Carolina Orthopaedic & Sports Medicine Center

Focused on You

2345 Court Drive
Gastonia, NC 28054
Phone: 704-865-0077
Fax: 704-867-6401

Patient Name: _____ SSN: _____

Address: _____
Street City State Zip

Home #: _____ Birth Date: _____ Age: _____ Sex: ☐ Male ☐ Female

Email Address: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced For X-ray purposes, are you pregnant? ☐ Yes ☐ No

Patient's Employer: _____ Employer Phone #: _____

Employer's Address: _____
Street City State Zip

Spouse's Name or if Minor, Parent/Guardian's Name: _____

SSN and Birth Date of Spouse or Parent/Guardian: _____

Name and Phone # of Emergency Contact: _____

Reason for Today's Visit: _____

Is this a work-related injury? If Yes, Give Date Occurred: _____

Did you go to the emergency room? ☐ Yes ☐ No If Yes, Give Hospital Name: _____

Date of Treatment: _____ Were X-rays taken? ☐ Yes ☐ No

If you were referred by another doctor for today's problem, give doctor's name: _____

Are you seeking a second opinion for today's problem? ☐ Yes ☐ No

Name and Address of Family Doctor: _____

INSURANCE INFORMATION - PLEASE PRODUCE YOUR INSURANCE CARD FOR US TO SCAN TO OUR FILES

Primary Insurance Company: _____

Name of Insured: _____ Relationship to Patient: _____

Employer of Insured: _____

SSN and Birth Date of Insured: _____

Secondary Insurance Company: _____

Name of Insured: _____ Relationship to Patient: _____

Employer of Insured: _____

SSN and Birth Date of Insured: _____

Acceptance of financial responsibility: I understand that I am responsible for all medical expenses regardless of insurance coverage and whether or not there is an accident with another person at fault. Authorization to treat and to release medical information: I hereby authorize medical treatment and the release of medical information requested from my insurance company. Authorization to pay: I hereby authorize payment directly to Carolina Orthopaedic & Sports Medicine Center.

Signature of Patient or Parent/Guardian: _____ Date: _____

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Patient Name: _____

Date of Accident: _____

Type of Accident: ☐ Auto ☐ Work-Related ☐ Other: _____

_____

If Work-Related, Give Name of Employer, Phone #, and Name of Person Who Will Verify: _____

_____

_____

How and when did the accident happen? _____

_____

_____

Patient Signature: _____ Date: _____

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Guidelines for Prescription Refills

1. Our office requires a **48-hour notice for prescription refills.**
2. Medications will be refilled between **9 a.m. and 4 p.m., Monday – Friday. No refills on the weekends or holidays. The "on-call" doctor will not refill medications.**
3. Safety of your prescriptions is YOUR responsibility. **LOST PRESCRIPTIONS WILL NOT BE REFILLED.** Lock up your prescriptions and keep them away from children.
4. Our doctors may not refill prescriptions for pain medicine if you are receiving similar medicines from another doctor.
5. Be aware of the effect of other medications you may be taking. Ask your doctor or your pharmacist whether you can take them along with pain medication.
6. Do not drink alcoholic beverages while taking pain medication. Obey warnings regarding sedation of certain medicines.
7. Follow the prescribed dose of the medication. Do not give your medications to other people and do not take medication from others.
8. Carolina Orthopaedic & Sports Medicine Center may request and use your prescription medication from other healthcare providers or third-party pharmacy benefit payors for treatment.

I agree and will comply with the above guidelines.

Signature of Patient or Parent/Guardian: _____

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Acknowledgment of Receipt of Notice of Privacy Practices

Chart #: _____ Birth Date: _____

Patient Name (Please Print): _____

I have been offered a copy of the Notice of Privacy Practices for Carolina Orthopaedic & Sports Medicine Center.

Signature: _____ Date: _____

Authorization for Release of Information

Name & Address of Covered Entity Authorized to Release Information:

CAROLINA ORTHOPAEDIC & SPORTS MEDICINE CENTER
2345 COURT DRIVE
GASTONIA, NC 28054

PERSONAL REPRESENTATIVE

A personal representative is anyone that you would like Carolina Orthopaedic & Sports Medicine Center to authorize as privileged to your information, including, but not limited to, prescription refills and/or samples, reasons for a particular visit, billing information, etc. If there are no names listed below, we are assuming that you are declining your option to choose a personal representative. Upon doing so, please keep in mind that our office will not give out any information, including prescription refills, to anyone other than the patient or parent/guardian.

Personal Representative: Initial Each Item That Is Subject to This Authorization.

_____ Leave Information on the Voice Mail

_____ Leave Information With My Spouse

_____ Leave Information With the Following Persons: _____

Description of Information to be Released.

☐ Information Results From Any Tests or X-Rays

☐ Other Information as Described: _____

This authorization shall be in force and effect until revoked by the patient, representative, or representative signing the authorization.

The permitted use of the information is to inform the patient.

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Health History Form

Patient Name: _____

Birth Date: _____ Age: _____ ☐ Right-Handed ☐ Left-Handed

Primary Care Physician: _____

Patient Medical History

☐ Stroke	☐ Asthma	☐ Alcoholism	☐ Stomach Ulcers	☐ MRSA
☐ Heart Trouble	☐ Kidney Failure	☐ Acid Reflux	☐ Liver Trouble	☐ Infections
☐ High Blood Pressure	☐ Kidney Stones/UTI	☐ Lung Disease	☐ Thyroid-Hyper/Hypo	☐ Anxiety
☐ Diabetes	☐ Lupus	☐ Tuberculosis	☐ Depression	☐ Other Illnesses
☐ Arthritis	☐ Cancer	☐ Atrial Fibrillation	☐ Sleep Apnea	
☐ Irregular Heart Rate	Type:_____	☐ COPD	☐ AIDS/HIV	
☐ Gout	☐ Osteoporosis	☐ Phlebitis	☐ Chronic Heart Failure	
☐ Seizures	☐ Bleeding Disorders	☐ Anemia	☐ Hepatitis	

Past Surgical Procedures _____

_____

Personal History

Tobacco/vape/e-cig use? ☐ Yes ☐ No _____ packs per day for _____ yrs. Date started? _____ Date quit?_____

Alcohol use? ☐ Never ☐ Rare ☐ Occasional ☐ Moderate Drinks per single occasion: _____

Regular exercise routine? ☐ Yes ☐ No Describe: _____ Hobbies? _____

Family Medical History (Please write beside diagnosis if this was Mother, Father, Sibling, Child, Family)

☐ Stroke _____ ☐ Diabetes _____ ☐ Seizures _____ ☐ Cancer _____

☐ Heart Trouble _____ ☐ Arthritis _____ ☐ Mental Illness _____ ☐ Bleeding Disorder _____

☐ High Blood Pressure _____ ☐ Gout _____ ☐ Kidney Trouble _____ ☐ Alcoholism _____

☐ Other Illnesses _____

Medications

Allergies to medications? ☐ No ☐ Yes: _____

_____

Current medications/dosages? ☐ No ☐ Yes: _____ _____

_____ _____

Latex allergy? ☐ No ☐ Yes _____ _____

Taking blood thinners? (Please Circle) Arixtra Aspirin Coumadin Eliquis Lovenox Plavix Pradaxa Other

Review of Systems (Recent or Current Conditions)

☐ Weight Change	☐ Hearing Changes	☐ Shortness of Breath	☐ Urinary Burning	☐ Other Illnesses
☐ Fever/Chills	☐ Ear Pain/Ringing	☐ Cough	☐ Frequent Headaches	_____
☐ Night Sweats	☐ Nosebleeds	☐ Nausea/Vomiting	☐ Seizures	_____
☐ Poor Appetite	☐ Hoarseness	☐ Stomach Pain	☐ Numbness	_____
☐ Rash	☐ Difficulty Swallowing	☐ Frequent Diarrhea	☐ Weakness	_____
☐ Insomnia	☐ Tooth/Gum Trouble	☐ Frequent Constipation	☐ Backache	_____
☐ Depression	☐ Chest Pain	☐ Blood in Stool	☐ Joint Pain	_____
☐ Anxiety	☐ Abnormal Heartbeat	☐ Incontinence	☐ Joint/Limb Swelling	_____
☐ Visual Changes	☐ Blackouts	☐ Urinary Frequency	☐ Lumps/Masses	_____

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Primary Injury or Condition

What makes it worse?

☐ Sitting ☐ Standing ☐ Lying Flat ☐ Doing Nothing ☐ Bending
☐ Lifting ☐ Twisting ☐ Coughing ☐ Walking ☐ Sneezing

What makes it better?

☐ Sitting ☐ Standing ☐ Lying Flat ☐ Doing Nothing
☐ Walking ☐ Exercise ☐ Heat ☐ Cold

Circle Your Pain Levels: (Least Pain …… Most Pain)

At Worst 0 · 1 · 2 · 3 · 4 · 5 · 6 · 7 · 8 · 9 · 10

At Best 0 · 1 · 2 · 3 · 4 · 5 · 6 · 7 · 8 · 9 · 10

Today 0 · 1 · 2 · 3 · 4 · 5 · 6 · 7 · 8 · 9 · 10

Since the Start of the Problem, Are You:

☐ Improving ☐ Getting Worse ☐ Staying the Same

Whom have you seen for this problem?

_____

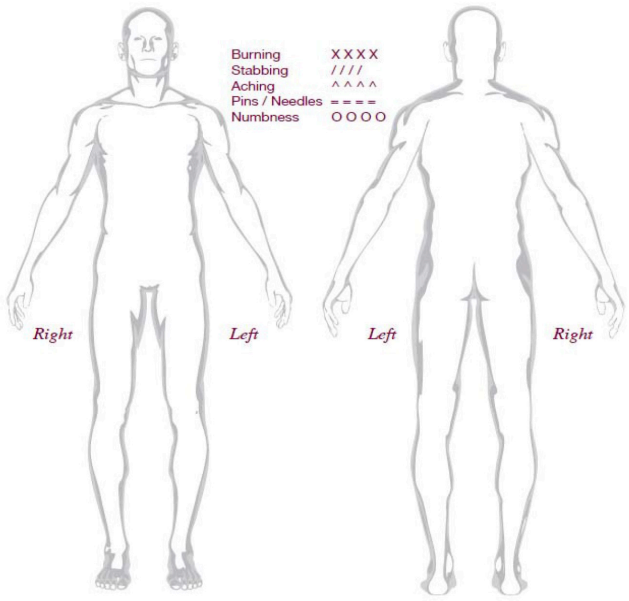
What test(s) have been done? When? Where?

X-Ray _____ CT Scan _____

MRI _____ Nerve Studies _____

Other _____

Mark the areas on your body where you feel the described sensations.
Use the appropriate symbol.
Mark areas of radiation, include all affected areas.



What treatment(s) have you had for this problem?

Medications _____ Helped? ☐ Yes ☐ No ☐ Not Sure

Physical Therapy Helped? ☐ Yes ☐ No When? _____ How many visits? _____

Injections (Type/Date) _____ Helped? ☐ Yes ☐ No ☐ Not Sure

Surgery (Type/Date) _____ Helped? ☐ Yes ☐ No ☐ Not Sure

Other _____ Helped? ☐ Yes ☐ No ☐ Not Sure

Have you ever had the same or similar problem before? ☐ Yes ☐ No ☐ Not Sure

Has anything helped? _____

Is this a work-related injury? ☐ Yes ☐ No If Yes, Name of Employer: _____

Date of Injury: _____

Patient Name (Please Print): _____

Patient Signature: _____ Date: _____

Physician/PA Signature: _____ Date: _____

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Office & Financial Policies

We would like to thank you for choosing Carolina Orthopaedic & Sports Medicine Center as your medical provider. To keep you informed of our current office and financial policies, we ask that you read and sign the following acknowledgment.

Late Appointments: Arriving 15 minutes late for your appointment may result in rescheduling of your appointment.

Cancelled Appointments: We request a 24-hour notice if you are unable to keep a scheduled appointment so that we may offer that time to another patient. Please call our office so that we can reschedule your appointment. Carolina Orthopaedic & Sports Medicine Center reserves the right to charge a no-show fee. Excessive no-shows will result in possible termination from the practice.

No Insurance: We require patients without insurance to provide a deposit at the time of service, and the remaining balance is due at check out. If you are unable to pay your balance in full, you will need to make prior arrangements with a financial counselor.

Liability Injury: Carolina Orthopaedic & Sports Medicine Center does not provide deferred billing for liability cases. Payments for liability services are required at the time of service.

Insurance: Please bring your insurance card with you at the time of your appointment. Insurance plans with which we contract require that all co-pays be paid prior to any services being rendered. The co-payment requirement cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier. If you do not have your co-pay at the time of your visit, your appointment may be rescheduled.

You are responsible for any co-insurance, deductibles, or non-covered services as required by your insurance. You will receive a statement from our office indicating what your insurance has paid. Any remaining balance is due upon receipt of the statement.

Medicaid Patients: Medicaid patients must present a current Medicaid card and be prepared to pay any applicable co-payments. If you do not bring your current Medicaid card and applicable co-payment, your appointment will be rescheduled.

Workers' Compensation: Workplace injury care requires authorization from your employer's Workers' Compensation carrier before we can process any of your medical claims. Failure to properly report this injury to your employer may result in your claims being denied. Denied claims will be your responsibility.

High Deductible Health Plans: High Deductible Health Plans (HDHP) are consumer-driven health plans that have a minimum deductible and out-of-pocket limit that is set each year and adjusted for inflation, if necessary. If you have a HDHP, Carolina Orthopaedic & Sports Medicine Center requires a deposit fee to hold your surgical appointment. The deposit will be applied to whatever patient balance is not paid by your health insurance plan (such as deductibles, co-insurances, co-pays, and/or non-covered services).

HMO: For HMO insurance plans that we participate with, your insurance carrier requires that you obtain a referral from your primary care physician (PCP) before receiving services. Please bring that referral with you. Any services received without a referral or proper authorization will be your responsibility.

UCR (Usual and Customary Rate): We are committed to providing the best possible care for our patients, and we charge what is usual and customary for our area. If we do not have a contract with your insurance company, you are responsible for payment-in-full regardless of any insurance company's arbitrary determination of UCR.

Delinquent Accounts: Delinquent accounts may be assigned to a collection agency. All collections costs will be added to your outstanding balance. Failure to pay a delinquent account will result in you not being able to make an appointment and/or possible termination from the practice.

Returned Checks: A $25.00 charge will be added to your account for any checks returned or ACH withdrawals rejected by your bank for any reason in addition to any fees that your financial institution may charge you.

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Office & Financial Policies

Disability or Insurance Forms: There will be a charge of $15.00 for the completion of medical forms. Payment is due at the time that you pick up the forms. Please allow 7 – 10 business days for the completion of these forms. If you would like the forms mailed to you or your insurance company, payment will be due prior to mailing.

Medical Records: We will provide you with a copy of your medical records upon request. You will need to sign a letter of release at the time of pickup. Please allow 5 – 7 days for us to copy your records. If you wish for your records to be mailed, there may be an associated fee to cover the mailing costs. You may be charged for additional copies of your medical records. Rates charged are within North Carolina state statutes.

X-Rays: We will provide you with a copy of your X-rays upon request. You will need to sign a letter of release at the time of pick-up. Please allow 48 hours from the time of your request. There is a $5.00 charge per CD containing your X-rays and is payable at the time of pickup.

Consent for Medical Treatment: I authorize Carolina Orthopaedic & Sports Medicine Center physicians and personnel to render medical treatment and evaluation if needed for this appointment and all appointments. I further authorize X-rays, injections, casting, or other diagnostic tests and treatments that may be necessary.

The authorization shall remain in effect until rescinded by the patient or authorized individual.

Signed (Patient or Authorized Individual) Date