ORTHO GEORGIA
Orthopaedic Specialists

PATIENT REGISTRATION

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: ___

Date of Birth: _____ Social Security Number: _____

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

Home Phone: _____ Mobile Phone: _____

Work Phone: _____ Email: _____

Contact Preference: □ Home Phone □ Work Phone □ Mobile Phone □ Email

Sex (circle one): Male Female Other: _____ 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: □ **Physician Referral / Name of Physician**: _____

□ Urgent Care □ Hospital ER □ Internet □ Social Media □ Billboard □ Television □ Word of Mouth □ Self-Referral

INJURY INFORMATION

Is Injury Work Related? □ Yes □ No Adjuster: _____ Employer: _____

Is Injury from a Car Accident? □ Yes □ No Another Party Responsible? □ Yes □ No If YES, who:

Injury Date: _____ Injured Body Part: _____

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

INSURANCE INFORMATION

Primary Insurance Company: _____ Policy/Id Number: _____
Group Number: _____ Address: _____
Responsible Party: Self _____ Other: _____ Relationship: _____
Secondary Insurance Company: _____ Policy/Id Number: _____
Group Number: _____ Address: _____
Responsible Party: Self _____ Other: _____ Relationship: _____

****If Policyholder/Responsible Party is different from the patient, please answer the questions below****

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

GUARANTOR INFORMATION (For Minors Only)

Parents Name: _____ Date of Birth: _____

Social Security Number: _____ Parent Employer: _____

EMERGENCY CONTACT

Name: _____ Phone: _____

Relationship: _____

ORTHOGEORGIA Orthopaedic Specialists

ORTHOPAEDIC HEALTH HISTORY

Date of Visit: _____

PATIENT INFORMATION

Patient's Name: Age: DOB:

REASON FOR TODAY'S VISIT

What body part are you being seen for today? _____ □ Right □ Left □ Bilateral

How did it start: _____ When did it start? _____

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 _____

PATIENT PHARMACY/LAB

Preferred Pharmacy: _____ Phone #: _____

Secondary Pharmacy: _____ Phone #: _____

Preferred Lab: □ Lab Corp □ Quest □ MCCG □ No Preference

PROVIDERS

Current Primary Care Physician: _____

OTHER PROVIDERS

Provider Name: _____ Specialty: _____

Provider Name: _____ Specialty: _____

Provider Name: _____ Specialty: _____

VITALS

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

ALLERGIES

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

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

MEDICATIONS

List all medications you are currently taking (please include the dosage). □ NONE □ See Attached List

_____ _____

_____ _____

_____ _____

_____ _____

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: _____

ORTHOPAEDIC HEALTH HISTORY

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

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: □ Yes □ No □ Unsure

SURGICAL HISTORY

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

□ Ankle Surgery (R / L)	□ Defibrillator	□ Hip Replacement (R / L)	□ Pacemaker
□ Appendix removal	□ Elbow Surgery (R / L)	□ Hip Surgery (R / L)	□ Shoulder Replacement (R / L)
□ Back Surgery	□ Gallbladder Surgery	□ Hysterectomy	□ Shoulder Surgery (R / L)
□ Breast Surgery	□ Gastric Bypass	□ Knee Replacement (R / L)	□ Thyroid removal
□ Open heart surgery	□ Hand Surgery (R / L)	□ Knee Surgery (R / L)	□ Tonsil removal
□ Carpal Tunnel (R / L)	□ Heart Surgery	□ Neck Surgery	□ Other: _____
□ Cesarean Section	□ Hernia Repair	□ ORIF of _____	□ Other: _____

Please list the date of your surgery and the doctor who did the surgery: _____

PAST MEDICAL HISTORY

□ AIDS/HIV	□ Dialysis	□ Migraine Headaches
□ Anemia	□ High Cholesterol	□ Osteoarthritis
□ Apnea (sleep)	□ Fibromyalgia	□ Osteoporosis
□ Asthma	□ Acid reflux	□ Rheumatoid Arthritis
□ Bleeding Disorder	□ GI Bleed	□ Seizures
□ Blood Clots/Disorder	□ Gout	□ Stroke
□ Blood Thinners	□ Heart Disease	□ Thyroid Disease
□ Cancer, Type: _____	□ Hepatitis, Type: _____	□ Ulcers
□ COPD	□ High blood pressure	□ Malignant hypothermia
□ Depression	□ Kidney Disease	Other: _____
□ Diabetes (Type I or II)	□ Liver Disease	Other: _____

REVIEW OF SYSTEMS

Circle Yes or No (Select Yes only for the symptoms you are currently experiencing)

Fever	Yes / No	Cough	Yes / No	Fainting spells	Yes / No
Night Sweats	Yes / No	Shortness of breath	Yes / No	Weakness	Yes / No
Weight Gain/Loss	Yes / No	Cough with blood	Yes / No	Dizziness	Yes / No
Vision Changes	Yes / No	Abdominal pain	Yes / No	Headaches	Yes / No
Hearing Loss	Yes / No	Vomiting	Yes / No	Fatigue	Yes / No
Nose/Sinus Problems	Yes / No	Diarrhea	Yes / No	Swollen glands	Yes / No
Chest Pain	Yes / No	Difficulty urinating	Yes / No	Itching/Hives	Yes / No
Irregular heartbeat	Yes / No	Rash	Yes / No	Numbness/Tingling	Yes / No

Patient Signature: _____Date: _____ Provider Signature: _____

ORTHO GEORGIA
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SPINE CENTER
NEW PATIENT WORKSHEET

Date of Visit: _____ Patient Full Name: _____

Reason for Visit: _____ Preferred Pharmacy: _____

Who referred you to our office? _____ Primary Care Physician: _____

Height: _____Weight: _____Allergies: _____ Age: _____

Are your current symptoms related to an injury? □ No □ Yes Please describe: _____

If your current symptoms are related to an injury, do you have a lawyer? □ No □ Yes

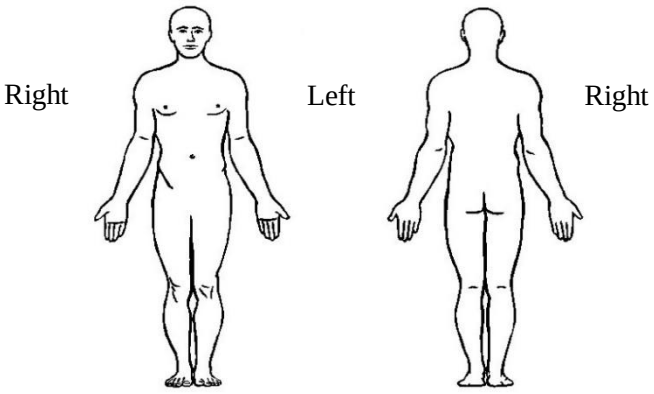
Is your current injury a work-related injury? □ No □ Yes Please describe:_____

Have you had this problem before? □ No □ Yes Please describe:_____

Are you currently using any DME or wanting any DME (i.e. walker, cane, brace, etc.) _____

Mark areas where you are having **PAIN** with an **X**, and **NUMBNESS/TINGLING** with an **O**:

Front Back

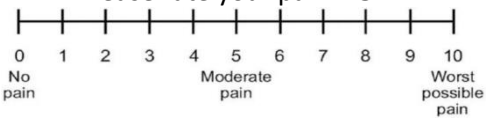


Pain is: □ Equal on both sides □ Only worse on the right side □ Only worse on the left side

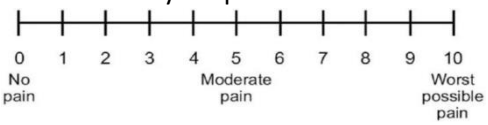
How would you describe your pain now?

□ Aching □ Burning □ Stinging □ Stabbing □ Throbbing □ Sharp □ Dull □ Intermittent □ Constant □ Worsening □ Improving □ Not Changing

Please rate your pain **NOW**:



Please rate your pain **AT ITS WORST**:



When did your current symptoms and/or injury begin/occur:

_____

Is your pain: □ Acute □ Chronic □ Abrupt □ Gradual □ Worse in morning □ Worse in Daytime □ Worse at night

What makes your pain BETTER? □ Nothing □ Sitting □ Standing □ Lying Down □ Position Change □ Heat □ Ice □ Rest □ Exercise □ Stretching □ Walking □Twisting □ Bending Forward □ Bending Backward □ Other:_____

What makes your pain WORSE? □ All activity □ Sitting □ Standing □ Lying down □ Walking □ Lifting □ Carrying □ Twisting □ Bending/Squatting □ Pushing/Pulling □ Exercise □ Going from sit to stand □ Stairs □ Pain wakes you from sleep □ Sneezing/Coughing □ Other: _____

Are you experiencing any of the following:

□ Arm/leg weakness □ Swelling □ Redness □ Warmth □ Instability □ Radiation down leg (right or left) □ Drainage □ Fever □ Chills □ Fall □ Inability to urinate/bowel changes □ Loss of balance

Have you had any previous neck or back surgery? If so, please explain: _____

What tests have you had for this problem?

□ XRAY □ MRI □ CT Scan □ Bone Scan □ EMG/Nerve Study □ Myelogram □ Blood work Where/Date: _____

Have you received any oral steroids or steroid injections?

□ No □ Yes If so, did it help □ Yes □ No (If yes, what kind?) _____

Have you tried any of the following? □ Physical Therapy □ Chiropractor □ Acupuncture □ Massage Therapy

If so, did it help □ Yes □ No If so, where/when/for how long: _____

What is your current work status?

□ Out of work □ Light duties □ Full duties □ Retired

Occupation OR previous occupation: _____

List anything else you cannot do or have had to change because of your symptoms: _____

What medications have you tried? (CIRCLE WHICH WORKED BEST) _____

Provider Notes:

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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 AND UNDERSTANDING OF FINANCIAL POLICY

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 available on the OrthoGeorgia website. www.orthoga.org/wp-content/uploads/privacy_notice.pdf.

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 with 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 with 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.

PAYMENT 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 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.

Patient/Parent/Guardian/Authorized Representative Signature _____

Date: _____

If not signed by the patient, please print your name and 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 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#

Attendance Policy for Office Visits, Surgery, Procedures, and Diagnostic Testing

It is the goal of OrthoGeorgia to provide all 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.

To accommodate all of our patients with the soonest possible appointment time, OrthoGeorgia has established an Attendance Policy. OrthoGeorgia asks that patients needing to reschedule or cancel their appointments do so at least 24 hours (1 business day) in advance of their appointment time. Patients are expected to adhere to the Appointment Attendance Policy. Failure to do so, including no-shows, late cancellations or rescheduling appointments, procedures, surgeries, or diagnostic testing may result in fees being assessed. Applicable fees are based on the type of service scheduled and are outlined below.

The No-Show fee schedule is as follows:

- Office Visit - $50
- Therapy Visit $25
- Diagnostic Services (MRI/CT/EMG) - $100
- Procedures & Surgical Services - $250

In addition to the above fee schedule, please make note that the following physicians maintain a separate policy regarding procedural and surgical cancellations.

Dr. Stapleton, Dr. Kelley, Dr. Brooks, Dr. Dasher, Dr. Pope & Dr. Barrera Procedural/Surgical Cancellation/No Show Policy:

Due to the blocks of time required and resources utilized for outpatient procedures and/or surgery, last minute cancellations and no shows cause problems and added costs for your Physician and Ortho Georgia. Once a procedure and/or surgery has been scheduled, ANY cancellation, reschedule or "No-Show" will result in a $250 cancellation fee.

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.

1,_____, have read the above No Show Policy and acknowledge that, should I No Show an appointment or fail to cancel based on the guidelines above, 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 in full.

Patient Name: _____ DOB: _____

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

Signature: _____ Date: _____

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 Deductibles are 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 15 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" and will be subject to the OrthoGeorgia "No-Show" Policy. 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.