

Piedmont Orthopaedic Associates, P.A.
Patient Information Form
P L E A S E P R I N T

Date: _____
Name: _____ **Birth date:** _____ **Sex:** ____ **SS#:** _____
Address: _____ **City:** _____ **State:** _____ **Zip** _____
Home Phone: _____ **Emergency Contact: Name:** _____ **Phone:** _____
Marital Status: _____ **Do you live in a skilled Nursing Facility?** ____yes ____no.
Name of facility: _____

Employer:

Name: _____ **Phone:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Occupation: _____

If Patient Is A Minor:

Father's Name: _____ **Address:** _____ **Phone:** _____ **DOB:** _____
Employer: _____ **SS #:** _____
Mother's Name: _____ **Address:** _____ **Phone:** _____ **DOB:** _____
Employer: _____ **SS#:** _____

Referring Doctor: _____ ***Family Doctor:*** _____

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

Was this an on the job injury? ____ Yes ____ No

Description of Problem: _____ **Date of Injury:** _____

How did injury happen? _____

Employer at time of accident: _____ **Phone:** _____

Claim #: _____ **Worker's Compensation Insurance:** _____

Insurance:

Primary: _____ **Name of Insured:** _____
Insured's DOB: _____ **ID#:** _____ **Employer:** _____

Secondary: _____ **Name of Insured:** _____

Insured's DOB: _____ **ID#:** _____ **Employer:** _____

PAYMENT IS REQUIRED AT TIME OF SERVICE:

Payment for medical care is solely the responsibility of the patient or his/her legal guardian. By signing below I give Piedmont Orthopaedic Associates, PA authorization to treat my medical condition. I also allow them to release my medical information as is necessary for treatment, payment and operation of Piedmont Orthopaedic Associates, P.A.

Patient or Legal guardian's Signature: _____ **Date:** _____

ACKNOWLEDGEMENT OF RECEIPT OF PATIENT FINANCIAL POLICY:

I have read and understand Piedmont Orthopaedic Associates, PA "Patient Financial Policy" and I agree to all terms listed in the policy.

Patient or Legal guardian's Signature: _____ **Date:** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE:

I understand that the purpose of this notice is to inform me of my rights in regards to my "Protected Health Information" and also the ways in which Piedmont Orthopaedics may use my Protected Health Information. I also understand that Piedmont Orthopaedic Associates has my permission to use my Protected Health Information as necessary for treatment, payment and /or operation.

Patient or LegalGuardian's Signature: _____ **Date:** _____

Piedmont Orthopaedics Patient Health Form

Name: _____ Birth Date: _____ Today's Date: _____

Current Medications (Please list): _____

Drug Allergies (Please List): _____

Currently using birth control pills? _____ Yes _____ No _____ Calcium? _____ Yes _____ No _____

Prior surgeries and hospitalizations with dates (Please list): _____

Circle any of the following you have or have had: Heart attack High cholesterol Cancer Diabetes Lung disease
Liver disease Thyroid Blood clots Circulatory problems Excessive bleeding Ulcers Gout
Staph\MRSA Hepatitis AIDS High blood pressure Are you pregnant? Yes No

Other Medical Problems: _____

Family history of: Health and ages of parents, brothers, sisters (if no longer living give age at death and cause). _____

Social History: Single Married Divorced Widowed Have Children Alcohol use Drug use Tobacco use

Occupation: _____

Review of Systems: Please Circle any of the following symptoms or problems you presently have:

Constitutional: Fever Weight loss

Eyes: Double vision Blurred vision

ENT & Mouth: Deafness Sinus trouble Dental problems Hoarseness

Cardiovascular: Chest pain Palpitations High blood pressure Irregular beats

Respiratory: Shortness of breath Asthma Cough Trouble breathing at night Sleep Apnea Heavy Snoring

GI: Loss of appetite Diarrhea Constipation Abdominal pain Heartburn

GU: Trouble urinating Loss of bladder control Painful urination

MS: Pain in joints or bones Swelling of joints Arthritis Stiffness

Skin-Breast: Rashes Lesions Scars Masses Ulcers

Neuro: Stroke Numbness or tingling Seizures Weakness Balance problems

Psych: Depression Hallucinations Sleep disturbances

Endocrine: Frequent urination Frequent thirst Hyper or hypoactivity Growth or hair changes

Hematologic and Lymphatic: Bleeding tendency Lymph node pain or enlargement Anemia

Allergic Immunologic: Dermatitis Eczema Latex, Drug or other Allergies

For the Nurse: Onset Date: _____ MD Initials: _____ Date: _____

Pulse: _____ BP: _____ Temp. _____ Max. Lifetime Ht. _____ Ht. _____ Weight: _____ Arm span: _____

Piedmont Orthopaedic Associates, P. A.

Financial Policy

This Financial Agreement represents an agreement between the Physicians and Staff of Piedmont Orthopaedics and the Patient/Debtor. We feel that everyone benefits when there is a definite and clear understanding of our Financial Policy prior to treatment. By executing this agreement you as the patient/debtor are agreeing to pay for all services rendered by this facility that are not paid by insurance or other entities, except those that are excluded in this policy.

Insurance

Insurance is a contract between you and your insurance carrier. It is the patient's responsibility to understand his/her policy and benefits. If your insurance carrier requires a primary care referral you are responsible to see that one is issued and sent to our office prior to your visit. As a courtesy to our patient, we will file the insurance claims for covered services and supplies. You are ultimately responsible for payment. If your insurance company has not responded to our request for payment within 45 days the allowed balance will be billed to the patient for payment. You will then be responsible to settle the claim with your carrier. Co-pays and co-insurance are required at the time of service.

Payment Options If You Have No Insurance

Patients without insurance coverage will be required to pay for services in full at the time of service. This includes patients with liability insurance claims. For your convenience we accept cash, check, debit cards, Visa, Master Card and Discover.

Personal Injury /Liability

If this is a liability claim, payment of the account is the responsibility of the individual who has received the treatment, not the individual who is being sued. For this reason and the fact that liability claims may go on for an extended period of time, we require our fee to be paid promptly. We cannot bill your attorney for charges incurred due to a personal injury case

Non-/Contracted Insurance/Indemnity

If your insurance carrier is not a carrier that we have a preferred provider contract with we will not accept their "Usual and Customary" fees. Usual and Customary fees are determined by the individual insurance company. Our fees reflect the Usual and Customary charges for this area.

Medicaid

We do not participate with Medicaid. If your insurance is Medicaid we will ask for payment at the time of service.

Workers Compensation

We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

School Insurance

Student accident claim forms have to be completed by both the school and the patient/parent. We must have this form at the time of the first visit. School insurance policies have minimal coverage and normally do not pay the balance in full. You will be responsible for the balance due.

Surgery / MRI

If you require surgery or an MRI it is the policy of this office to obtain pre-certification and benefit information from your insurance carrier. We will provide you with an estimate of your financial obligation prior to surgery/MRI. It is the required policy of this office that payment of your estimated balance is paid prior to the procedure. Please remember that this is An estimate and the carrier will make final benefit determination after receipt of the claim.

Fracture Care

A fracture or "broken bone" is most often diagnosed by x-ray and can vary greatly in severity and treatment options. However for billing and insurance coding purposes, fracture care is listed in the Surgery Section of the AMA's Coding Book (CPT) and is subject to special Global or Surgical "Package" rules, regardless of whether these services were provided in the office or at the hospital. You should receive a copy of our fracture care "Billing" information from the Medical Assistant or the Front Desk.

Injections

Some insurance companies refer to injections, as "surgery." You may see the term "Surgery" on your Explanation of Benefits if you receive any of these services.

Supplies

For the convenience of our patients, Piedmont Orthopaedic Associates, when possible, will furnish medically necessary supplies to our patients. Be aware that not all supplies are covered by insurance. Please make sure you understand your insurance policy for supplies. Non-covered supplies will need to be paid at the time of receipt. We will file with your carrier for covered supplies. **Health care regulations restrict the reuse and resale of used items, therefore once an item is removed from our facility you will not be able to return the item.**

Divorce

In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment cost it is the authorizing parent's responsibility to collect from the other parent.

Past Due Accounts

If you have been seen by one of our physicians in the past and have a past due balance, the balance must be paid prior to your visit. If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs, which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all attorney fees that we incur plus all court costs.

Disability / Medical Forms

A fee is charged to complete disability / medical forms. We ask that you complete the patient-portion of the forms and submit them to our office as soon as they are received. Please allow one to two weeks for completion of the forms. Fee for all forms is \$15.00.

Returned checks

There is a fee (currently \$25) for any check returned by the bank.

Once you have signed our Patient Information Form you agree to all terms and conditions contained herein and the agreement will be in full force and effect.

Compound Authorization for Release of Information

Piedmont Orthopaedic Associates
35 International Drive 1050 Grove Road
Greenville, SC 29615 Greenville, SC 29605
864-234-7654

Name of Patient _____ Date of Birth _____

Piedmont Orthopaedic Associates, P.A. is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

| Entity to Receive Information. Check each person/entity that you approve to receive information. | Description of information to be released. Check each that can be given to person/entity on the left in the same section. |
|--|---|
| <input type="checkbox"/> Voice Mail | <input type="checkbox"/> Results of lab tests/x-rays, Appointment Reminder <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Give information to employer <input type="checkbox"/> Give information to school | <input type="checkbox"/> Appointment absentee information |
| <input type="checkbox"/> Spouse | <input type="checkbox"/> Family billing information <input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows: _____ |
| <input type="checkbox"/> Parent (provide name) _____ | <input type="checkbox"/> Family Billing Information <input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows: _____ |
| <input type="checkbox"/> Other (provide name) _____ _____ | <input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows _____ |
| <input type="checkbox"/> Support Group (provide name) _____ | <input type="checkbox"/> Demographic Information |

Rights of the Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Piedmont Orthopaedic Associates, P.A. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

Date _____

Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation)