ORTHOGEORGIA
Orthopaedic Specialists

PATIENT REGISTRATION

OFFICE USE ONLY: Date: _____ Time: _____ AM/PM Initials _____

PATIENT INFORMATION

Last Name: _____ First Name: _____Middle Initial: _____
Date of Birth: _____ Social Security Number: _____-_____-_____
Address: _____ City:_____ State: _____
Zip: _____ Sex (circle one): Male Female Home Phone: (_____) _____ - _____
Work Phone: (_____) _____ - _____ Mobile Phone: (_____) _____ - _____
Email: _____
Contact Preference: □ Home Phone □ Work Phone □ Mobile Phone □ Email
Marital Status: □ Married □ Single □ Divorced □ Separated □ Widowed □ Partner
Language: □ English □ Spanish □ Other: _____
Race: □ Black or African American □ White □ Other: _____
Ethnicity: □ Hispanic or Latino/Spanish □ Not Hispanic or Latino □ Other: _____
How Did You Hear About Us: □ Patient in the Practice □ Physician Referral □ Urgent Care □ Hospital ER □ Internet □ Social Media □ Billboard □ Magazine □ Television □ Word of Mouth □ Self Referral

PHARMACY/LAB INFORMATION

Preferred Pharmacy: _____ Phone #: _____
Preferred Lab: □ Lab Corp □ Quest □ MCCG □ No Preference

INSURANCE INFORMATION

Insurance Company: _____ Is Injury Work Related? □ Yes □ No
Policy Number: _____ Address: _____
Is Injury From a Car Accident? □ Yes □ No Another Party Responsible? □ Yes □ No Injury Date: _____
Were you referred by a doctor? □ Yes □ No If yes, who? _____
**If Policyholder/Responsible Party is different from the patient, please answer the questions below:
Name: _____ Patient's Relationship to Policyholder/Responsible Party: _____
Date of Birth: _____ Address: _____
City: _____ State: _____ Zip: _____ Social Security Number: _____-_____-_____

GUARANTOR INFORMATION (For Minors Only)

Parents Name: _____ Date of Birth: _____
Social Security Number: _____-_____-_____ Parent Employer: _____

EMERGENCY CONTACT

Name: _____ Phone: (_____) _____ - _____ Relationship: _____

AUTHORIZATION

I hereby authorize payment directly to OrthoGeorgia and/or Macon Outpatient Surgery, Inc. for any surgical and/or medical benefits due. I further authorize release of any information, photographs, and/or slides acquired in the course of my examination and/or treatment to recover such patients. I understand that payment is due at the time of service. I further understand and agree that my insurance is filed as a courtesy and that I am ultimately responsible for any balance due after the insurance company has made payment.

_____ _____
Patient Signature Date

ORTHOPAEDIC HEALTH HISTORY

OrthoGeorgia
Orthopaedic Specialists

Date of Visit: _____ OG MR# _____

PATIENT INFORMATION

Patient's Name: _____ Age: _____ DOB: _____

HISTORY OF CHIEF COMPLAINT

What body part are you seeing the doctor for today? □ Right □ Left □ Bilateral _____
Please explain your reason for today's visit: _____
How did it start? _____ When? _____
Was this caused by an injury? □ Yes □ No If yes, what is the date of injury: _____
Have you had any x-rays, MRI, CT for this problem? □ Yes □ No If yes, When? _____ Where?_____

VITALS

Pain Scale (0 - no pain, 10 - worst pain): 0 1 2 3 4 5 6 7 8 9 10 Height: _____ Weight: _____

MEDICATIONS

List all medications you are currently taking. Please include the dosage. □ NONE □ See Attached List

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

ALLERGIES

List Allergies and Reactions: □ NONE □ **Latex Allergy** □ **Tape Allergy** □ **Iodine/Betadine Allergy** □ **Egg Allergy**
Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____

PROVIDERS

Current Primary Care Physician: _____ Referred By: _____

PATIENT PHARMACY

Preferred Pharmacy: _____ Phone #: _____
Secondary Pharmacy: _____ Phone #:_____

SURGICAL HISTORY

Please check if you have had any of these surgeries in the past: □ **NONE**

□ Ankle Surgery	□ Defibrillator	□ Hip Replacement	□ Pacemaker
□ Appendectomy	□ Elbow Surgery	□ Hip Surgery	□ Shoulder Replacement
□ Back Surgery	□ Gallbladder Surgery	□ Hysterectomy	□ Shoulder Surgery
□ Breast Surgery	□ Gastric Bypass	□ Knee Replacement	□ Thyroidectomy
□ CABG	□ Hand Surgery	□ Knee Surgery	□ Tonsillectomy
□ Carpal Tunnel Release	□ Heart Surgery	□ Neck Surgery	Other: _____
□ Cesarean Section	□ Hernia Repair	□ ORIF of _____	Other: _____

PAST MEDICAL HISTORY

□ AIDS/HIV	□ Dialysis	□ Migraine Headaches
□ Anemia	□ DVT/Phlebitis	□ Osteoarthritis
□ Arthritis	□ Fibromyalgia	□ Osteoporosis
□ Asthma	□ GERD	□ Rheumatoid Arthritis
□ Bleeding Disorder	□ GI Bleed	□ Seizures
□ Blood Clotting Disorder	□ Gout	□ Stroke
□ Blood Thinners	□ Heart Disease	□ Thyroid Disease
□ Cancer	□ Hepatitis, Type: _____	□ Ulcers
□ COPD	□ Hypertension	Other: _____
□ Depression	□ Kidney Disease	Other: _____
□ Diabetes	□ Liver Disease	Other: _____

FAMILY HISTORY

Please tell us about any family members who have or have had major health problems: □ Unknown/Adopted

Mother: □ Alive □ Deceased

Health problems: _____

Father: □ Alive □ Deceased

Health problems: _____

Siblings: □ Brother □ Sister □ Alive □ Deceased

Health Problems: _____

SOCIAL HISTORY

Marital Status: □ Married □ Single □ Divorced □ Separated □ Widowed □ Domestic Partner

Hand Dominance: □ Right □ Left □ Bilateral

Exercise Level: □ None □ Occasional □ Moderate □ Heavy

Are you currently employed? □ Yes □ No Employer: _____

Occupation: _____

Smoking Status: □ Never smoker □ Former Smoker □ Current Every Day Smoker □ Current Some day Smoker
□ Smoker - current status unknown □ Unknown if ever smoked

How much do you smoke? □ 1 PPW □ 2 PPW □ 1/4 PPD □ 1/2 PPD □ 1 PPD □ 1.5 PPD □ 2 PPD □ 3+ PPD

Has smoked since age: _____ Chewing tobacco: □ None □ 1 per day □ 2-4 per day □ 3+ per day

Illicit Drugs: _____ Alcohol Intake: □ None □ Occasional □ Moderate □ Heavy

Are you currently pregnant: □ No □ Yes □ Unsure

Is this a work related injury? □ Yes □ No Is this an Auto related injury? □ Yes □ No

If you were injured, is litigation ongoing? □ Yes □ No

REVIEW OF SYSTEMS

Select Yes only for the symptoms you are currently experiencing

	Y	N		Y	N		Y	N
Fever	□	□	Cough	□	□	Fainting spells	□	□
Night Sweats	□	□	Shortness of breath	□	□	Weakness	□	□
Weight Gain/Loss	□	□	Cough with blood	□	□	Dizziness	□	□
Vision Changes	□	□	Abdominal pain	□	□	Headaches	□	□
Hearing Loss	□	□	Vomiting	□	□	Fatigue	□	□
Nose/Sinus Problems	□	□	Diarrhea	□	□	Swollen glands	□	□
Chest Pain	□	□	Difficulty urinating	□	□	Itching/Hives	□	□
Irregular heartbeat	□	□	Rash	□	□	Numbness/Tingling	□	□

Patient Signature: _____ Date: _____ Provider Signature: _____

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize Macon Orthopaedic and Hand Center, dba OrthoGeorgia to release any information concerning my medical condition necessary during the course of my examination and treatment. I authorize the use of this form on all of my insurance submissions. I authorize payment directly to the physicians and understand that I am responsible for my bill.

ACKNOWLEDGEMENT OF RECEIPT OF FINANCIAL POLICY AND PATIENT RESPONSIBILITY

I acknowledge that the OrthoGeorgia Financial Policy & Patient Responsibility Agreement has been provided to me. I have read and understand all of the financial and patient responsibilities that may arise during my course of treatment at OrthoGeorgia

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that the OrthoGeorgia Privacy Notice has been made available to me. A paper copy of this Notice will be provided at my request. This Notice is also displayed in the offices of OrthoGeorgia.

DIAGNOSTIC STUDIES

I understand that OrthoGeorgia can provide services for diagnostic studies and tests. I understand that I have the option of choosing another facility if I so desire. OrthoGeorgia will provide me a list of other facilities at my request.

REHABILITATION SERVICES

I understand that OrthoGeorgia can provide rehabilitation services at their facility to include physical therapy and occupational therapy. I understand that I have the option of choosing another facility if I so desire. OrthoGeorgia will provide me a list of other facilities at my request.

MEDICATION HISTORY AUTHORIZATION

☐ I give OrthoGeorgia permission to obtain/retrieve and view my medication history. I understand that this information will be disclosed/divulged as part of my medical record release.

☐ I do not give OrthoGeorgia permission to obtain/retrieve and view my medication history. I understand that this information will be disclosed/divulged as part of my medical record release.

_____ _____

Patient or Patient Representative Printed Name | Personal Representative Relation to Patient

_____ _____

Patient or Personal Representative Signature | Date

Consent to Treatment and Other Acknowledgments

By reading and signing this document, I, the undersigned patient (or authorized representative) consent to and authorize the performance of any treatments, examinations, medications, anesthesia, medical services, and surgical or diagnostic procedures (including but not limited to the use of lab and radiographic studies) as ordered or approved by my attending physician(s), or any healthcare professional assigned to my care by my attending physician(s), and I acknowledge and consent to the following:

1. INDEPENDENT CONTRACTORS: OrthoGeorgia may utilize independent contractors for office, outpatient or inpatient treatment/procedures. These include, but are not limited to, surgical assistants, physical therapists, and consulting and referral physicians. Healthcare professionals that are independent contractors are not agents or employees of OrthoGeorgia and are responsible for their own actions. I understand that OrthoGeorgia shall not be liable for the acts or omissions of independent contractors. This Consent to Treatment also applies to any independent contractor utilized by my physician(s).

2. VALUABLES: OrthoGeorgia assumes no responsibility for, and I hereby release OrthoGeorgia from liability for, loss or damage to any of my personal property while on the premises and/or receiving treatment.

3. AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF THIRD PARTY PAYMENTS: I hereby expressly authorize OrthoGeorgia and all healthcare professionals providing care to release all necessary information to any insurance company, health plan or other entity (third party payor) which may be responsible for paying for my care. I authorize and direct all payors to pay all benefits due for such care directly to OrthoGeorgia and all professionals (including independent contractors) providing for such care, and I hereby assign such sums to them. I understand this authorization and assignment shall remain valid unless I provide written notice of revocation to OrthoGeorgia and the third party payor signed and dated by me; however, such revocation shall not be effective as to information released and/or charges incurred prior to such revocation.

4. PAYMENT FOR SERVICES: In return for services to be provided by OrthoGeorgia, I promise to pay for services rendered by OrthoGeorgia to me or for my benefit. If the services I receive from OrthoGeorgia are covered by a third party payor, OrthoGeorgia may elect to bill and accept payment from such third party. I will pay the portion of these bills which the third party payor determines are my responsibility. In the case of services which I agree to receive but which are not covered by the third party, I will pay the amount due upon receipt of services. If no third party is involved in paying for my services, I agree to pay in full for such services at the time the services are received.

5. AUTHORIZATION AND RELEASE FOR PHOTOGRAPHS: I authorize and release OrthoGeorgia and its employees and agents to take photographs, videos, x-rays, and/or other photographic, electronic or other images of me and to use them as may be medically appropriate. Such images may be used for educational or other purposes as necessary and appropriate. These images may be maintained as a permanent part of my medical record. I understand and acknowledge that OrthoGeorgia may use cameras for security and patient monitoring, and patient confidentiality will be maintained for all such images.

6. NO GUARANTEE OF RESULTS: OrthoGeorgia physicians and healthcare professionals cannot guarantee any specific result(s) of any examination, treatment, procedure or medical care. I release OrthoGeorgia, its physicians and healthcare professionals from any liability for any accident or injury that is not directly caused by the negligence of OrthoGeorgia or its employees.

7. During the course of my care and treatment, I understand that various types of examinations, tests, diagnostic or treatment procedures ("procedures") may be necessary. These procedures may be performed by physician(s), nurses, technicians, physician assistants, or other healthcare professionals. While routinely performed without incident, there may be material risks associated with these procedures. If I have any questions concerning these procedures, I will ask my physician(s) to provide me with additional information. I also understand my physician may ask me to sign additional Informed Consent documents relating to specific procedures.

8. I understand that the healthcare professionals involved in my care will rely on my documented medical history, as well as other information provided by me, my immediate family, or others having information about me, in determining whether to perform or recommend procedures. I agree to provide accurate and thorough information regarding my medical history and any conditions or events which may impact medical decision-making.
By signing this document, I certify that I have read and understand its contents and that information provided by me is accurate and complete (including insurance information and current eligibility for benefits).

A copy of this document may be utilized the same as the original.

_____ Date: _____

Patient/Parent/Guardian/Authorized Representative

If not signed by the patient, please indicate relationship to the patient on the line below:

_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPAA), in order for your healthcare provider or staff of OrthoGeorgia to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

_____I **do not** authorize OrthoGeorgia to release any or all information concerning my medical care to any individual except as set forth above.

_____I **authorize** OrthoGeorgia to verbally release any or all information concerning my medical care to the following individuals,

_____	_____
Name	Relationship to Patient
_____	_____
Name	Relationship to Patient
_____	_____
Name	Relationship to Patient
_____	_____
Patient Signature	Date

_____	_____	_____
Print Patient Name	Date of Birth	Social Security#

_____
MRN#

ORTHOGEORGIA NO SHOW POLICY

It is the goal of OrthoGeorgia to provide all of our patients with World Class Orthopedic Care here in Middle Georgia. Our physicians and staff want to ensure a thorough and prompt appointment process so all patients get the treatment they deserve. One key to providing excellent patient care is appointment availability. OrthoGeorgia is a busy practice and, since provider schedules are often full, it is imperative that patients unable to keep a scheduled appointment contact us in a timely manner to reschedule and allow the open appointment to be offered to patients in need.

In an effort to accommodate all of our patients with the soonest possible appointment time, effective April 1st, 2023, OrthoGeorgia will introduce this Patient No-Show Policy. OrthoGeorgia asks that patients needing to reschedule or cancel their appointments do so at least 24 hours in advance of their appointment time. No Show fees will be assessed to patients who do not cancel their appointment in the specified time frame. The fee schedule will be dependent on the type of services being rendered. The No-Show fee schedule is as follows:

Office Visit - $50

Therapy Visit - $25

Diagnostic Services (MRI/CT/EMG) - $100

Surgical Services - $250

EXCEPTIONS:

OrthoGeorgia understands certain emergency circumstances may prevent patients from being able to cancel their appointments more than 24 hours prior and these will be considered on a case-by-case basis.

I, _____, have read the above No Show Policy and acknowledge that, should I No Show an appointment or fail to cancel more than 24 hours prior to my appointment time, I could be assessed a “No Show” Fee. I further understand I will be unable to be seen for a visit at OrthoGeorgia until any “No Show” Fees have been paid.

Patient Name: _____ DOB:_____

Parent/Guardian Name (if patient is a minor): _____

Signature:_____ Date:_____

OrthoGeorgia

Financial Policy & Patient Responsibility Agreement

We would like to thank you for choosing **OrthoGeorgia** as your healthcare provider. **OrthoGeorgia** is committed to providing you with the best possible medical care. It is important that you understand that payment for this healthcare is your responsibility. The following information outlines your financial responsibilities related to payment for professional services. This policy applies to all **OrthoGeorgia** locations.

For Our Patients with Medical Insurance Benefits:

We participate in most major health plans. We have contracts with many HMO's, PPO's, insurance companies and government agencies including Medicare and Medicaid. Our business office will submit claims for any services rendered to a patient who is a member of one of these plans and will assist you in any way we reasonably can to help get your claims paid. It is the patient's responsibility to provide all necessary information before leaving the office. If you have a secondary insurance we will automatically file a claim with them as soon as the primary carrier has paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. It is also your responsibility to inform OrthoGeorgia timely of any changes to your health coverage; such as, loss of coverage, due to employment changes and/or termination. You are financially obligated for any services you receive.

Please bring your ID and insurance card with you at the time of your appointment.

If you are insured by a plan we do business with but don't have an insurance card with you, payment in full for each visit is required until we can verify your coverage.

Medical services that are considered by your insurance company to be non-covered, out of network, or not medically necessary will be your responsibility.

Co-Payments/ Co-insurance/ Deductibles:

Your insurance company requires us to collect co-payments at the time of service. Waiver of co-payments may constitute fraud under state and federal law. Please help us in upholding the law by paying your co-payment at each visit. For your convenience we accept cash, checks or the following credit cards: Visa, MasterCard and Discover. If you do not have your co-payment your appointment may be rescheduled.

You may have co-insurance and/or deductible amounts required by your insurance carrier**. Until deductiblesare satisfied**, an upfront deposit of $200 will be requested at check-in for each visit. Any additional services rendered during your visit will be collected at check-out. Any outstanding balance on your account, after adjusting for all of your insurance's responsibilities, will be billed to you. Other services provided within your care at OrthoGeorgia, such as therapy, will be a separate benefit and that information will be provided to you at the time of service or prior to the time of service.

Waiver of Patient Responsibility:

It is the policy of the practice to treat all patients in an equitable fashion related to account balances. The practice will not waive, fail to collect, or discount co-payments, co-insurance, deductibles, or other patient financial responsibility in accordance with state and federal law, as well as participating agreements with payers.

For Our Patients with No Medical Insurance or Limited Plans:

If you do not have group/individual medical insurance or a limited plan, payment for all professional services is expected at the time of your visit. Please note, we do offer self pay rates for patients without health insurance. A deposit of $500.00 will be required at check-in for every physician visit. Other fees may vary depending on the type of service.

Late Arrivals:

A patient who arrives more than 15 minutes after his/her appointment is considered a late arrival. A late arrival, not considered to be the responsibility of the Practice, will be registered and worked into the schedule as soon as possible. If the patient is more than 30 minutes late, the appointment may be rescheduled.

Appointment No-Shows:

Any patient who fails to arrive for a scheduled appointment without cancelling the appointment at least 24 hours prior to the scheduled time is considered a “no-show”. A patient who fails to present themselves two times for scheduled appointments is considered a chronic no-show. A patient who is a chronic no-show may be dismissed from the Practice.

Delinquent Balance Appointment:

Patients with a delinquent balance are required to make payment in full for future services. A delinquent account is defined as a patient balance in excess of 120 days if the patient has not made any payments or sought assistance during this time. If such payment is not made, services may be refused. Any unpaid balance, regardless of payment plan, must be paid in full before moving forward with a new illness/injury and/or physician.

Nonpayment:

All patient responsible balances that remain delinquent after 90 days, with no response to our requests for payment, may be referred to a collection agency. **OrthoGeorgia** will charge a fee of 27% of the total balance due if an account is turned over to an outside collection agency. Please be aware that if a balance remains unpaid, you and/or your immediate family members may be discharged from this practice.

_____

It is your responsibility to demonstrate respect and be considerate of caregivers, staff, other patients, property of others, and the facility. Be aware that any behavior considered disrespectful, disruptive or abusive will result in dismissal from our facility.

Thank you for understanding our policies. Please let us know if you have any questions or concerns.