Patient Information

UNIVERSITY ORTHOPAEDICS

Patient Name: _____ SSN: _____ DOB: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow(er) ☐ Other

Ethnicity: ☐ White ☐ African-American ☐ Hispanic/Latino ☐ Other: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

Email Address: _____ Cell phone provider: _____

Do we have your authorization to text and/or email you appointment reminders? ☐ Yes ☐ No

Work Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled ☐ Student

Employer: _____ Occupation: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Relationship: _____

Phone/Cell #: _____ Cell phone company: _____

How were you referred to University Orthopaedics: _____

Insurance Information

Primary Insurance: _____ Policy Holder: _____

Relationship to Policy Holder: _____ Policy Holder DOB: _____

Policy Holder SSN: _____ Policy Holder Employer: _____

Policy ID: _____ Group #: _____ Specialist Co-Pay: $_____

Secondary Insurance: _____ Policy Holder:

_____

Relationship to Policy Holder: _____ Policy Holder DOB: _____

Policy Holder SSN: _____ Policy Holder Employer: _____

Policy ID: _____ Group#: _____ Specialist Co-Pay: $_____

Patient Disclaimer

I hereby authorize UNIVERSITY ORTHOPAEDICS (UO) to treat my/my child's injuries within the scope of their specialty and abilities. I authorize UO to furnish information, which may be required to process and pay claims for service rendered to myself of my dependents. I authorize my insurance carrier to pay UO directly for all claims. I agree to pay all fees related to my care if payment is not received from my insurance or me within 90 days including a 5% service fee for each month that the account is not in current standing and a $125 fee if my account has to be sent to a collections agency. I also agree that if the account results in a lawsuit for collections that the case will be tried in Dekalb County, and I will pay all attorney fees and court costs.

BY SIGNING BELOW I ACKNOWLEDGE THAT I HAVE READ THE ABOVE STATEMENTS AND UNDERSTAND MY RESPONSIBILITY

Signature of Responsible Party: _____ Date: _____

Name (Please print): _____

Relationship to Patient (if other than patient): _____

Health History

UNIVERSITY ORTHOPAEDICS

Name: _____ Email: _____ Date: _____

DOB: _____ Height: _____ Weight: _____ lbs

Sex: ☐ Male ☐ Female Pregnant: ☐ Yes ☐ No ☐ Unknown

Please state the reason for your visit:

☐	**Shoulder**	☐ Right	☐ Left	☐ Both	☐	**Elbow**	☐ Right	☐ Left	☐ Both
☐	**Hand/Wrist**	☐ Right	☐ Left	☐ Both	☐	**Hip**	☐ Right	☐ Left	☐ Both
☐	**Foot/Ankle**	☐ Right	☐ Left	☐ Both	☐	**Knee**	☐ Right	☐ Left	☐ Both
☐	**Neck**				☐	**Back**	☐ Lower	☐ Upper	☐ Other: _____
☐	Other: _____								

Is your complaint due to an injury? ☐ Yes ☐ No If yes, continue to section below:

When did the accident/injury occur? _____

Where did the accident/injury occur? _____

Did the accident/injury occur at work? ☐ Yes ☐ No

Was the accident/injury the result of an auto accident? ☐ Yes ☐ No

If none of the above, please state how the accident/injury occurred: _____

_____

Medical Doctor (Name): _____ Phone Number: _____

Cardiologist (Name): _____ Phone Number: _____

PAST MEDICAL HISTORY:

Please check if you have, or have had any of these medical conditions:

☐ NO PAST MEDICAL PROBLEMS

☐ Acid reflux

☐ Adverse reaction to anesthesia

Type of reaction: _____

☐ Alzheimer's/significant memory loss

☐ Anemia

☐ Angina or chest pain

☐ Asthma

☐ Atrial Fibrillation or erratic heartbeat

☐ Bladder problems

☐ Bleeding ulcers

☐ Blood clot

☐ Legs ☐ Lungs

☐ Cancer Type: _____

☐ Congestive heart failure

☐ Coronary artery disease

☐ Dental disease

☐ Depression

☐ Diabetes Type: ☐ I ☐ II

☐ Emphysema

☐ Epilepsy/Seizures

☐ Fibromyalgia

☐ Gout

☐ Hemophilia/Excessive bleeding

☐ Hepatitis

☐ High blood pressure/Hypertension

☐ High cholesterol

☐ HIV or AIDS

☐ Infections: _____

MRSA? ☐ Yes ☐ No

☐ Kidney disease

☐ Osteoarthritis

☐ Osteoporosis

☐ Pneumonia

☐ Psychiatric disorder

☐ Rheumatoid arthritis

☐ Sickle cell

☐ Sleep apnea

☐ CPAP machine

☐ Stroke (CVA)

☐ Thyroid disease

☐ Other not listed, explain:

_____

_____

SURGICAL HISTORY:

Please check below if you have had any of these surgeries:

- ☐ NO PREVIOUS SURGERY
- ☐ Abdominal surgery
  - Type of surgery: _____
- ☐ Aneurysm
- ☐ Angioplasty/Stents
- ☐ Artery bypass of arm or leg
- ☐ Bone/Joint surgery
  - Type of surgery: _____
- ☐ Breast surgery
  - Type of surgery: _____
- ☐ Carotid surgery
- ☐ Cervical spine surgery
- ☐ Colon surgery
- ☐ Coronary bypass (CABG)
- ☐ Gastric bypass surgery
- ☐ Heart valve replacement
- ☐ Hysterectomy
- ☐ Lumbar spine surgery
- ☐ Pacemaker/Defibrillator
- ☐ Prostate surgery
- ☐ Other not listed, explain:
  - _____
  - _____

FAMILY HISTORY:

Please check below if any of your immediate relatives have had any of the following and list who:

- ☐ NO FAMILY MEDICAL HISTORY TO REPORT
- ☐ Adopted
  - ☐ Yes ☐ No
- ☐ Adverse reaction to anesthesia
  - Relation: _____
- ☐ Bleeding disorders
  - Relation: _____
- ☐ Blood clots/Pulmonary embolism
  - Relation: _____
- ☐ Cancer
  - Relation:
- ☐ Depresion
  - Relation: _____
- ☐ Diabetes
  - Relation: _____
- ☐ Heart disease
  - Relation: _____
- ☐ Hypertension
  - Relation: _____
- ☐ Osteoarthritis
  - Relation: _____
- ☐ Osteoporosis
  - Relation: _____
- ☐ Rheumatoid arthritis
  - Relation: _____
- ☐ Stroke
  - Relation: _____
- ☐ Other not listed, explain:
  - _____
  - _____
  - _____
  - _____

SOCIAL HISTORY:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow/Widower

Hobbies: _____

Smoking: ☐ Never smoked ☐ Current smoker How many packs/day? _____

☐ Former smoker How many years did you smoke? _____ When did you quit? _____

Do you dip or chew tobacco? ☐ Yes ☐ No If Yes, how much per day? _____

Do you drink alcoholic beverages? ☐ Yes ☐ No If Yes, how many drinks per week? _____

Do you use recreational drugs? ☐ Yes ☐ No If Yes, what and how often? _____

REVIEW OF SYSTEMS:

Please check below if you have, or recently experienced, any of these medical conditions:

☐ NO SYMPTOMS TO REPORT

Abdominal pain:	Y ☐	N ☐	Fever/Chills/Night sweats:	Y ☐	N ☐	Seizures:	Y ☐	N ☐
Anxiety:	Y ☐	N ☐	Fatigue:	Y ☐	N ☐	Shortness of breath:	Y ☐	N ☐
Arm/Leg pain:	Y ☐	N ☐	Gynecological problems:	Y ☐	N ☐	Skin wounds/Rashes:	Y ☐	N ☐
Black, tarry stools:	Y ☐	N ☐	Impotence:	Y ☐	N ☐	Swollen glands:	Y ☐	N ☐
Chest pain:	Y ☐	N ☐	Incontinence:	Y ☐	N ☐	Urinating at night:	Y ☐	N ☐
Dental problems:	Y ☐	N ☐	Irregular heart rate:	Y ☐	N ☐	Vision problems:	Y ☐	N ☐
Easy bleeding/Bruising:	Y ☐	N ☐	Leg swelling:	Y ☐	N ☐	Weight gain/loss:	Y ☐	N ☐
			Psychological problems:	Y ☐	N ☐			

LIST ALL KNOWN ALLERGIES TO MEDICATIONS: ☐ NO MEDICATION ALLERGIES

1. _____ Reaction type: _____
2. _____ Reaction type: _____
3. _____ Reaction type: _____

Are you allergic to latex? ☐ Yes ☐ No If so what is the allergy? _____

Tape allergy? ☐ Yes ☐ No

CURENT MEDICATIONS:

Please list medication name and strenght

☐ NOT CURRENTLY TAKING MEDICATION

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____

NAME _____ DOB _____

PHARMACY NAME: _____ PHONE NUMBER: _____

Patient Privacy Act Notice

The Standards for Privacy of Individually Identifiable Health Information ("Privacy Rule") establishes, for the first time, a set of national standards for the protection of certain health information. The U.S. Department of Health and Human Services ("HHS") issued the Privacy Rule to implement the requirement of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The Privacy Rule standards address the use and disclosure of individuals' health information—called "protected health information" by organizations subject to the Privacy Rule—called "covered entities", as well as standards for individuals' privacy rights to understand and control how their health information is used. Within HHS, the Office for Civil Rights ("OCR") has responsibility for implementing and enforcing the Privacy Rule with respect to voluntary compliance activities and civil money penalties.

A major goal of the Privacy Rule is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well being. The Rule strikes a balance that permits important uses of information, while protecting the privacy of people who seek care and healing. Given that the health care marketplace is diverse, The Rule is designed to be flexible and comprehensive to cover the variety of uses and disclosures that need to be addressed.

This is a summary of key elements of the Privacy Rule and not a complete or comprehensive guide to compliance. Basic Principle. A major purpose of the Privacy Rule is to define and limit the circumstances in which an individual's protected health information may be used or disclosed by covered entities. A covered entity may not use or disclose protected health information, except either: (1) as the Privacy Rule permits or requires; or (2) as the individual who is the subject of the information (or the individual's personal representative) authorizes in writing.

I, _____ herby authorize University Orthopedics to leave medical information pertaining to my care by the following methods and will assume responsibility to notify UO whenever this information changes:

Home Phone ☐ Yes ☐ No Number: _____ OK to leave a message: ☐ Yes ☐ No

Cell Phone ☐ Yes ☐ No Number: _____ OK to leave a message: ☐ Yes ☐ No

Email ☐ Yes ☐ No Email: _____

Please list name(s) of person(s) we can discuss your medical care with other than yourself:

Spouse or Significant Other: _____ ☐ Yes ☐ No

Parent: _____ ☐ Yes ☐ No

Other: _____ Relationship: _____ ☐ Yes ☐ No

Financial and Billing Policy

Thank you for choosing University Orthopaedics, PC. We are committed to the success of your treatment. We hope you understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which we require you to read, agree to and sign, prior to any treatment. This financial policy applies to all services rendered by our providers.

It is our policy that the patient, rather than the insurance company, is responsible for complete payment of charges. All patients with insurance coverage are required to pay for non-covered services, any deductible amount not previously met, and any co-payment and co-insurance amount due at the time services are rendered. For patients with dual insurance coverage, we will bill both the primary and secondary insurance if you have provided us with the necessary information. PLEASE NOTE: AFTER 120 DAYS (4 MONTHS) OF ATTEMPTED COLLECTION FROM YOUR INSURANCE, ALL BALANCES ARE DUE AND PAYABLE BY THE PATIENT. We will be happy to provide you with any documentation needed to obtain reimbursement from your insurance company.

Patients insured under a plan which we are NOT contracted with will be required to pay for the first visit in full. For any follow-up visits you will need to pay 20% at the time services are rendered. There may be a 25% down-payment required prior to any surgery.

If you are insured with a plan, which we ARE contracted with (including Medicare), you will need to pay for any non-covered services, any outstanding deductible and your co-payment/co-insurance prior to surgery.

Patients with no health insurance coverage are expected to pay for services at the time services are rendered.

Failure to make payment arrangements, or pay outstanding balances within 30 days of notification of amount due, may result in termination of care from University Orthopaedics and Sports Medicine, PC.

Our accepted methods of payment are cash, personal checks and all major credit cards. If requested, a short payment schedule may be arranged for patients who have special financial conditions.

It is the patient's responsibility to verify their benefits for their particular plan and to make sure all proper authorizations have been obtained. Some insurance plans will reduce benefits if the insured is treating with doctors outside of the designated network or without the proper authorization.

CO-PAYS, CO-INSURANCE AND DEDUCTIBLES

All Co-Pays, Deductibles and Co-Insurance are required to be paid at the time of service. Should the practice need to bill for a Co-Pay a $10 fee will be added.

HEALTH INSURANCE

University Orthopaedics and Sports Medicine, PC. will bill your health insurance carrier as courtesy to you if presented with the information and assignment of benefits at the time of service. All applicable co-pays, deductibles and co-insurance must be paid at the time of service.

PAYMENT RESPOINSIBILITY

In the event the insurance claim submitted is denied due to one or all of the following reasons, the patient will be held responsible for all charges incurred during his/her treatment.

RETURNED CHECKS

There will be a $30.00 fee for any returned checks.

WORKER'S COMPENSATION

It is required at the time of service that the patient gives Worker's Compensation and health insurance information. Charges for services incurred as a result of a work-related injury will be billed to the Worker's Compensation carrier or the employer. Upon denial by Worker's Compensation, the health insurance carrier or the patient will be responsible.

MANAGED CARE (HMO)

Unless an authorization is obtained from your PCP, or your health care carrier, you will be responsible for payment in full at the time of service. Your insurance will be billed as a courtesy to you.

REFUNDS

All refunds must be requested in writing and a refund will be issued to the appropriate party within 2 weeks.

CANCELLATION AND NO-SHOW

Since we do have limits to how many patients we can see each day, it is important that you notify us at least 24 hours in advance of your appointment should you need to cancel or reschedule. This includes scheduling a same-day appointment and later canceling it.

When one doesn't show up for his/her appointment or cancels with little advanced notice, it takes away our opportunity to provide another patient attention for a medical need.

Any patient who fails to show up for an appointment, or fails to give at least 24-hour advanced notice of cancellation, will be subject to a fee of $25 - $100 (depending on the type of appointment). If you have an appointment on a Monday and need to cancel or reschedule, please call the office on Friday. Our answering service does not take messages for the office after hours.

Again, thank you for trusting us with your care. If you have any questions regarding financial responsibilities or payment options, please contact our insurance department.

"I have read, understand and agree to the provisions of this policy"

Patient/Legal Guardian Signature: _____ Date: _____

Name (Please print): _____

Relationship to Patient (if other than patient): _____

Patient Acknowledgement

UNIVERSITY ORTHOPAEDICS

By signing this document below and by initialing each paragraph, the patient or responsible party listed below acknowledges they have read and understood the following:

PAYMENT RESPONSIBIBITY

____ Payment for office services or the co-payments and/or the co-insurance is payable when service is rendered. Payment for medical services is between University Orthopedics and the patient/responsible party. Therefore, University Orthopedics cannot accept responsibility for collecting or negotiation settlement on any disputed (1) health insurance claim, (2) worker's compensation claim, (3) accidental injury/illness, liability claim, (4) claim where patient is or will be represented by an attorney, and/or (5) claim to be settled in a court of law.

INSURANCE LIMITATIONS

____ Most insurance carriers require a written referral from a Primary Care Physician in advance of service provided by University Orthopedics. Patients or person responsible for the patient must (1) obtain physician referrals and (2) contact the insurance carrier to verify benefits in advance of service. At the time of service, patients are responsible for payment for non-covered services, deductibles and co-insurances. Patients are also responsible for any penalties imposed by their insurance company for seeing the patient out-of-network. University Orthopedics will file a patient's insurance as a courtesy.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

____ I authorize the physician to release any record, x-rays, and photographs acquired in the course of my treatment to referring physicians, insurance companies, hospitals or surgery centers. I authorize the release of all information necessary to transmit and process claims electronically and/or through any other reasonable and customary means in order to secure payment.

PHYSICIAN ASSISTANTS

____University Orthopedics utilizes Physician Assistants in our offices. Physician Assistants may provide care for you during your visit. By signing this form you give permission to have Physician Assistants assist in your care.

CONSENT TO TREAT

____I hereby voluntary consent to my treatment at University Orthopedics and authorize such treatments, examinations and diagnostic procedures (including by not limited to the use of lab and radiographic studies) as ordered by my attending/ covering physician.

Patient Name (print) _____

Signature of Patient/Responsible Party _____ Date _____

Witnessed By (office staff) _____ Date _____

Patient Agreement –
Pain Treatment with Opiod Medications

UNIVERSITY ORTHOPAEDICS

I, _____, understand and voluntarily agree that (initial each statement after reviewing):
Print full name

_____ I will keep (and be on time for) all my scheduled appointments with the doctor and other members of the treatment team.

_____ I will participate in all other types of treatment that I am asked to participate in.

_____ I will keep the medicine safe, secure and out of the reach of children. If the medicine is lost or stolen, I understand it will not be replaced until my next appointment, and may not be replaced at all.

_____ I will take my medication as instructed and not change the way I take it without first talking to the doctor or other member of the treatment team.

_____ I will not call between appointments, or at night or on the weekends looking for refills. I understand that prescriptions will be filled only during scheduled office visits with the treatment team.

_____ I will make sure I have an appointment for refills. If I am having trouble making an appointment, I will tell a member of the treatment team immediately.

_____ I will treat the staff at the office respectfully at all times. I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment will be stopped.

_____ I will not sell this medicine or share it with others. I understand that if I do, my treatment will be stopped.

_____ I will sign a release form to let the doctor speak to all other doctors or providers that I see.

_____ I will tell the doctor all other medicines that I take, and let him/her know right way if I have a prescription for a new medicine.

_____ I will use only one pharmacy to get all of my medicines: _____
Pharmacy name and phone #

_____ I will not get any opioid pain medicines or other medicines that can be addictive such as benzodiazepines (klonopin, xanax, valium) or stimulants (Ritalin, amphetamine) without telling a member of the treatment team **before I fill that prescription**. I understand that the only exception to this is if I need pain medicine for an emergency at night or on the weekends.

_____ I will not use illegal drugs such as heroin, cocaine, marijuana, or amphetamines. I understand that if I do, my treatment will be stopped.

_____ I understand that I may lose my right to treatment in this office if I break any part of this agreement.

Pain Treatment Program Statement

We here at UNIVERSITY ORTHOPAEDIC CLINIC (UOC) are making a commitment to work with you in your efforts to get better. To help you in this work, we agree that:

- We will help you schedule regular appointments for medicine refills. If we have to cancel or change your appointment for any reason, we will make sure you have enough medication to last until your next appointment.
- We will make sure that this treatment is as safe as possible. We will check regularly to make sure you are not having bad side effects.
- We will keep track of your prescriptions and test for drug use regularly to help you feel like you are being monitored well.
- We will help connect you with other forms of treatment to help you with your condition.
- We will help set treatment goals and monitor your progress in achieving those goals.
- We will work with any other doctors or providers you are seeing so that they can treat you safely and effectively.
- We will work with you medical insurance providers to make sure you do not go without medicine because of paperwork or other things they may ask for.
- If you become addicted to these medications, we will help you get treatment and get off of the medications that are causing you problems safely, without getting sick.

_____ _____ _____
Patient Signature | Patient name (printed) | Date

_____ _____ _____
Provider Signature | Provider name (printed) | Date