

Patient Name: _____ **SSN:** _____

Address: _____
Street City State Zip

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

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 or guardian's name: _____

SSN & Birthdate of spouse or parent or guardian: _____

Name & Phone# of Emergency Contact: _____

Reason for today's visit: _____

Is this a work-related? _____ **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: _____

SS # and Birthdate of Insured: _____

Secondary Insurance Company: _____

Name of Insured: _____ **Relationship to patient:** _____

Employer of Insured: _____

SS # and Birthdate 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 and Sports Medicine Center, P.A.

Signature of patient, parent or guardian: _____ **Date:** _____

Patient Name: _____

DATE OF ACCIDENT: _____

Type of Accident: **Auto** **Work Related** **Other**

If work related, give name & phone # of person who will verify: _____

How and when did the accident happen? _____

Patient Signature

Date



GUIDELINES FOR PRESCRIPTION REFILLS

1. Our office requires a **24-hour notice for prescription refills.**
2. Medications will be refilled between **9 AM and 4 PM Monday - Friday.** No refills on the weekends or holidays. The "on-call" physician will not refill medications.
3. Safety of your prescriptions is YOUR responsibility. **LOST PRESCRIPTIONS WILL NOT BE REFILLED.** Lock up your prescriptions medicines and keep them away from children.
4. Our physicians may not refill prescriptions for pain medicine if you are receiving similar medicines from another physician.
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 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, parent, or guardian: _____



Acknowledgement of Receipt of Notice of Privacy Practices

Chart #: _____ Date of Birth: _____

Patient Name (please print): _____

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

Signature

Date

Authorization for Release of Information

Name & Address of Covered Entity Authorized to Release Information:

**CAROLINA ORTHOPAEDIC & SPORTS MEDICINE CENTER, P.A.
620 SUMMIT CROSSING PLACE, SUITE 108
GASTONIA, NC 28054**

PERSONAL REPRESENTATIVE

A personal representative is anyone that you would like for Carolina Orthopaedic & Sports Medicine Center, P.A. to, including, but not limited to, prescription refills and/or samples, reasons for a particular visit, billing information, etc. If there are no name 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 patient guardian.

Personal Representative to receive information. Initial each 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 xrays.

Other information as described: _____

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

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

Health History From

Name you prefer to be called: _____

Date of Birth _____ Age _____

Right-Handed Left-Handed

Primary Care Physician _____

Patient Medical History

- | | | | | |
|---|---|---|--|--|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Gout | <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> AIDS/HIV |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Seizures | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Anemia | <input type="checkbox"/> Other Illnesses |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Serious Injuries | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Liver Trouble | <input type="checkbox"/> MRSA |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Thyroid Trouble | <input type="checkbox"/> Infections |
| <input type="checkbox"/> Irregular Heart Rate | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety |

Past Surgical Procedures

Tobacco Use? Yes No _____ packs per day for _____ years. Year quit? _____

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

Regular Exercise Routine: Yes No Describe _____ Hobbies? _____

Family Medical History

- | | | | | |
|--|------------------------------------|---|--|--|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures | <input type="checkbox"/> Cancer | <input type="checkbox"/> Other Illnesses |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Bleeding Disorder | _____ |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Gout | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Alcoholism | _____ |

Medications

Allergies to Medications: None List: _____

Latex Allergy? Yes No _____

Current Medications / Dosages

See List _____

Review of Systems (recent or current conditions)

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

Primary Injury or Condition

What makes it worse?

- Sitting Standing Lying Flat Doing nothing
 Bending Lifting Twisting Coughing Sneezing

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 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 _____

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 _____

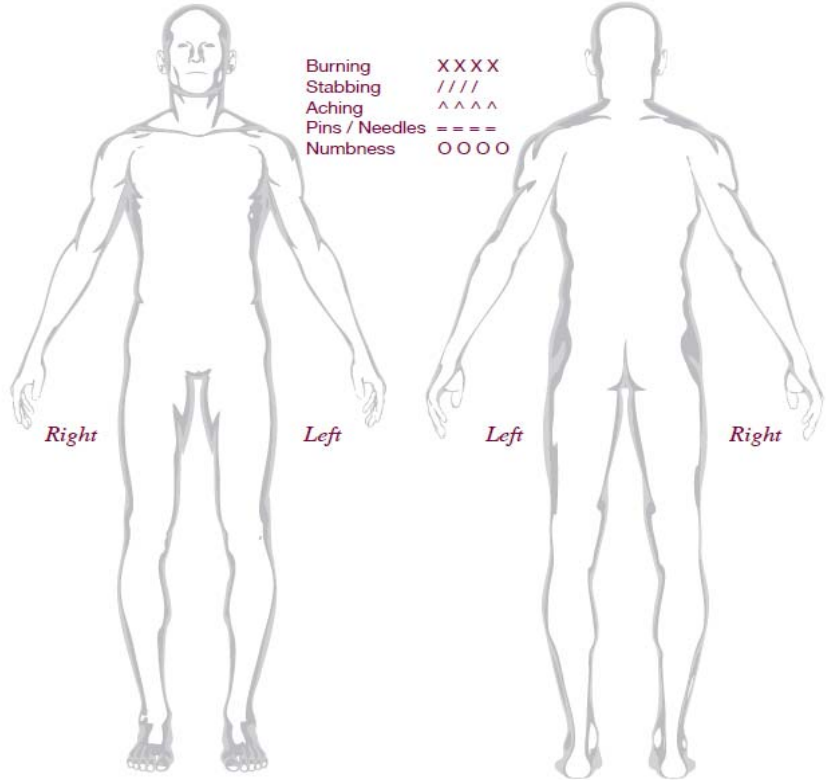
Has anything helped? _____

Is this a work injury? Yes No If yes, Name of Employer: _____

Date of injury: ____ / ____ / ____

Patient Signature: _____ Date: ____ / ____ / ____

Physician / PA Signature: _____ Date: ____ / ____ / ____



Office & Financial Policies

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

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. COSMC 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: COSMC 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, COSMC 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 Physician Care (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.

Return 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.

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 5 - 7 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 a copy of your medical records upon request. You will need to sign a letter of release at the time of pick-up. 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 of your medical records. Rates charged are within North Carolina state statues.

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, P.A. 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 patient or authorized individual.

Signed (patient or authorized individual)

Date