TOC The Orthopaedic Center
World Class Orthopaedics, Spine & Sports Medicine

WELCOME

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

Date: _____ **Dr:** _____ **Chart #:** _____

Patient's Name: First _____ **MI** _____ **Last** _____

Patient's Address: _____ **City** _____ **State** _____ **Zip** _____

Employer Name: _____ **City:** _____

Which doctor referred you? _____ **Who is your PCP?** _____

Email Address _____ **Nickname** _____

Contact Preference ❑ Phone ❑ Mail ❑ Email ❑ Secure Messaging

Sex ❑ M ❑ F **Primary Phone #** _____ **Secondary Phone #** _____

SS # _____ **Birthdate** _____

Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Race ❑ American Indian or Alaskan ❑ Asian ❑ Black or African American ❑ Native Hawaiian ❑ White ❑ Other

Ethnicity ❑ Hispanic or Latino ❑ Not Hispanic or Latino **Language** _____

Emergency Contact (not living with you)

Name: _____ **Relationship to Patient:** _____

Work Phone _____ **Home Phone** _____ **Mobile** _____

Additional Person Authorization

Purpose: To ensure authorization that releases TOC to speak with additional persons regarding patient care.

I, _____, patient of TOC, authorize the following individuals to be able to discuss my care and/or appointments at The Orthopaedic Center with my attending physician and clinical staff, as well as any insurance or billing issues.

_____	_____	_____	_____
Name	Relationship	Name	Relationship
_____	_____	_____	_____
Name	Relationship	Name	Relationship

X _____ _____ _____

Signature of Patient and/or Authorized Representative **Date** **Witness**

Responsible Party (If Different From Patient)

Name:_____ **Relationship to Patient**_____ ❑ **M** ❑ **F**

DOB:_____ **SS#**_____ **Address**_____

Work Phone_____ **Home Phone**_____ **Mobile**_____

Employer Name_____ **City**_____

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

Primary Insurance Company_____

Name Of Insured (as it appears on the card)_____ **SS#**_____

Subscriber Name_____ **Relationship to Patient**_____

Date of Birth_____ **Policy #**_____ **Group #**_____

Employer Name_____ **City**_____

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

Primary Insurance Company_____

Name Of Insured (as it appears on the card)_____ **SS#**_____

Subscriber Name_____ **Relationship to Patient**_____

Date of Birth_____ **Policy #**_____ **Group #**_____

Employer Name_____ **City**_____

Preferred Pharmacy_____

Accident Information

Is this visit related to an accident or a specific event? ❑ Yes ❑ No **If yes, date of Injury:**_____

Place of Injury ❑ Work ❑ Auto ❑ Other_____

Current Problem (area of body)_____

❑ Left Side ❑ Right Side **State Injury Occured in:**_____

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 at 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

ACKNOWLEDGEMENT TO USE AND DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I understand and have been offered a TOC Notice of Privacy Practices that provides a more complete description of information uses and disclosures; that I have the right to review the notice prior to signing this acknowledgement; that TOC reserves the right to change its notice and practices.

X_____ _____ _____

Signature of Patient and/or Authorized Representative — Date — Witness

PAYMENT OF MEDICARE BENEFITS TO PROVIDER EXTENDED AUTHORIZATION

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made directly to The Orthopaedic Center on my behalf.

X_____ _____ _____

Signature of Patient and/or Authorized Representative | Date | Witness

PAYMENT OF MEDICAID BENEFITS TO PROVIDER EXTENDED AUTHORIZATION

I certify that the information given by me in applying for payment under Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the State of Alabama and/or Tennessee or its fiscal agents any information needed for this or a related Medicaid claim. I request that payment of authorized benefits be made directly to The Orthopaedic Center on my behalf.

X_____ _____ _____

Signature of Patient and/or Authorized Representative | Date | Witness

You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mail, using any e-mail address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

I/We have read this disclosure and agree that the Lender/Creditor may contact me/us as described above.

X_____ _____ _____

Signature of Borrower/Customer | Date | Witness

As a patient of The Orthopaedic Center, P.C., you should be aware that you may be referred to a health care facility with whom physicians of The Orthopaedic Center, P.C. may have an ownership, investment and/or financial relationship. You are, however, free to choose to obtain health care services elsewhere from another provider of your choice, and you may request to be provided with a list of alternative providers, if any, that may be available. You will not be treated differently by The Orthopaedic Center, P.C. regardless of whether you choose to obtain health care services elsewhere.

Thank you for filling out this form completely. The information you have provided will help us serve your healthcare needs more effectively and efficiently.

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

Because these provider networks often add or delete insurance companies, we suggest that you contact your insurance company to verify their participation. You will be responsible for any out of network balance. 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, including their initial visit when referred internally to another TOC physician. 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 <u>do not</u> 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, <u>be prepared to pay for your services in full as you incur them</u>. 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. At the time of check in, $150 must be paid on the first visit with $100 to be paid at check in on each subsequent office visit.

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 or $7/CD
- Patient co-pays not paid at the time of service - $15 rebill processing fee *(effective 1/1/11)*
- $20 fee will be accessed for appointments seen in our After Hours Clinic.

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.

_____ _____
Signature of Patient/ Responsible Party Date

_____
Relationship to Patient

Today's Date: _____

Patient's Legal Name: _____

Age: _____ Gender: _____ DOB: _____ Height: _____ Weight: _____

Referred by: _____ Family Physician: _____

1. *Specific location of injury or pain:* _____Right _____Left *Body Part:* _____
2. *Was this an accident?* _____ Yes _____ No (If "No", skip to #5)
3. *If an accident, please explain how it happened:*

_____

4. *What was the date of the accident?* ____/____/____ *Where did it occur?* _____
5. *If not an accident, how long have you experienced this problem?* _____
6. *Describe the quality of your pain* (ex: Sharp, Dull, Constant, Occasional) _____
7. *What are your symptoms?* _____
8. *On a scale of 1 to 10 (10 being the worst), what is the severity of your pain?* _____
9. *What activities make the problem feel worse?* _____
10. *What makes the problem feel better?* _____
11. *What tests/procedures you have had in the last 60 days for this problem?* (ex: xray, MRI, CT, injection)

_____

12. *Where was the test done?* _____

MEDICAL HISTORY: If you have any of the following, PLEASE FILL IN THE OVAL COMPLETELY:

○ **ADD/ADHD**	○ **Cancer : Colon**	○ **Heart Disease**	○ **Rheumatoid Arthritis**
○ **AIDS/HIV**	○ **Cancer : Lung**	○ **Hepatitis / Jaundice**	○ **Scoliosis**
○ **Alzheimer's**	○ **Cancer : Prostate**	○ **High Blood Pressure**	○ **Seizures**
○ **Anemia**	○ **Colitis / Crohn's**	○ **Implantable Defibrillator**	○ **Sleep Apnea**
○ **Asthma**	○ **COPD / Emphysema**	○ **Kidney Disease**	○ **Stomach Ulcers**
○ **Blood Clot/DVT Leg**	○ **Depression / Anxiety**	○ **Lupus**	○ **Stroke**
○ **Blood Clot/Lung**	○ **Diabetes**	○ **Pacemaker**	○ **NONE**
○ **Cancer : Breast**	○ **Drug Abuse**	○ **Psoriasis**	

○ **OTHER:**

Have you, or have you ever been under the care of a pain clinic?	○ **Yes**	○ **No**
Have you received the FLU Vaccine within the past year?	○ **Yes**	○ **No**
Have you received the PNEUMONIA Vaccine within the past year?	○ **Yes**	○ **No**

Preferred Pharmacy: _____ **Phone No:** _____

Today's Date: _____

Patient's Legal Name: _____ *XXXXXPG2*

SURGICAL HISTORY: If you have any of the following, PLEASE FILL IN THE OVAL COMPLETELY. Also, please list the year.

- ○ Appendectomy
- ○ Arthroscopy : Shoulder
- ○ Arthroscopy : Knee
- ○ Bunionectomy
- ○ Cardiac Stent
- ○ Carpal Tunnel Release
- ○ Gallbladder
- ○ Gastric Bypass
- ○ Heart Surgery
- ○ Hip Replacement
- ○ Hysterectomy
- ○ Knee Replacement
- ○ Mastectomy
- ○ Spinal Surgery
- ○ Stomach Procedure
- ○ Vascular Procedure

○ **OTHER:**

Have you ever received General Anesthesia? ○ Yes ○ No

If Yes, did you have any problems with the Anesthesia? ○ Yes ○ No

If Yes, please explain: _____

MEDICATIONS: If you take any of the following medications, PLEASE FILL IN THE OVAL COMPLETELY.

- ○ Adderall (Dextroamphetamine)
- ○ Ambien (Zolpidem)
- ○ Buspar (Buspirone)
- ○ Celebrex (Celecoxib)
- ○ Celexa (Citalopram)
- ○ Coumadin (Warfarin)
- ○ Cozaar (Losartan)
- ○ Cymbalta (Duloxetine)
- ○ Dilantin (Phenytoin)
- ○ Dolophine/Metadose (Methadone)
- ○ Insulin (Name:_____)
- ○ Flexeril (Cyclobenzaprine)
- ○ Flomax (Tamsulosin)
- ○ Glucophage (Metformin)
- ○ HCTZ (Hydrochlorothiazide)
- ○ Klonopin (Clonazepam)
- ○ Lasix (Furosemide)
- ○ Lexapro (Escitalopram)
- ○ Lipitor (Atrovastatin)
- ○ Lopressor (Metoprolol)
- ○ Lyrica (Pregabalin)
- ○ Mobic (Meloxicam)
- ○ Neurontin (Gabapentin)
- ○ Nexium (Esomeprazole)
- ○ Norco/Lortab/Vicodin/Lorcet
- ○ Norvasc (Amlodipine)
- ○ Percocet
- ○ Plavix (Clopidogrel)
- ○ Pravachol (Pravastatin)
- ○ Prinivil/Zestril (Lisinopril)
- ○ Prozac (Fluoxetine)
- ○ Robaxin (Methocarbamol)
- ○ Skelaxin (Metaxalone)
- ○ Synthroid (Levothyroxine)
- ○ Tenormin (Atenolol)
- ○ Ultram (Tramadol)
- ○ Tylenol (Acetaminophen)
- ○ Valium (Diazepam)
- ○ Xanax (Alprazolam)
- ○ Zocor (Simvastatin)
- ○ Zyrtec (Cetirizine)

NSAIDS (select below)

- ○ Naprosyn/Aleve (Naproxen)
- ○ Motrin/Advil (Ibuprofen)

Vitamin Supplements (list)

_____

○ **NONE**

○ **OTHER:**

ALLERGIES: If you have allergies to any of the following, PLEASE FILL IN THE OVAL COMPLETELY.

- ○ Amoxicillin
- ○ Ampicillin
- ○ Bactrim / Septra
- ○ Cephalosporins (Ceftin / Cefzil / Keflex / Suprax)
- ○ Codeines
- ○ Hydrocodone
- ○ Insulin
- ○ Iodine/Shellfish
- ○ Keflex
- ○ **Latex**
- ○ **Nickel/Metal**
- ○ Penicillin
- ○ Septra
- ○ Sulfa Drugs
- ○ Tape/Adhesive
- ○ Seasonal Allergies
- ○ **NONE**

○ **OTHER:**

Today's Date: _____

Patient's Legal Name: _____

* X X X X X P G 3 *

SOCIAL HISTORY: PLEASE FILL IN THE OVAL COMPLETELY to answer the following questions.

Do You Currently Use Tobacco? ○ Yes ○ No **Appoximate AGE when you started?** _____

If YES, what type do you use? ○ Smoking ○ Smokeless Vapor ○ Chewing

Packs Per Day? ○ 1 ○ 2 ○ 3 ○ 4 >

Please Select a Smoking Status:

- ○ NEVER smoker
- ○ FORMER smoker
- ○ CURRENT Everyday Smoker
- ○ CURRENT Sometimes Smoker
- ○ LIGHT Tobacco User
- ○ HEAVY Tobacco User
- ○ Current Status Unknown
- ○ Unknown if Ever Smoked

Do you use Alcohol? ○ Yes ○ No **Drinks per Day?** ○ 1-3 ○ 4-6 ○ 7+ ○ Occasional

Marital Status? ○ Single ○ Married ○ Divorced ○ Widowed

Number of Children? ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 >

Hand Dominance? ○ Right ○ Left ○ Ambidextrious

Currently Working? ○ Yes ○ No **OCCUPATION:** _____

FEMALES ONLY: Could you be pregnant? ○ Yes ○ No **Last Menstural Cycle?** _____

FAMILY HISTORY: PLEASE FILL IN THE OVAL COMPLETELY if you have a family member with the following:

○ Unknown / Adopted

	Father	Mother	Brother	Sister	Son	Daughter	Other
AIDS/ HIV	○	○	○	○	○	○	○
Anemia	○	○	○	○	○	○	○
Blood Clots	○	○	○	○	○	○	○
Cancer (Breast)	○	○	○	○	○	○	○
Cancer (Colon)	○	○	○	○	○	○	○
Cancer (Lung)	○	○	○	○	○	○	○
Cancer (Prostate)	○	○	○	○	○	○	○
Coronary Artery Disease	○	○	○	○	○	○	○
Diabetes	○	○	○	○	○	○	○
Gout	○	○	○	○	○	○	○
Heart Attack	○	○	○	○	○	○	○
Hemophilia	○	○	○	○	○	○	○
Hypertension	○	○	○	○	○	○	○
Kidney Disease	○	○	○	○	○	○	○
Liver Disease	○	○	○	○	○	○	○
Muscle Disease	○	○	○	○	○	○	○
Osteoarthritis	○	○	○	○	○	○	○
Osteoporosis	○	○	○	○	○	○	○
Rheumatoid Arthritis	○	○	○	○	○	○	○

Today's Date:_____

Patient's Legal Name: _____

REVIEW OF SYSTEMS: If you have any of the following PLEASE FILL IN THE OVAL COMPLETELY.

Please make a selection for EACH BOX.

CONSTITUTIONAL	ENDOCRINE	CARDIOVASCULAR	GASTROINTESTINAL
○ Weight Loss / Gain	○ Thyroid Trouble	○ Chest Pain	○ Rectal Bleeding
○ Weakness	○ Low Blood Pressure	○ Irregular Heart Beat	○ Gallbladder Trouble
○ Loss of Appetite	○ Excessive Thirst	○ Swelling of Legs / Feet	○ Liver Problems
○ **NONE**	○ **NONE**	○ **NONE**	○ **NONE**

HEMATOLOGICAL	EENT	INTEGUMENTARY	RESPIRATORY
○ Bleeding Problems	○ Blurred Vision	○ Rashes	○ Shortness of Breath
○ Easy Bleeding	○ Hoarseness	○ Skin Ulcers	○ Pain when Breathing
○ Easy Bruising	○ Ears Ringing	○ Changes in Skin	○ **NONE**
○ **NONE**	○ **NONE**	○ **NONE**	

GENITOURINARY	MUSCULOSKELETAL	MENTAL HEALTH	NEUROLOGICAL
○ Bladder Problems	○ Joint Pain	○ Nervousness	○ Headache
○ Incontinence	○ Cramps	○ Depression	○ Dizziness
○ Kidney Stones	○ Limitation in Activity	○ Sleep Disorder	○ Seizures
○ Burning Urination	○ Muscle Pain	○ Fainting Spells	○ Numbness / Tingling
○ **NONE**	○ **NONE**	○ **NONE**	○ Faintness
			○ **NONE**

I hereby certify by my signature that the medical information given on this form is correct to the best of my knowledge.

Patient Signature _____ Date_____

FOR PHYSICIAN USE ONLY:

PHYSICAL EXAMINATION **Vitals Signs** B/P _____ P _____ R _____ T _____

	Within Normal Limits? YES	NO	Findings
HENT	□	□	_____
Eyes	□	□	_____
Neck	□	□	_____
Heart	□	□	_____
Lungs	□	□	_____
Abdomen	□	□	_____
Neurological	□	□	_____
Musculoskeletal	□	□	_____
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/Time**_____