergic to and the reaction it causes:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PRIMARY PHARMACY \_\_\_\_\_ PHONE NO. \_\_\_\_\_

ARE YOU OR HAVE YOU BEEN UNDER CARE OF A PAIN CLINIC?  Yes  No

DO YOU HAVE A HISTORY OF BLOOD CLOTS OR DVT?  Yes  No

Prior Surgeries: \_\_\_\_\_  
\_\_\_\_\_

**ROS** Please check all **CURRENT** positive findings that apply to you or mark none.

<b>CONSTITUTIONAL</b>	<input type="checkbox"/> weight loss	<input type="checkbox"/> weight gain	<input type="checkbox"/> loss of appetite	<input type="checkbox"/> weakness	<input type="checkbox"/> NONE
<b>EENT</b>	<input type="checkbox"/> blurry vision	<input type="checkbox"/> hoarseness	<input type="checkbox"/> ringing in ears		<input type="checkbox"/> NONE
<b>CARDIAC</b>	<input type="checkbox"/> chest pain	<input type="checkbox"/> irregular heartbeat	<input type="checkbox"/> swelling in the legs or feet		<input type="checkbox"/> NONE
<b>RESPIRATORY</b>	<input type="checkbox"/> pain when breathing	<input type="checkbox"/> shortness of breath			<input type="checkbox"/> NONE
<b>GASTROINTESTINAL</b>	<input type="checkbox"/> liver problems	<input type="checkbox"/> blood in stool	<input type="checkbox"/> gallbladder problems		<input type="checkbox"/> NONE
<b>GENITOURINARY</b>	<input type="checkbox"/> bladder problems	<input type="checkbox"/> incontinence	<input type="checkbox"/> pain with urination	<input type="checkbox"/> kidney stones	<input type="checkbox"/> NONE
<b>INTEGUMENTARY</b>	<input type="checkbox"/> rashes	<input type="checkbox"/> skin ulcers	<input type="checkbox"/> changes in skin		<input type="checkbox"/> NONE
<b>NEUROLOGICAL</b>	<input type="checkbox"/> headaches	<input type="checkbox"/> numbness/tingling	<input type="checkbox"/> seizures	<input type="checkbox"/> dizziness <input type="checkbox"/> faintness	<input type="checkbox"/> NONE
<b>MENTAL HEALTH</b>	<input type="checkbox"/> depression	<input type="checkbox"/> sleep disorder	<input type="checkbox"/> nervousness	<input type="checkbox"/> fainting spells	<input type="checkbox"/> NONE
<b>HEMATOLOGIC</b>	<input type="checkbox"/> easy bleeding	<input type="checkbox"/> easy bruising	<input type="checkbox"/> bleeding problems		<input type="checkbox"/> NONE
<b>ENDOCRINE</b>	<input type="checkbox"/> thyroid problems	<input type="checkbox"/> low blood pressure	<input type="checkbox"/> thirst		<input type="checkbox"/> NONE
<b>MUSCULOSKELETAL</b>	<input type="checkbox"/> joint pain	<input type="checkbox"/> muscle pain	<input type="checkbox"/> cramps	<input type="checkbox"/> limitation in motor activity	<input type="checkbox"/> NONE

**HISTORY** Please check all that apply (Family refers to parents, brothers, sisters, or children)

Condition	You	Family	Condition	You	Family	Condition	You	Family
Jaundice or Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Cancer Type _____		
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>			

Have you ever been diagnosed/treated for any other conditions/illness not listed above \_\_\_\_\_

Women: Are you pregnant? Yes  No  Date of last menstrual period: \_\_\_\_\_

**SOCIAL HISTORY:**

Do you smoke? Yes  No  # of Years \_\_\_\_\_ Packs per day \_\_\_\_\_  
 Do you drink alcoholic beverages? Yes  No  Drinks per week \_\_\_\_\_  
 Marital Status: Married  Single  Divorced  Widowed  Number of Children \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Currently Working: Yes  No

<i>I hereby certify by my signature that the medical information given on this form is correct to the best of my knowledge.</i>			
Patient Signature _____		Date _____	
<b>DO NOT SIGN BELOW UNLESS ASKED TO UPDATE YOUR FORM DURING A RETURN VISIT</b>			
<i>I hereby certify that I have reviewed and updated the medical information on this form and it is currently accurate.</i>			
Patient Signature - Update # 1 _____	Date _____	Physician Signature - Update # 1 _____	Date _____
Patient Signature - Update # 2 _____	Date _____	Physician Signature - Update # 2 _____	Date _____
Patient Signature - Update # 3 _____	Date _____	Physician Signature - Update # 3 _____	Date _____

**PHYSICAL EXAMINATION:** Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Vital Signs:** B/P \_\_\_\_\_ P \_\_\_\_\_ R \_\_\_\_\_ T \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ R or L Hand Dominant \_\_\_\_\_

	Within Normal Limits		Findings
	Yes	No	
HENT	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neck	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other Data _____			

**IMPRESSION/DIAGNOSIS:** \_\_\_\_\_

**PLAN:** \_\_\_\_\_

The patient has been advised of the plan and/or procedure, including the potential risks and benefits, and agrees to proceed.

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_