

Check names of any doctors you have seen before: \_\_\_\_\_ Kelly \_\_\_\_\_ Richardson \_\_\_\_\_ Hattaway  
 \_\_\_\_\_ Slappey \_\_\_\_\_ Stapleton \_\_\_\_\_ Beringer \_\_\_\_\_ Pope

Which doctor are you seeing today:

**PATIENT INFORMATION**

Last Name	First Name	MI	Mr. / Mrs. / Ms.
SSN#	Date of Birth	Age	Sex
Street Address	Apt#	City	State Zip Code
Home Phone	Cell Phone	Email Address	
Spouse's Name	Spouse's Phone		
Closest Relative (Not living with patient)	Relationship	Phone	

**GUARANTOR INFORMATION**

Guarantor Name	Guarantor Address	Phone
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**INSURANCE INFORMATION**

<b>Primary</b> Insurance Co.	<b>Secondary</b> Insurance Co.
Insured's Name	Insured's Name
SS# of Policyholder	SS# of Policyholder
Policy ID#	Date of Birth
Relationship to Patient	Relationship to Patient
Employer Name	Employer Name

Have you visited our website? Yes No

How did you find out about our office? \_\_\_\_\_ Advertisement (683) \_\_\_\_\_ Friend (680)  
 \_\_\_\_\_ Relative (681) \_\_\_\_\_ Doctor: \_\_\_\_\_ Internet \_\_\_\_\_ Health Plan

Who is your primary care physician?

Have you been seen by any physician for this condition (If yes, whom and when):

Is this condition work related? Yes No

Marital Status: S / M / D Do you live: with Family / Alone / Assisted Living Facility

Name & Address of your preferred Pharmacy:

Level of Education: Occupation: Student? Yes / No  
 If yes, where?

List any current medications:

\_\_\_\_\_  
 Signature of Patient / Guarantor Date

Patient Name:      Date: 4/13/2009



**Medical disorders: If you have had any of the following, Place Mark inside Circles**

- No Medical History
- AIDS/HIV
- Alcoholism
- Alzheimer's
- Anemia
- Arthritis
- Asthma
- Blood Clot Leg
- Blood Clot Lung
- Other Disease
- Cancer Breast
- Cancer Colon
- Cancer Lung
- Cancer Prostate
- COPD
- Depression
- Diabetes
- Drug Abuse
- Gout
- Heart Attack
- Hypertension
- Hepatitis
- Kidney Disease
- Osteoarthritis
- Seizures
- Ulcers, Bleeding

**Surgical History: If you have had any of the following, Place Mark inside Circles**

- No Surgical History Reported
- Carpal Tunnel Left Wrist
- Arthroscopy Left Elbow
- Arthroscopy Left Shoulder
- Arthroscopy Left Ankle
- Arthroscopy Left Knee
- Arthroscopy Left Hip
- Left Hip Replacement
- Left Knee Replacement
- Spinal Fusion
- Other Surgery
- Carpal Tunnel Right Wrist
- Arthroscopy Right Elbow
- Arthroscopy Right Shoulder
- Arthroscopy Right Ankle
- Arthroscopy Right Knee
- Arthroscopy Right Hip
- Right Hip Replacement
- Right Knee Replacement
- Laminectomy

Patient Name:      Date: 4/13/2009



**Family History:**

If any family Member below has any of the following history, Place Mark inside Circles

**Father Medical History**

- |   |                                    |  |
|---|------------------------------------|--|
| <input type="radio"/> AIDS/HIV                | <input type="radio"/> Diabetes     | <input type="radio"/> Kidney Disease       |
| <input type="radio"/> Anemia                  | <input type="radio"/> Gout         | <input type="radio"/> Liver Disease        |
| <input type="radio"/> Blood Clots             | <input type="radio"/> Heart Attack | <input type="radio"/> Muscle Disease       |
| <input type="radio"/> Cancer                  | <input type="radio"/> Hemophilia   | <input type="radio"/> Osteoporosis         |
| <input type="radio"/> Coronary Artery Disease | <input type="radio"/> Hypertension | <input type="radio"/> Rheumatoid Arthritis |
|   |                                    | <input type="radio"/> Osteoarthritis       |

**Mother Medical History**

- |   |                                    |  |
|---|------------------------------------|--|
| <input type="radio"/> AIDS/HIV                | <input type="radio"/> Diabetes     | <input type="radio"/> Kidney Disease       |
| <input type="radio"/> Anemia                  | <input type="radio"/> Gout         | <input type="radio"/> Liver Disease        |
| <input type="radio"/> Blood Clots             | <input type="radio"/> Heart Attack | <input type="radio"/> Muscle Disease       |
| <input type="radio"/> Cancer                  | <input type="radio"/> Hemophilia   | <input type="radio"/> Osteoporosis         |
| <input type="radio"/> Coronary Artery Disease | <input type="radio"/> Hypertension | <input type="radio"/> Rheumatoid Arthritis |
|   |                                    | <input type="radio"/> Osteoarthritis       |

**Sibling Medical History**

- |   |                                    |  |
|---|------------------------------------|--|
| <input type="radio"/> AIDS/HIV                | <input type="radio"/> Diabetes     | <input type="radio"/> Kidney Disease       |
| <input type="radio"/> Anemia                  | <input type="radio"/> Gout         | <input type="radio"/> Liver Disease        |
| <input type="radio"/> Blood Clots             | <input type="radio"/> Heart Attack | <input type="radio"/> Muscle Disease       |
| <input type="radio"/> Cancer                  | <input type="radio"/> Hemophilia   | <input type="radio"/> Osteoporosis         |
| <input type="radio"/> Coronary Artery Disease | <input type="radio"/> Hypertension | <input type="radio"/> Rheumatoid Arthritis |
|   |                                    | <input type="radio"/> Osteoarthritis       |

Patient Name:    Date: 4/13/2009



\* R O S \*

**Review of Systems: If you have any of the following, Please Place Mark inside Circles**

**Constitutional**

- Weight Loss/Gain
- Weakness
- Fatigue
- Fever

**Eyes**

- Glasses or Contacts
- Blurred Vision
- Glaucoma
- Cataracts
- Excessive Tearing

**Ear Nose Mouth Throat:**

- Ears Ringing
- Earaches
- Hearing Aid
- Frequent Colds
- Nasal Discharge
- Hay Fever
- Nosebleeds
- Dentures
- Bleeding Gums
- Frequent Sore throats

**Endocrine**

- Thyroid Trouble
- Excessive Sweating
- Excessive thirst

**Cardiovascular**

- High Blood Pressure
- Chest Pain
- Rheumatic Fever
- Palpitations
- Has Pacemaker

**Skin**

- Rashes
- Sores
- Lumps
- Dryness
- Itching

**Neurological**

- Headache
- Dizziness
- Seizures
- Loss of Sensation
- Vertigo

**Gastrointestinal**

- Heart Burn
- Rectal Bleeding
- Abdominal Pain
- Gallbladder trouble
- Hepatitis

**Immunologic**

- Reactions to Drugs
- Skin Rashes
- Reactions to Foods

**Musculoskeletal**

- Joint Pain
- Arthritis
- Muscular Weakness
- Stiffness
- Muscular Pain

**Blood or Lymph**

- Anemia
- Easy Bruising
- Easy Bleeding
- Swollen Glands

**Respiratory**

- Shortness of Breath
- Cough
- Wheezing
- Asthma
- Bronchitis

**Genitourinary**

- Blood in Urine
- Urinary Infections
- Kidney Stones
- Burning Urination
- Sexual Disease

**Psychological**

- Nervousness
- Depression
- Mood Changes

Patient Name:      Date: 4/13/2009



**Social History:** Please respond to the following by Placing Mark inside Circles

**Substance Use:**

Do you:

Use Tobacco?                       Yes       No       Former

Use Alcohol?                       Yes       No

Use Caffeine?                       Yes       No

Use Illicit Drugs?                       Yes       No

I do not use any of the above     

Hand Dominance?                       Right Handed       Left Handed

**Females Only:**

Could you be pregnant?                       Yes       No

**Allergies:** Do you have allergies to any of the following medications or substances

No Known Allergies

Penicillin                       Amoxil                       Tegretol

Codeines                       Keflex                       Bactrim

Sulpha Drugs                       Cefzil                       Pediazole

Iodine                       Ceftin                       Dilantin

Ampicillin                       Suprax                       Novacaine

Vantin                       Septra                       Insulin

Depakene                       Lamictal

**Other Allergies:**

Latex                       Metal

Patient name \_\_\_\_\_ Date \_\_\_\_\_

Which hand do you write with? \_\_\_\_\_

Where is your pain? (you may circle more than one.)

Back                  Leg                  Neck                  Arm

When did your pain start? \_\_\_\_\_

Is it related to any injury?  Yes  No

If yes, explain? \_\_\_\_\_

Is there a lawsuit pending? \_\_\_\_\_ Is this a workmens' compensation injury? \_\_\_\_\_

What activities make the pain worse? \_\_\_\_\_

What activities or positions make the pain less? \_\_\_\_\_

How much relief do you get from lying down? \_\_\_\_\_

Do you have: numbness? \_\_\_\_\_ Tingling or burning? \_\_\_\_\_ Weakness? \_\_\_\_\_

How much time have you lost from work? \_\_\_\_\_

Have you been seen by another physician for this condition? \_\_\_\_\_

If yes, name of that doctor \_\_\_\_\_

His or her treatment \_\_\_\_\_

Have you had surgery on your back or neck? \_\_\_\_\_

If yes, date of previous surgery \_\_\_\_\_

Do you smoke?  Yes  No If yes, how many packs a day? \_\_\_\_\_

Please list all other medical problems: \_\_\_\_\_

\_\_\_\_\_

List current medications:

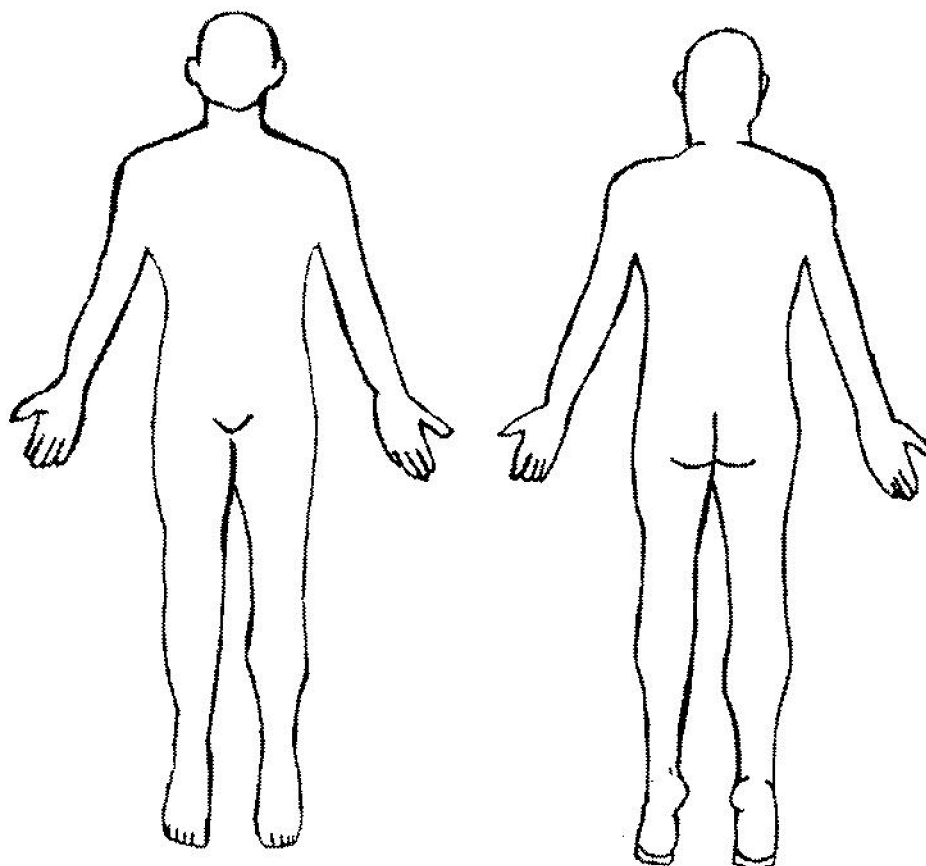
\_\_\_\_\_

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

1) What is the main problem you want help with today? \_\_\_\_\_

2) On the drawing, below please indicate where your pain/discomfort is using the following scale:

Ache or stabbing: XXXX "Pins & Needles" or Burning: = = = = Numbness: OOOO



3) How intense or severe is your pain/discomfort? \_\_\_\_\_

4) Indicate with a dot on the scale below the severity of your pain/discomfort:

\_\_\_\_\_ 10  
0 No Pain Agony

Rating for today

\_\_\_\_\_ 10  
0 No Pain Agony

Rating for a typical day

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

***What do I need to bring with me on my first visit?***

You will need to bring any paper work you received from our office completely filled out, your insurance card(s), a picture ID, a list of all medications you are taking, your co-pay amount (if required by your insurance), and deductibles that are due. You will also need to bring all X-rays, MRIs, CAT scans, etc. (if any have been preformed) related to the problem you were referred for which were ordered by another physician.

***What insurance do you participate with?***

Our practice is with most managed care insurance companies. It is up to the patient to ensure that we are participating providers with your insurance. If we do not participate, payment is required at the time of service.

As a courtesy to our patients, Forsyth Street Orthopaedics files all primary and secondary insurance claims. Most claims are filed electronically. Patients can expect to receive notification from their insurance within 15 to 30 days. Secondary claims are filed only once. If no payment is received from the carrier in 30 days, any balance remaining will be the patient’s responsibility.

Our practice accepts cash, personal check, Visa, MasterCard or CareCredit. Please feel free to contact our Patient Accounts department at 478-743-3000 with any questions or concerns. We will make every attempt to assist you.

***What is my financial responsibility?***

Insurance is an agreement between you and your insurance company. We do not become involved in disputes between you and your insurance company regarding any deductibles, co-payments, non-covered or denied services. You will need to contact your insurance to determine what is and is not covered.

**If you have...**

**You are responsible for...**

**Our staff will...**

**Commercial Insurance**  
 Also know as Indemnity, regular Insurance or an 80%-20% plan

A minimum payment of 20% of the total for services rendered will be due at the time of service.

Submit your insurance claim for you. We will assist in any pre-certification or pre-authorization process necessary. We will collect all payments that are due following your visit.

**HMO & PPO plans**  
 with which we are a participating provider.

If the services you receive are covered by the plan: All applicable co-pays and deductibles are required at the time of service.

Submit your insurance claim for you. We will assist in any pre-certification or pre-authorization process necessary. We will collect all payment that is due following your visit with the exception of your co-pay which will be collected at check-in.

**Medicare**

If you have regular Medicare, and have not met your \$124 deductible, you will be billed for any balance due. Payment for any services not covered by Medicare is to be paid at the time of service. If you wish to be on “automatic crossover” for your secondary insurance, you must call your secondary insurance to set this up.

Submit your insurance claim for you as well as any claims to your secondary insurance.

**Auto Insurance/Third Party Insurance**

We do not file your auto or third party insurance. We will file your private health insurance and provide you with an itemized statement for you to file with your auto carrier or third party insurance.

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

***What are my payment options?***

We accept cash, personal check, Visa, MasterCard or Care Credit.

If you are interested in using Care Credit please access their web site, [www.carecredit.com](http://www.carecredit.com), to review their plans and submit your application. When you come in for your office visit please have your Care Credit approval with you. We accept the following arrangements in regards to Care Credit financing:

- a) No interest for 3 or 6 months
- b) Extended payments for 36, 48 or 60 months at an interest rate of 11 %

In addition to your Care Credit charges, we will charge a one time processing fee based on your account balance.

We do offer “in house” financing for balances less than \$300. A \$30 fee will be charged for all returned checks. You can call our business office at 743-3000 if you have any further questions.

***What if my child needs to be treated?***

A parent or legal guardian must accompany a minor (under 18) on their first visit. The accompanying adult will be responsible for payment as outlined above.

***Are medications available for purchase?***

We offer several medications in our office under our Redi RX program. Your prescription must be written by one of our doctors and paid for by cash or credit card at the time of purchase. We will not file insurance for your prescription purchases. Our medications are FDA approved and custom sealed for your safety. Prescriptions filled through our REDI RX program may cost less than your co-pay or co-insurance with your pharmacy. We can provide you with a list of available medications and direct you to our REDI RX office at your request.

***How do I get a refill on my medication?***

You can contact one of our office nurses between the hours of 8:30 am - 4:30 pm Monday – Friday. We can not refill prescriptions after hours or on the weekends. Please let your doctor know in advance if you will need a 90 day refill.

***How will my medical information be used?***

In accordance with the Health Insurance Portability and Accountability Act, our office has developed a “Notice of Privacy Practices”. You may obtain a copy of our “Notice of Privacy Practices” at the receptionist desk.

**PROMISSORY/ HIPAA:**

**Acknowledgement of Financial Responsibility:** By signing below I verify that all information provided to Forsyth Street Orthopaedics is true and correct. I understand that I am responsible for all services rendered, including attorney fees and collection costs in the event of default. I promise to reimburse this provider for all services rendered from any settlement made on my behalf from any/all responsible parties and/or their insurers. I further authorize Forsyth Street Orthopaedics to release to the insurance companies, including but not limited to HCFA (government payers) and their agents, any information needed to determine benefits payable. I authorize my power of attorney to be given to the physician and/or billing staff in any collections or appeals process regarding any insurance claim processed on my behalf.

**Receipt of “Notice of Privacy Practices”:** By signing below I acknowledge that I have received or had a copy of the “Notice of Privacy Practices” made available to me.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Relationship to Patient

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

1) If you DO NOT have Tricare Insurance, please sign and date here.

Signature \_\_\_\_\_ Date \_\_\_\_\_

2) If you have Tricare (formerly known as Champus), PLEASE READ, INITIAL, AND DATE BELOW.  
Thank you for your cooperation.

**TRICARE SECONDARY**

Forsyth Street Orthopaedic, Rehabilitation & Surgery Centers are non-participating providers of Tricare Insurance (formerly know as Champus) and are aware that we are not to charge over 115% of the allowable charge.

If you would like to be seen in our office, we ask that you sign this form stating that you are aware that you will be responsible for the remainder of your bill and the 115% rule does not apply to your charges.

**BALANCE BILLING FOR NON-PARTICIPATING PROVIDERS**

The 1993 Defense Appropriations Act limits the amount that non-participating providers can charge a patient, on covered services, to 115% of the TRICARE allowable charge. Any amount over this cap cannot be collected from the patient.

This law supersedes the statement patients often sign that says they are personally responsible for any balance after insurance payments, *unless the statement specifies that the patient is aware of the 115% limit is willing to pay the additional money.* This is the only exception to the law.

NOTE: Congressional Federal Register 32CFR, Part 199, Dated June 1, 1993-Final Rule

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_