Date: ______________________________

Patient Information

Last Name: ______________________________ First Name: ______________________________ MI: __________

Date of Birth: ____/____/_____ Age: __________ SSN: __________________________________

Sex at Birth: Male or Female Sex You Identify as or want to be Addressed as (Preferred Sex): Male or Female

Race: Black or African American / American Indian or Alaska Native/ Asian / Caucasian / Hispanic/ Pacific Island/ Hawaiian/ Refused (*Please circle)*

Ethnicity: □ Hispanic / Latino □ Not Hispanic/Latino

Mailing Address: ____________________________________ City/State:_________________________ Zip Code: _______

Primary Phone Number: ______________________________ Alternate Phone Number: ____________________________

Alternate Address: __________________________________ City/State: ________________________ Zip Code: ________

Email Address: ____

Martial Status: Single Married Divorced Widowed Life Partner Primary Language: __________________________
(*Please circle)*
Employment Status: Full Time / Part Time / Student / Self Employed / Unemployed / Active Duty / Disabled /
(*Please circle)* Medical Leave /Unknown / Retired – If Retired, Date of Retirement: ___________________________

Patient's Employer: (If Student, list name of school) ____

Employer Address: ____

Employer Telephone #: ____

Family Physician: ____

Spouse or Parent/Guardian

Relationship to patient: ___________________________ Name of Spouse or Guardian: ______________________________

Date of Birth: ____/____/____ SSN: ______________________________ Telephone Number: __________________________

Address: ____ City/State: _______________________ Zip code: ___________

Employer: ____

Employer Address: ____

Employer Telephone #:____

Revised 1/24/2020

WITHOUT THE FOLLOWING INFORMATION, WE CAN NOT FILE A CLAIM AND YOU WILL BE RESPONSIBLE FOR THE BILL ON THE DAY OF SERVICE

Primary Insurance Information

Name of Insurance: ____

Card Holder Name: ____________________________________ Relationship to Patient: _________________________

Card Holder SSN: ______________________________________ Date of Birth of Card Holder ____/____/_____

Policy Number: ____ Group Number: _____________________________

Employer: ____

Secondary Insurance Information

Name of Insurance: ____

Card Holder Name: ____________________________________ Relationship to Patient: _________________________

Card Holder SSN: ______________________________________ Date of Birth of Card Holder ____/____/_____

Policy Number: ____ Group Number: _____________________________

Employer: ____

HIPAA Contacts

Name of person(s) you wish to receive any test results, medical or billing information on your behalf:

Name: ______________________________________ Relationship to you: ___________________________________

Date of Birth: ____/____/_____ Primary Telephone Number: ____

Name: ______________________________________ Relationship to you: ___________________________________

Date of Birth: ____/____/_____ Primary Telephone Number: ____

□Check box if you would like yourself to be your **only** HIPAA contact.

I acknowledge that this HIPAA authorization remains in effect until I give written notification to discontinue.

____ __________________________________ _____/_____/_____

Print Name (PARENT OR GURADIAN IF PATIENT IS UNDER 18) Signature Date

Patient Portal

Southern Orthopaedics and Sports Medicine PC have a patient portal, where you can access your medical information online, anytime.

Would you like to sign up for Patient Portal? □ Yes □ No □ Already Signed Up

If yes, we will email you an invitation to the email address you provided above to setup personal, secure account and you can access your important health information at your convenience. You can communicate with us and verify your next appointment.

Cancellation/No Show Policy

Our goal is to provide quality medical care in a timely manner. In order to do so, we have implemented an appointment/cancellation policy. If you are unable to keep your appointment, please call at least 24 hours in advance to reschedule.
Appropriate cancellation of an appointment is calling the office and speaking with the front office staff or leaving a message on the voicemail box by 10:00 a.m., one (1) working day in advance of the schedule appointment time.
If a patient fails to give appropriate notice three times in a 12-month period, they may be subject to be dismissed from the practice.

I have read and understand the information above and I agree to the terms described:

X____ Date: ____

Signature of Patient or Legal Guardian

WHOM MAY WE THANK FOR REFERRING YOU TO US?

Doctor's Name / Address: ____ Phone: ___________________________

□ Friend □ Family □ Yellow Pages □ Social Media □ SSI □ Television □ Worker's Comp □ Other ____________________________

PAYMENT POLICY

The doctors and staff of Southern Orthopaedics and Sports Medicine, PC are committed to providing our patients with the **best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to relieve this, we need your assistance and understanding of our payment policy.** Once we have verified your insurance coverage, we will submit a claim for the services rendered; however, all co-payments and/or co-insurance amounts and deductibles are due at the time of service. If you do not have insurance coverage, full payment is due at the time of service. We accept cash, personal checks, or credit cards.

Auto Accidents / Other Accidents

We do not routinely accept auto insurance in lieu of patient payment. If your auto insurance policy has adequate med-pay **which can be verified, we will consider this on a case by case basis. We do not agree to postpone payment due to litigation** or other party liability. In these cases, the patient is responsible for payment at the time of service.

Worker's Compensation

Patients who are injured on the job must have immediately reported the injury to their employer. The employer will be responsible for directing the employee to a doctor who is listed on their **PANEL OF PHYSICIANS**. Before we will be able to see you as a patient, **we will require that your employer or worker's compensation panel contact our office by telephone or fax** verifying that your workers compensation claim is valid. **If our office does NOT receive the information requested from your company, we will have to reschedule the appointment**. This information is necessary to avoid the patient being responsible for the bill. Should your claim be controverted for any reason you will be responsible for payment.

Medicaid

Southern Orthopaedics and Sport Medicine is no longer accepting any form of Medicaid. We will only file these claims if the patient has gone through the local Emergency Room when our practice is on call as long as the patient follows the guidelines listed: The patient must see their Primary Care Physician to obtain a referral. Without a referral we **cannot** schedule an appointment for the patient per Medicaid guidelines established October 1, 2003. Please bring a copy of your Medicaid card to each visit otherwise we will have to bill you directly. You will be responsible for all services not covered by Medicaid. This will include certain supplies and any office visits made after your twelve (12) authorized visits. **EXCEPTION: IF YOU WERE REFERRED BY THE EMERGENCY DEPARTMENT OF SOUTHEAST GEORGIA HEALTH SYSTEM**.

Insurance

Your insurance coverage is a contract between you and your insurance company. As a courtesy, we bill your office visit, surgery charges, and ALL Medicare services with your insurance carrier. You may be requested to pre-pay your unmet deductible and co-insurance prior to any surgery performed or following emergency services. If you need to set up an **extended payment arrangement, contact our Insurance Department. If no payment has been received after 90 days,** from date the services were rendered, necessary collection procedures will begin. Our billing department will be happy to answer any questions or assist you with any problem you may have with your account. I understand it is my obligation to notify the health care provider about any other party who may be responsible for paying for my treatment.

Collection and Returned Checks

There will be a $30.00 fee for returned check(s). **This fee plus the amount of the check must be paid within ten (10) business days from the return of the check by either: cash, money order, certified check or credit card to avoid further action against you.** If it becomes necessary to refer your account to an outside collection agency, a 30% collection fee on the unpaid balance will be assessed.

I HAVE READ AND UNDERSTAND THE ABOVE CONTRACT: ____

Authorization for Release of Information

I authorize any holder of medical or other information about me to release any information needed to the Social Security Administration, Healthcare Financing Administration or its intermediaries, or any other insurance company for this or a related Other Insurance Company/Medicare claim. I permit a copy of this authorization to be used in place of the original.

Date: _________________________ **Signature:** ____

parent's signature (if patient is a minor)

MEDICAL HISTORY / ACCIDENT REPORT

Date_______________

Patient Name: ____ Age: __________________________

Reason for seeing the doctor today: (**be specific--what happened?**) ______________________________

____

Where did injury/accident occur? _________________________________ Date of Injury/accident: ________

Is there other insurance that will pay this bill (ie. AUTO, WORKERS' COMP)? ❑ Yes ❑ No

If so, what insurance? ____

Was this job-related? ❑ Yes ❑ No Have X-rays been made? ❑ Yes ❑ No

Current Medications: (include dosage and frequency) ____

____

Do you have past or current history of the following: (Please check **ONLY** the ones that apply)
(EVEN IF YOU ARE OR ARE NOT TAKING MEDICATION FOR THE PROBLEM)

___ Kidney Disease/Dialysis ___ Emphysema ___ Depression
___ High Cholesterol ___ High Blood Pressure ___HIV
___ Heart Disease (or Murmur) ___Ulcers ___ Thyroid Disorder
___Anesthesia Reaction ___Hepatitis ___Asthma
___Diabetes ___Pacemaker ___ Other

Have you ever been treated for any prior orthopaedics injuries? ❑ Yes ❑ No If yes, please list:

____

Allergies (Medications, Metals, Adhesives, etc.)? ❑ Yes ❑ No If yes, please list:

____

List **ANY** surgical procedures you have had in the past and the name of the surgeon:

____

Do you smoke? ❑ Yes ❑ No How many cigarettes per day? _______

Do you drink alcohol? ❑ Yes ❑ No How much? _________________ Occupation: __________________

Are you pregnant? ________________ Are you right or left handed? ❑ Right ❑ Left

Review of Symptoms (please write yes or no) ______ Shortness of Breath ______Cough

______Chest pain ___ Abdominal pain ______Dizziness

___ Urinary difficulty ___ Muscle or joint pain ______ Other: _________________

3231 Glynn Avenue | Brunswick, GA 31520 | 912.265.9006

MEDICATION AGREEMENT & REFILL POLICY

As part of your treatment, our medical staff may prescribe medication for you. Many of these medications can have serious side effects if they are not managed properly. Your health and safety are very important to us, and we need your help to make sure your treatment follows our guidelines. If Southern Orthopaedics & Sports Medicine has any questions regarding your healthcare, including medications, we reserve the right to contact your other treating physicians and pharmacies.

1. I agree to follow the dosing schedule prescribed to me by my doctor.
2. I agree to <u>never</u> share my medications with others, nor will I sell or exchange my medications for any reason.
3. I agree to always keep my medications safeguarded and within my control.
4. I agree to notify Southern Orthopaedics if I experience any adverse effects or dosage problems with my prescribed medications. I will not discard any unused medications. Before any new medication can be prescribed, I may be asked to bring any unused medications to Southern Orthopaedics for disposal.
5. I agree that if I receive narcotic prescriptions from Southern Orthopaedics, I am not allowed to receive the same type of medications from other physicians without express consent or consultation with Southern Orthopaedics.
6. I agree to use only <u>one</u> pharmacy for my pain-related medication unless extenuating circumstances prevent this from being possible. In this event, I will notify Southern Orthopaedics of all pertinent information pertaining to additional pharmacies, mail-order, or other sources.
7. I understand that medication refill prescriptions involving narcotic pain medicine requires a <u>scheduled</u> office visit when my doctor is on duty in the office. Narcotic pain medication refills will not be called into a pharmacy, nor will they be increased over the telephone.
8. **I agree to keep all scheduled appointments. I understand that no medications will be given for canceled or no-show appointments.** I understand that if I am more than 15 minutes late to my appointment time, I will have to reschedule.
9. I understand that medication refills cannot be made after hours, on weekends, or on holidays.
10. I understand that I should not drive or operate heavy machinery while I am taking medications that may cause drowsiness or impaired cognitive function.
11. I understand that I am solely responsible for the safekeeping of my medications and I must treat my medications as I would my money or valuable possessions. Southern Orthopaedics will have no obligation to replace LOST OR STOLEN prescriptions or medications.
12. I understand that abusive behavior or harassment toward any Southern Orthopaedics & Sports Medicine's staff will **NOT** be tolerated. Harassment includes, but is not limited to, more that two (2) phone calls to the office in one business day.
13. I understand that I cannot present to Southern Orthopaedics unannounced seeking medications refills.
14. I understand that dealing with a forged or falsified prescription will result in immediate dismissal from Southern Orthopaedics & Sports Medicine. I understand that I may be dismissed from Southern Orthopaedics & Sports Medicine if I do not abide by the terms of this medication agreement.

By signing the agreement, you affirm that you have the full right and power to be bound by this agreement and that you have read, understood, and accepted these terms. No medications will be prescribed without acceptance of this agreement.

Pharmacy Name ____________________________

Phone Number ______________________________

Patient's Name ______________________________

Date of Birth ________________________________

Patient's Signature___________________________

Date _______________________________________