



Today's Date ____/____/____

Medical Record #: _____

******Please present a valid insurance card and a valid driver's license to the receptionist******

Last Name: _____
 First Name: _____ MI _____
 Name you prefer to be called _____
 Street Address _____
 City _____ State _____ Zip _____
 Billing Address _____
 City _____ State _____ Zip _____
 Home Phone (____) _____ - _____
 Work Phone (____) _____ - _____ Ext _____
 Alternate/Cell Phone (____) _____ - _____

Date of Birth: ____/____/____ Age: _____
 Social Security # _____ Sex: Male Female
 Marital Status: S M D W Other _____
 Patient's Occupation _____
 Employer _____
 Employer's Address: _____
 City _____ State _____ Zip _____
 Spouse's Name: _____
 Spouse's Date of Birth: ____/____/____
 Spouse's Daytime Phone Cell/Work(____) _____ - _____

******PLEASE COMPLETE IF PATIENT IS A MINOR, STUDENT OR HAS A LEGAL GUARDIAN ******

Responsible Party's Name _____
 Relationship to Patient _____ Date of Birth: ____/____/____ Social Security #: _____
 Address _____ City _____ State _____ Zip _____
 Home Phone (____) _____ Alternate/Cell Phone (____) _____ Work Phone (____) _____
 Employer Name & Address _____ Occupation _____
 Emergency Contact _____ Relationship _____ Phone (____) _____

Reason for visit today <input type="checkbox"/> Right <input type="checkbox"/> Left Body Part _____	Date of onset _____
Is this due to an injury? Y N explain _____	
Any prior treatment for this condition? (meds, PT, Surgery)? _____	
Any X-Rays taken? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, where? _____	Date Taken: _____
Whom may we thank for referring you today? _____	Primary Physician Care _____
Work related? <input type="checkbox"/> Yes <input type="checkbox"/> No If there has been a claim filed we must have written authorization from the Worker's Compensation adjuster, including claim number and all billing information before you will be seen.	

INSURANCE INFORMATION:

PRIMARY INSURANCE: **All POS, HMO, Medicaid, WellCare, Amerigroup Plans Require a Referral from your PCP**

Insurance Carrier Name: _____ PPO, POS, or HMO (Circle One)
 Policyholder Name _____ Date of Birth ____/____/____
 S.S.# _____ Patient's Relationship to Policyholder _____
 Policy # _____ Group # _____ SPECIALIST COPAY \$ _____

SECONDARY INSURANCE (If Applicable)

Insurance Carrier Name: _____ PPO POS HMO (Circle One)
 Policyholder's Name: _____ Policyholder's Date of Birth: ____/____/____
 S.S.#: _____ Relationship to Patient: _____
 Policy #: _____ Group #: _____ SPECIALIST COPAY \$: _____

Our Office Insurance Policy:

I authorize release of any medical information necessary to process my insurance claim to the insurance company shown above. I hereby authorize payment of medical benefits due me to Georgia Sports Orthopedic Specialists, PC. I understand that even if a patient carries medical insurance, professional services are rendered and charged to the patient, not the insurance company. In the event insurance payments are received directly by me for services rendered that have not been paid for, I promise to immediately sign over and forward those payments to Georgia Sports Orthopedic Specialists, PC. I accept financial responsibility for all charges incurred and hereby promise to pay all charges promptly, including those not paid by my insurance. If my account has to be referred to outside collection, I will be charged a service charge to cover the additional charges.

Signature _____ Date ____/____/____

Current Medical History:

	YES	NO		YES	NO
Anemia			HIV/AIDS or Known Risk		
Asthma			Irregular Heartbeat		
Bleeding Disorders			Kidney Disease		
Hemophilia/ Free Bleeding			Latex Allergy		
Other:			Liver Disease		
Cancer			Lung Disease		
Claustrophobia			Nerve Problems		
Diabetes			Osteoarthritis		
Epilepsy			Rheumatic Fever		
Glaucoma			Rheumatoid Arthritis		
Heart Attack			Sickle Cell Disease		
Heart Disease			Stroke		
Hepatitis Type <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C			Tuberculosis		
High Blood Pressure			Ulcers		
Please list any other health problems:					

Social History:

Occupation _____ (-or-) School _____
Current smoker? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, how many packs per day? _____ Have you quit? How long ago? _____
Do you have any history of alcohol abuse? <input type="checkbox"/> No <input type="checkbox"/> Yes
Do you have any history of drug abuse? <input type="checkbox"/> No <input type="checkbox"/> Yes
Recreational activities / Hobbies
Sports
Current teams you are playing on (name of team and type)

Family Medical History:

	YES	NO	Relationship
Anesthetic complications			
Arthritis			
Cancer			
Diabetes			
Free Bleeding			
Heart Disease			
High Blood Pressure			
Kidney Disease			
Stroke			
Ulcers			
Other			

Review of Systems: Please indicate if you are experiencing any of the following:

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
<u>General:</u> Fever			<u>GI:</u> Poor Appetite		
Chills			Nausea		
Easy Bruising			Vomiting		
Memory Loss			Ulcers		
Night Sweats			Blood in Stool		
<u>Head:</u> Sinus Problems			Abdominal Pain		
Visual Problems			<u>GU:</u> Blood in Urine		
Dizziness			Burning w/Urination		
Hearing Loss			Urinary Retention		
<u>Skin:</u> Rashes			Urinary Incontinence		
Other Skin Condition			<u>Neuro:</u> Numbness of Feet or Hands		
<u>Heart/Lungs:</u> Irregular Heartbeat			Balance Problems		
Shortness of Breath			Fainting Spells		
Chest Pain			Facial Weakness		
Heart Attack			<u>Bones:</u> Joint Pain		
Productive Cough			<u>Joints:</u> Joint Swelling		
Wheezing			Back/Neck Pain		
Legs Swelling			Muscle Pain		
			Muscle Cramping		
			Morning Stiffness of Hands/Wrists		

Past Surgical History: Please list any surgical procedures and dates:

<u>Surgery</u>	<u>Date</u>

Current Medications: Please list all current medications and dosages.

<u>Medication</u>	<u>Dosage</u>	<u>Drug Allergies</u>	NONE

I authorize release of medical information (which may include medical treatment for physical/emotional illness, communicable diseases, alcohol and drug treatment, and HIV/AIDS related information) to my insurance carrier, employer/employer's representative (Workers Compensation), or to my above listed physicians for services rendered at Georgia Sports Orthopedic Specialists, PC. I also authorize release of payment information from my insurance carriers to Georgia Sports Orthopedic Specialists, PC.

Signature: _____ Date ____/____/____



Name _____
Date of Birth ____/____/____

PRACTICE FINANCIAL POLICY

If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our financial policy.

- Co-payments for office services are required at the time you register.
- As a courtesy, we will process and file your insurance claims for services at no cost to you.
- For services that are covered by indemnity insurance (non-HMO/PPO), the practice requires payment of approximately 20% of the total estimated charges or the co-payment specified by your insurance.
- For services that are not covered by insurance, the practice requires payment of 100% of total charges unless payment arrangements have been worked out.
- Returned checks are subject to a handling fee of \$25.00. In the event your account must be turned over for collection, you will be billed and are responsible for all fees involved in that process.
- The completion of insurance/disability forms represents an administrative duty above and beyond the provision of health care. The time and effort involved in providing this detailed information results in significant costs when multiplied over the large number of requests we receive. The refusal of these agencies to cover the costs requires our office to institute the following fees for information required:
 - \$25.00 for completion of loan deferment forms, Family Medical Leave Act forms, Private Disability insurance forms.
 - \$25.00-\$50.00 for a copy of your medical record.
 - \$50.00-\$75.00 for narrative reports detailing diagnosis, treatment and future medical care including work capacity statements in addition to a copy of the medical record.

You must realize that:

1. Your insurance is a contract between you and your employer and/or the insurance company. While we may be a provider of services, we are not a part to that contract. We encourage you to contact your insurance carrier personally in order to remain informed of your benefits.
2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover or which they may consider medically unnecessary, and, in some instances, you will be responsible for these amounts. We will make every effort to ascertain your coverage for our services before treatment and will make you aware of our findings. However, this does not guarantee payment from your insurance carrier.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account at (770)532-2611. We will allow you 60 days to pay any balance remaining after insurance payment. After that time, your account will accrue interest at the rate of 1.5% per month (18% annually, 19.56% APR). Our billing coordinator will make arrangements for monthly payments over an approved term.

By signing this policy, you are agreeing to the financial terms listed above with Georgia Sports Orthopedic Specialists, P.C.

Responsible Party Signature/and or Patient Signature: _____

Relationship of Responsible Party to Patient: _____

Date: ____/____/____



Prescription Policy

1. Georgia Sports Orthopedic Specialists, P.C. is not a pain management clinic. Our physicians will not refill controlled substances multiple times for pain management purposes. All patients who are in need of multiple refills on controlled substances for pain will be referred to a pain management clinic or to their primary care physician.
2. All prescription requests must be received before 2:00pm in order to be filled on the same day.
3. Prescriptions will not be filled after hours, weekends or holidays.
4. Our physicians will not refill prescriptions, which are misplaced, lost or stolen.
5. Due to high volume of calls to our office, please check with your pharmacy after 4:30pm regarding your prescription. If we are unable to refill your prescription someone from our office will contact you at the number you have provided to us.
6. Please request prescription refills from your physician at your appointment.
7. Our physicians will not be able to call in prescriptions if you have not been in for several months, for either existing diagnosed problems and/or for new problems that have not been diagnosed by our physicians, you will be advised to call your primary care physician for those medications or will be referred to the emergency room
8. During the course of treatment with our office, do not obtain pain medications from any other physicians.
9. If you are under a Controlled Substance Contract with a Pain Management physician we will be unable to prescribe any narcotic medications without written permission from that physician.

By signing this policy, you are agreeing to adhere to the prescription policy terms listed above with Georgia Sports Orthopedic Specialists, P.C.

Patient Signature _____ Date _____

Alternative Contact Authorization

I DO DO NOT authorize you to contact or leave messages at my place of work.

Signature: _____ Date: _____

I DO DO NOT authorize you to leave messages on my home answering machine regarding appointments and to inform me that laboratory/diagnostic imaging results are in. Results are never left on answering machines. You will have to contact our office to get those results and may be required to schedule an appointment to discuss results with the physician.

Signature: _____ Date: _____

I authorize Georgia Sports Orthopedic Specialists to release/discuss my medical record with the following individuals:

- | | |
|----------|----------|
| 1) _____ | 2) _____ |
| 3) _____ | 4) _____ |

All revocations of the above releases must be received in writing.

Signature: _____ Date: _____

PATIENT ACKNOWLEDGMENT AND CONSENT

I have been given a copy of *Georgia Sports Orthopedic Specialists, P.C.*'s Notice of Privacy Practices, version effective April 14, 2003. I consent to the uses and disclosures of my health information as outlined in the Notice.

Signature of Patient or Representative

Date

Print Name of Patient

Print Name of Representative

Please describe the Representative's authority to act on behalf of Patient (initial one):

- () The representative is the parent of the patient, who is a minor.
- () The representative is the guardian of the patient, who has been adjudicated incompetent.
- () The representative is acting under a Durable Power of Attorney for Health Care for the patient, and has presented a copy of this document to *Georgia Sports Orthopedic Specialists, P.C.* personnel.

FOR *Georgia Sports Orthopedic Specialists, P.C.* USE ONLY

If acknowledgment of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain their acknowledgment and the reason you could not obtain it:

