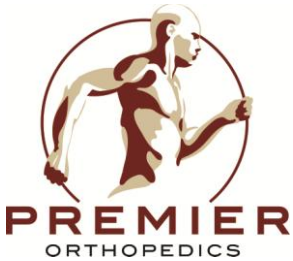

Orthopedics ~ Surgical Center ~ Physical Therapy ~ MRI Services

2405 Osler Court, Albany, GA 31707
1107 South Greer Street, Cordele, GA 31015

PATIENT INFORMATION

Appointments ~

To schedule a visit, call our office at 229-435-1458 or 1-800-543-6185 between 7:30 a.m. to 5:00 p.m. Monday through Thursday and 7:30 a.m. to 12:30 p.m. on Friday. You may also reach us by fax at (229) 435-7073. If you call us after hours, our phone allows you to leave a message or direct you to an answering service. If there is an emergency, the service will contact the on-call physician and relay the message to him. If the situation is critical, go immediately to the emergency center at your local hospital.

To make your visit as successful as possible, we ask that you bring the following information to your appointment:

- New patient forms (for first time patients)
- X-ray films and reports
- MRI films and reports
- Any pertinent test results
- List of current medication(s) including prescription and over the counter types
- Physician referral forms, name and address from your primary care provider (if applicable)
- Insurance card(s) or any letters of authorization for your visit (i.e., BC/BS, CIGNA, Phoebe)
- Medicare , Medicaid, Wellcare, Peach State, or other insurance card
- Picture identification card (i.e., driver's license, etc.)

Insurance, Billing, Payment, and Fees ~

Premier Orthopedics is contracted with many insurance carriers. We are happy to bill your insurance carrier as a courtesy. We require a copy of your insurance card and a picture identification prior to services being rendered. If services are denied by your carrier or if you are ineligible to receive benefits, you are financially responsible for all charges incurred. If you are not able to provide proof of insurance coverage, you will be considered uninsured and you will be responsible for full payment at time of service.

Health care plans vary significantly by carrier, by employer, and/or contract. We cannot know the benefits and exclusions of each patient's health plan. It is your responsibility to know and understand your insurance coverage and benefits and how they will apply to your treatment by the doctor.

Please be prepared to pay for all patient due amount at the time of the service. This includes:

- Co-payments (We will not bill for Co-Pays)
- Co-insurance
- Deductibles
- Outstanding Balances

For your convenience, we accept cash, checks, debit cards, Visa, MasterCard, Discovery, American Express, and Care Credit. If payment is not made at the time of service, there will be a $15.00 fee added to your account to cover our costs associated with processing patient statements.

Returned Checks: There will be a $30.00 service charge on returned checks.

Insurance: We may accept assignments of insurance benefits upon your first visit; however, we do require your portion of the bill to be paid at the time of service. Because the bill is your responsibility, should your insurance company not pay – you will receive a bill for the remaining balance. We will do everything reasonably required to facilitate the filing of your insurance claim. This necessitates you providing us with your insurance information, along with all other relevant documents (i.e. accident report, claim number, policy number, letter from automobile insurance stating medical payment benefits are available or exhausted).

PPO Plans: (with which we are contracted): We have agreed to take a discount from your insurance carrier. Your co-insurance or deductible is your responsibility and is due at the time of service. In the event your insurance carrier coverage changes to a plan where we are not a participating provider, you will be responsible for any out of network deductible or co-insurance amounts.

Medicare: We accept assignment with Medicare. Medicare pays their allowed amount after satisfaction of the annual deductible. We will bill your supplemental insurance as a courtesy; however, you are responsible regardless of payment for the remaining amount that Medicare does not pay.

Self-Pay Patients: There is a minimum deposit of $350.00 (cash, check, or credit card) due upon sign-in for all private pay patients on the initial visit. Should your charges exceed more than your deposit, you will be billed the remaining balance.

Referrals and Authorizations: If your insurance company requires a referral from your primary care physician (PCP) for an orthopedic consultation, please make sure you obtain the authorization number before calling for an appointment. Our office must be in receipt of the referral from the PCP before booking your appointment. If our office has not yet received your referral, you will be asked to contact your PCP's office to have them fax the referral to us.

Referrals for additional orthopedic services that your orthopedic physician may require (i.e. MRI, Physical Therapy, CT Scans, etc.) will be ordered by our office. Please allow 5 to 7 working days to process your referral in most cases.

Worker's Compensation/Industrial Injuries: Premier Orthopedics works with many industrial medicine entities, including Worker's Compensation and the Department of Labor. If you are injured on the job or feel that your problem may be work-related, please make sure you have informed your employer. Our Worker's Compensation coordinator will need to obtain authorization from your employer's Worker's Compensation carrier prior to your visit. If your employer is self-insured, we will need an authorization from them that your injury will be covered. If your treatment is denied as being non work-related, you are financially responsible for all incurred charges.

Disability Forms: All forms that need to be completed by our medical staff should be given to the receptionist or check-out staff. Due to the complexity of some of these forms, please allow 10 – 14 days for completion. Our office does charge for this service and any fee must be paid prior to the release of the completed form.

Supplies: Some insurers do not pay for supplies such as braces, crutches, etc., that are provided by our office. If we inform you that a supply prescribed by your physician will not be covered, we expect payment when you receive the supply. In the event that your insurance company is billed and does not remit payment, you will be billed for the supplies that are unpaid by the carrier.

General Policies ~

Minor Patients: A minor patient must have a parent or guardian present with the patient in order to be seen by the physician. The parent / adult guardian accompanying the minor will be responsible for full payment as outlined in other listed financial policies.

Medications: As of January 2, 2010, there will be no refills called in after business hours. We ask that you make your doctor aware of any refills needed at the time of your appointment. If refills are needed in between appointments, please call your pharmacy and ask them to fax us a refill request. It may take up to 48 hours from the time of your request.

Cell Phones: Please understand that your time with our provider is an extremely important time for you and the provider. Please turn **OFF** your cell phone while in the clinical area and exam room.

Past Due Balances: If your account becomes 90 days delinquent, it is our policy to make a good faith effort to work with patients to find a mutually acceptable arrangement. However, we do utilize the services of a collection bureau to assist with outstanding, unresolved balances older than 90 days.

We appreciate you reviewing our Patient Policies and we request that you please let us know if you have any questions or concerns. It is our pleasure to serve you for all your orthopedic needs.

INTERNAL ACCT# _____

PREMIER ORTHOPEDICS, PC

Doctor / Provider Name: _____ Today's Date: _____

How did you hear about our office? ☐ TV ☐ Newspaper ☐ Dr. Referral ☐ Friend / Family ☐ Internet/Website ☐ Yellow Pages ☐ Other

Primary Care Physician: _____ PCP City & State: _____ PCP Phone Number: _____

Referral Source: _____ Premier Patient ID # (office use only): _____

Date symptoms/injury first appeared: ___/___/___ Is this an auto accident claim? ☐ Yes ☐ No Is this a work-related injury? ☐ Yes ☐ No

Is the visit due to an injury? ☐ Yes ☐ No If Yes, how did the injury occur? _____

PATIENT INFORMATION

Date of Birth: ___/___/___ Age: _____ Social Security Number: _____

Full Name: _____ (Last) _____ (First) _____ (Middle) Preferred: _____

Physical Street Address: _____ City, State: _____ Zip: _____

Mailing Address (if different than physical): _____ City, State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____ Occupation: _____ May we contact you at work? ☐ Yes ☐ No

Patient's Spouse Name: _____ Emergency Contact: _____ Emergency Phone: _____

Gender: ☐ Male ☐ Female Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Number of children: _____

Race: ☐ Caucasian ☐ Black / African American ☐ Hispanic ☐ Asian ☐ American Indian ☐ Indian ☐ Native American ☐ Alaska Native

Ethnicity: ☐ Non-Hispanic ☐ Hispanic ☐ Other _____ Language: ☐ English ☐ Spanish ☐ Other _____

Please indicate where you may be reached during business hours: ☐ Home ☐ Work ☐ Cell Phone

May we contact you at home? ☐ Yes ☐ No

If calling your home, leave a message with:

☐ Yes ☐ No Voicemail / Answering Machine
☐ Yes ☐ No Mobile / Cell Phone
☐ Yes ☐ No Family Member / Friend
If so, who? _____

May we contact you at your place of business? ☐ Yes ☐ No

If calling your home, leave a message with:

☐ Yes ☐ No Voicemail / Answering Machine
☐ Yes ☐ No Mobile / Cell Phone
☐ Yes ☐ No Family Member / Friend
If so, who? _____

May we contact you via email? ☐ Yes ☐ No If yes, please list the preferred email address: _____

RESPONSIBLE PARTY

Person responsible for billing: ☐ Self ☐ Spouse ☐ Parent ☐ Employer ☐ Other _____ Relationship to patient: _____

Insured Name: _____ Date of Birth: _____ Social Security Number: _____

Street Address: _____ City, State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____

Employer: _____ Occupation: _____

Street Address: _____ City, State: _____ Zip: _____

PRIMARY INSURANCE COVERAGE

Insured Policyholder's Name (if other than patient): _____ Address: _____

Date of Birth: _____ Home Phone: _____ Work Phone: _____

Employer Name: _____ Occupation: _____ Social Security Number: _____

Insured Group Number: _____ Policy Number: _____

SECONDARY INSURANCE COVERAGE

Insured Policyholder's Name (if other than patient): _____ Address: _____

Date of Birth: _____ Home Phone: _____ Work Phone: _____

Employer Name: _____ Occupation: _____ Social Security Number: _____

Insured Group Number: _____ Policy Number: _____

MEDICARE & MEDICAID COVERAGE

Medicare Part A #: _____ Effective Date: _____

Medicare Part B #: _____ Effective Date: _____

Medicaid Number: _____ Issuing State: ☐ Georgia ☐ Other: _____

INDUSTRIAL INJURY (WORKERS COMP)

Date of Injury: _____ Date Injury Report Filed: _____

Employer at the Time of Accident: _____ Employer Phone: _____

Employer Mailing Address: _____ City, State: _____ Zip: _____

Injury Authorized to Treat: _____ Contact Person: _____

AUTO ACCIDENT / THIRD PARTY

Date of Accident: _____ Name of Representing Attorney: _____

Policy Holder's Name: _____ Relationship to Patient: _____

Insurance Company responsible for Medical Bills: _____

Insurer Mailing Address: _____ City, State: _____ Zip: _____

Insurance Claim Number: _____ Agent/Adjuster Name: _____ Phone Number: _____

AUTHORIZATION & ASSIGNMENT OF BENEFITS

I hereby authorize Premier Orthopedics, PC to release information concerning my illness and treatments to insurance companies, attorneys, other physicians, and/or other specific interested parties. I hereby assign to the physicians all payments for medical services to my dependents or myself. I understand that I am responsible for any balance not paid by my insurance or third party. I understand that a copy of this authorization shall and may be treated as an original. Patient does hereby consent to the rendering of medical care and treatment, which may include diagnostic testing procedures and such treatment and care as considered necessary or appropriate by the rendering physician.

Signature of Patient: _____ Date: _____

Signature of Parent / Guardian: _____ Date: _____

INTERNAL ACCT# _____

PREMIER ORTHOPEDICS, PC

Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Referral Source: _____ Primary Care Physician: _____

Reason for today's visit: _____

Is the visit due to an injury? Yes _____ No _____ How did the injury occur? (please be detailed) _____

_____

Workers Compensation claim? Yes _____ No _____ Motor vehicle accident? Yes _____ No _____

~ ALLERGIES ~

List all allergies (or provide a list): _____

~ CURRENT MEDICATIONS ~

List all current medications with medication name, dosage, and condition (or provide a list):

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please list the name of your primary pharmacy where you purchase MOST of your medications even if you use multiple pharmacies:

Name (i.e. CVS, Walgreens): _____ Street Address: _____ City, State: _____

Do you give Premier Orthopedics permission to access your current electronic medication history to verify drug names and dosages? ☐ Yes ☐ No

~ PAST MEDICAL HISTORY ~

Vaccinations: Have you ever had the Pneumonia vaccination? ☐ Yes ☐ No Have you had the Flu shot this flu season? ☐ Yes ☐ No

Have you or a family member ever had any of the following:

	Patient		Family Member			Patient		Family Member	
	Yes	*No*	*Yes*	*No*		*Yes*	*No*	*Yes*	*No*
Diabetes	☐	☐	☐	☐	Frequent Kidney Infections	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	Kidney stones	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	Kidney Failure	☐	☐	☐	☐
Blackouts / Seizures	☐	☐	☐	☐	Frequent Heartburn	☐	☐	☐	☐
Dizzy Spells / Vertigo	☐	☐	☐	☐	Stomach Ulcer	☐	☐	☐	☐
Chest Pains	☐	☐	☐	☐	Gall bladder disease	☐	☐	☐	☐
Irregular heart rate	☐	☐	☐	☐	Pancreatitis	☐	☐	☐	☐
Heart attack	☐	☐	☐	☐	Ulcerative Colitis / Crohn's Disease	☐	☐	☐	☐
Heart Failure	☐	☐	☐	☐	Diverticulitis	☐	☐	☐	☐
Heart murmur	☐	☐	☐	☐	Liver Disease	☐	☐	☐	☐
Heart surgery	☐	☐	☐	☐	Hepatitis A, B, or C	☐	☐	☐	☐
Stroke / CVA	☐	☐	☐	☐	Gout	☐	☐	☐	☐
TIA's (transient ischemic attacks)	☐	☐	☐	☐	Lupus	☐	☐	☐	☐
Blockage of blood vessels: neck	☐	☐	☐	☐	Rheumatoid arthritis	☐	☐	☐	☐
Blockage of blood vessels: legs	☐	☐	☐	☐	Osteoarthritis	☐	☐	☐	☐
Asthma / Emphysema	☐	☐	☐	☐	Psoriasis	☐	☐	☐	☐
Sleep Apnea	☐	☐	☐	☐	Cancer	☐	☐	☐	☐
Fractures / Dislocations	☐	☐	☐	☐	HIV	☐	☐	☐	☐
					Are you Pregnant?	☐	☐		

~ PAST SURGICAL HISTORY ~

List *ALL* previous surgeries: _____ _____ _____

_____ _____ _____ _____

List any other medical history you think is important and we should know: _____

_____

~ Social History ~

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Living Situation:** ☐ Alone ☐ Spouse or Family ☐ Friends

Employed: ☐ Yes ☐ No ☐ Full Time ☐ Part Time Type of Work: _____ **Disabled:** ☐ Yes ☐ No

Student: ☐ Yes ☐ No Grade: _____ School: _____

Are you: ☐ Right handed ☐ Left Handed Hobbies, Sports, Activities you enjoy: _____

Tobacco usage: ☐ Every day ☐ Some days ☐ Quit ☐ Never Year started use: _____ Year you quit: _____

Which type / How much: ☐ Cigarettes / Packs per day _____ ☐ Cigars / Number per week ☐ Smokeless / Amount per day _____

Exposed to second hand smoke? ☐ Yes ☐ No **Use illegal substances?** ☐ Yes ☐ No Type: _____ Frequency: _____

Alcoholic beverages: ☐ Yes ☐ No Type: ☐ Beer ☐ Wine ☐ Liquor - Type: _____ Number of drinks per day: _____

Colonoscopy: Have you ever had a colonoscopy? ☐ Yes ☐ No If yes, when was it last performed? _____ / _____ (Month / Year)

Results: ☐ Normal ☐ Abnormal _____

~ Review of Systems ~

Constitutional Symptoms

Recent weight change	☐ Yes	☐ No
Fever	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No
Headaches	☐ Yes	☐ No

Eyes and Vision

Wears glasses	☐ Yes	☐ No
Wears Contact lenses	☐ Yes	☐ No
Blurred or double vision	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No

Ears / None / Mouth / Throat

Hearing loss or ringing	☐ Yes	☐ No
Earaches or drainage	☐ Yes	☐ No
Chronic sinus problems	☐ Yes	☐ No
Frequent nose bleeds	☐ Yes	☐ No
Sore throat or voice change	☐ Yes	☐ No

Cardiovascular

Chest pain	☐ Yes	☐ No
Palpitations	☐ Yes	☐ No
Swelling of:		
hands, ankles, feet	☐ Yes	☐ No
Abnormal blood pressure	☐ Yes	☐ No

Pulmonary

Chronic or frequent cough	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No
Sleep apnea/disturbed sleep	☐ Yes	☐ No

Endocrine

Heat or cold intolerance	☐ Yes	☐ No

Skin

Persistent rash or itching	☐ Yes	☐ No
Psoriasis	☐ Yes	☐ No

Genitourinary

Frequent urination	☐ Yes	☐ No
Burning or painful urination	☐ Yes	☐ No
Blood in urine	☐ Yes	☐ No
Kidney stones	☐ Yes	☐ No

Gastrointestinal

Loss of appetite	☐ Yes	☐ No
Nausea or vomiting	☐ Yes	☐ No
Frequent diarrhea	☐ Yes	☐ No
Rectal bleeding	☐ Yes	☐ No
Abdominal pain or heartburn	☐ Yes	☐ No
Peptic ulcer	☐ Yes	☐ No
Hepatitis A, B, or C	☐ Yes	☐ No

Neurological

Light headed or dizzy	☐ Yes	☐ No
Tremors	☐ Yes	☐ No
Paralysis	☐ Yes	☐ No

Psychiatric

Depression	☐ Yes	☐ No
Memory loss or confusion	☐ Yes	☐ No
Insomnia	☐ Yes	☐ No
Nervousness	☐ Yes	☐ No

Hematologic / Lymphatic

Anemia	☐ Yes	☐ No
Phlebitis	☐ Yes	☐ No
Past blood transfusion	☐ Yes	☐ No
Exposure to HIV	☐ Yes	☐ No

Musculoskeletal

Osteoporosis	☐ Yes	☐ No
History of fractures	☐ Yes	☐ No
History of arthritis	☐ Yes	☐ No
Rheumatoid Disease	☐ Yes	☐ No
History of gout	☐ Yes	☐ No

INTERNAL ACCT# _____

PREMIER ORTHOPEDICS, PC

Current Medication List

MUST BRING COMPLETED TO YOUR APPOINTMENT

Patient Name:_____ DOB:_____/_____/_____
(Please Print)

Date this List was completed: _____/_____/_____

Pharmacy Frequently Used: _____

Pharmacy Phone Number: (_____)_____-_____

NOTE: LIST PRESCRIPTION AND OVER THE COUNTER

DRUG NAME	MILLIGRAMS PRESCRIBED	DISPENSED (Ex: 1-3x's daily)

INTERNAL ACCT# _____

Patient Name:_____ DOB:_____/_____/_____
(Please Print)

DRUG NAME	MILLIGRAMS PRESCRIBED	DISPENSED (Ex: 1-3x's daily)

INTERNAL ACCT# _____

PREMIER ORTHOPEDICS, PC

2405 OSLER COURT ~ ALBANY, GEORGIA 31707 ~ (229) 435-1458
1107 GREER STREET ~ CORDELE, GEORGIA 31015 ~ (229) 273-1730

PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Effective January 1, 2007

As Required by the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

I have received or had the opportunity to read a copy of the **Notice of Privacy Practices** of Premier Orthopedics, P.C. on the date indicated below.

I understand that if any changes are made to this Notice of Privacy Practices, a revised copy of the Notice will be posted in the offices of Premier Orthopedics, P.C.

I also understand that if I wish to receive additional copies of this Notice of Privacy Practices in the future or if I have any questions with regard to this Notice of Privacy Practices, I may contact:

HIPAA Compliance Officer, 2405 Osler Court, Albany, Georgia 31707 (229) 435-1458

_____ _____

Printed Name of Patient Date

_____

Signature of Patient or Patient's Representative

_____ _____

Printed Name of Patient or Patient's Representative Relationship to patient

Please list all persons that we may discuss your Private Healthcare Information (PHI) with including friends and family. This information may include, but is not limited to the following: Appointment information, billing or insurance issues, lab results, treatment plan or medications prescribed, etc…

_____ _____

_____ _____

_____ _____

THIS SPACE TO BE USED BY PRACTICE ONLY.

Date acknowledgement denied by patient: _____

Reason denied by patient: _____

Name of person reviewing denial: _____

Signature of Premier Representative: _____ Date: _____