SOUTHERN ORTHOPAEDICS & SPORTS MEDICINE
A Joint Effort

Dr. Michael J. Dunn
Board-Certified: American Board Orthopaedic Surgery
Fellowship Trained in Hand, Upper Extremity & Microsurgery
Certifiticate Of Added Qualification For Surgery Of The Hand
Fellow of the American Academy of Orthopaedic Surgeons

Dr. J. Kevin Brooks
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Dr. Ralph W. Morales
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R. Blake Burrell, PA-C
Physician Assistant

Richard C. Sipe, PA-C
Physician Assistant

Mark Dunham NP-C
Nurse Practioner

INTRO FORM

DATE: _____

Name: _____ SSN#: _____
Last First Middle

Home Address: _____ City/State: _____ Zip: _____

Mailing Address: _____ City/State: _____ Zip: _____
(If part-time resident please list alternate address)

Home Phone: _____ Work Phone: _____ Cell: _____

Date of Birth: _____ Age: _____ Marital Status: M S D W

Sex: ❑ Male ❑ Female Race: ❑ White ❑ Black ❑ Hispanic ❑ Other: _____

E-mail: _____

Primary Language you speak: _____

Patient's Occupation: _____

Patient's Employer (if student, name of school): _____

Employer Address: _____ City/ST/ZIP _____

Spouse or Guardian Information:

Name: _____ SSN: _____ DOB: _____

Employer: _____

Relationship to patient: _____

Emergency Contacts: / HIPPA Contacts: Name and Phone: _____

Nearest Relative not living with you: Phone: _____

Nearest Friend not living with you: Phone: _____

Primary Physician: Phone: _____

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

Doctor's Name/Address: _____ Phone: _____

❑ Friend, ❑ Family, ❑ Yellow Pages-Bellsouth, ❑ St. Simons Island or Peach Pages, ❑ Radio,

❑ Work Comp ❑ Other: _____

Please sign verifying all information on this form is correct: _____

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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: _____

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 me 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 medpay 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 phone 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 Sports 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 can not schedule an appointment for the patient per Medicaid guidelines established October 1, 2003. Please bring a copy of your Medicaid card to. Punch 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 ED: 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 and 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 the 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.

Collections And Returned Checks

There will be a $30.00 fee for all returned check. This fee plus the amount of the check must be paid with 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, Health care 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

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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 never 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 one 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 scheduled 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 _____ Date of Birth _____

Phone Number _____ Patient's Signature _____

Patient's Name _____ Date _____

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FEDERAL LAW ENFORCEMENT TRAINING CENTER PATIENTS (Department of Labor-Workers Comp)

In order to FILE your claims for the treatment of a Workers Comp Injury sustained while training at FLETC in Brunswick, Georgia, we must have the Department of Labor Case Number assigned to this injury.

You should receive this number within three (3) weeks by e-mail or mailed directly to your "HOME" address. If you do not receive it within this time period please contact your agency directly and have them provide the case number to you.

Per US Department of Labor, you are responsible for obtaining this case number and providing it to our office. Should your case be denied for any reason it is your responsibility to provide us with any Healthcare Insurance coverage you currently have. Please remember Healthcare Insurance Companies have a claims filing limit.

******* IF THE CASE NUMBER IS NOT PROVIDED TO US (Southern Orthopaedics)*******
OR SHOULD YOUR CASE BE DENIED BY THE US DEPARTMENT OF LABOR FOR ANY REASON YOU WILL BE PERSONALLY RESPONSIBLE FOR ALL CHARGES.

If you have any questions or have received your Department of Labor Case Number please contact Lynn or Nikki at 912-265-9006 x 320.

Acknowledgement

I understand that the Department of Labor requires that I obtain a Case number and that the Case number needs to be reported to Southern Orthopaedics. I also understand that if I do not obtain the Case number that I am personally responsible for all costs associated with my injury and that I authorize Southern Orthopaedics to collect the money owed to them by any means available

_____ _____

Patient Signature Date

_____

Patient Patients Name

Case Number - MANDATORY

HIPPA Notice of Privacy Practices

SOUTHERN ORTHOPAEDICS & SPORTS MEDICINE, PC

3231 GLYNN AVENUE
BRUNSWICK, GA 31520

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1, Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and related services. This includes the coordination or management of your health care with a third part. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures; Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object, unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our **HIPPA** Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature: _____ Date: _____