CAROLINA ORTHOPAEDICS

Today's Date ________________

Last Name: ______________________________ First Name: _____________________________ Middle Initial: __________

Date of Birth: ________________ Age: ________ Social Security #: ________-______-________ Sex: □ Male □ Female

Patient Address: ____

City: ____ State: _______________________ Zip: ____________

Home Phone: ______-______-________ Cell Phone: ______-______-________ Work Phone: ______-______-________

What is the best contact phone number to reach you?: ____

Email Address: ______________________________ Marital Status: □ Married □ Single □ Divorced □ Widowed

Employer: ________________ Occupation: ________________ □ Retired □ Student □ Disabled □ Military

Emergency Contact: __________________________________ Relationship: ____________________________________

Emergency Contact Phone Number: ______-______-_______ Alternate Number: ______-______-________

May we leave a voicemail on your □ Home Phone □ Cell Number □ Work Number □ Do Not Leave A Message

Primary Insurer:

Responsible Party (Guarantor) for Insurance & Bills: □ Self □ Spouse □ Parents □ Mother □ Father □ Other ___________

Insurance Company: ____

Name of Insured: _________________________________ Relationship to Policyholder: □ Self □ Spouse □ Dependent

Policyholder Name: ___________________________ SS# of Policyholder:_______________ Policyholder DOB: ____________

Secondary Insurer (If Applicable):

Responsible Party for Insurance & Bills: □ Self □ Spouse □ Parents □ Mother □ Father □ Other __________________

Insurance Company: ____

Name of Insured: _________________________________ Relationship to Policyholder: □ Self □ Spouse □ Dependent

Policyholder Name: ___________________________ SS# of Policyholder:_______________ Policyholder DOB: ____________

Primary Care Physician: ______________________________ **Referring Physician**:___________________________________

If no referring doctor, how did you hear about Carolina Orthopaedics?

□ Internet □ Friend/Family □ Existing Patient □ Insurance Company □ Other _________________________________

Preferred Pharmacy: _______________________________ **Preferred Pharmacy Phone Number**: ______-______-_________

Preferred Pharmacy Address: ____

Advance Directives:

□ None □ DNR □ Living Will □ Durable Power of Attorney □ HC Proxy

Patient's Name & DOB____ **Today's Date**_______________

Reason for today's visit: ____ Date of Injury: ___________________

Was this the result of an accident? ◻ YES ◻ NO If so, please describe: ___________________________________

Is your injury Work Related: ◻ YES ◻ NO Is your injury the result of a Car Accident: ◻ YES ◻ NO

Have you been treated previously or had surgery for this same condition?: ◻ YES ◻ NO If so, please explain below:

____

When did your symptoms begin?: ____

Current Medications (Please include all prescription and over-the-counter medications) ◻ See List (Please Attach)

Name / Dose	Name / Dose
1. ____________________	7. ____________________
2. ____________________	8. ____________________
3. ____________________	9. ____________________
4. ____________________	10. ____________________
5. ____________________	11. ____________________
6. ____________________	12. ____________________

Do you use chronic pain medicine? ◻ Y ◻ N If so, who is your primary prescriber? ______________________

Drug Allergies: ◻ YES ◻ NO If so, what? ____

Do you have any metal allergies (e.g. nickel, etc.) ◻ YES ◻ NO If so, what? ___________________________

Do you have a latex allergy? ◻ YES ◻ NO

PERSONAL MEDICAL HISTORY

◻ Y ◻ N Heart Attack	◻ Y ◻ N Liver Disease	◻ Y ◻ N Stomach Ulcer
◻ Y ◻ N Congestive Heart Failure	◻ Y ◻ N Hepatitis:	◻ Y ◻ N Bleeding Disorder
◻ Y ◻ N Atrial Fibrillation	Please Check One ◻ A ◻ B ◻ C	◻ Y ◻ N Gout
◻ Y ◻ N High Blood Pressure	◻ Y ◻ N Thyroid Disease	◻ Y ◻ N Cancer (Type____________)
◻ Y ◻ N COPD	◻ Y ◻ N Fibromyalgia	◻ Y ◻ N Drug/Alcohol Dependency
◻ Y ◻ N Diabetes	◻ Y ◻ N Rheumatoid Arthritis	◻ Y ◻ N Heart Disease
◻ Y ◻ N Depression	◻ Y ◻ N Osteoarthritis	◻ Y ◻ N Sleep Apnea
◻ Y ◻ N Anxiety	◻ Y ◻ N Pneumonia	Do you use a CPAP? ◻ Y ◻ N
◻ Y ◻ N Stroke/TIA	◻ Y ◻ N Kidney Disease	◻ Y ◻ N Obesity
◻ Y ◻ N Epilepsy/Seizures	◻ Y ◻ N Claustrophobia	◻ Y ◻ N Osteoporosis
◻ Y ◻ N GERD	◻ Y ◻ N Scoliosis	◻ Y ◻ N HIV/AIDS
◻ Y ◻ N DVT (Blood Clots)	◻ Y ◻ N Skin Infection	◻ Y ◻ N Other__________________
◻ Y ◻ N Pulmonary Embolism	MRSA ◻ Y ◻ N: Location___________	______________________________
◻ Y ◻ N Asthma		

Do you have a pacemaker? ◻ YES ◻ NO

Do you have a defibrillator? ◻ YES ◻ NO

Have you ever had an infection following a surgery? ◻ YES ◻ NO If so, please explain_____________________________

Patient's Name & DOB____ **Today's Date**_______________

SURGICAL HISTORY (Previous Surgeries)

Surgery	Date Performed	Surgery	Date Performed
1. ______________		6. ______________	
2. ______________		7. ______________	
3. ______________		8. ______________	
4. ______________		9. ______________	
5. ______________		10. ______________	

Have you ever had general and/or spinal anesthesia? ☐ YES ☐ NO Any issues? ____________________________________

PERSONAL AND SOCIAL HISTORY:

Do you use tobacco? ☐ YES ☐ NO ☐ FORMER If so, what type and how much? ______________________________

Have you ever tried to quit? ☐ YES ☐ NO ☐ IN THE PROCESS

Do you regularly participate in sports and physical activity? ☐ YES ☐ NO If so, how often? ______________________

Do you drink alcohol? ☐ YES ☐ NO If so, how often and how much? ____

Do you drink caffeine? ☐ YES ☐ NO If so, how often and how much? ____

FAMILY HISTORY (Please check any that have occurred in blood relatives):

☐ **Unknown** ☐ **Adopted**

Mother	Father	Grandparents	Siblings
☐ Alive & Well	☐ Alive & Well	☐ Alive & Well	☐ Alive & Well
☐ Cancer: ____________	☐ Cancer: ____________	☐ Cancer: ____________	☐ Cancer: ____________
☐ CVA/Stroke	☐ CVA/Stroke	☐ CVA/Stroke	☐ CVA/Stroke
☐ Diabetes	☐ Diabetes	☐ Diabetes	☐ Diabetes
☐ Cardiovascular Disease	☐ Cardiovascular Disease	☐ Cardiovascular Disease	☐ Cardiovascular Disease
☐ Other: ____________	☐ Other: ____________	☐ Other: ____________	☐ Other: ____________
☐ Deceased: Age ______	☐ Deceased: Age ______	☐ Deceased: Age ______	☐ Deceased: Age ______
Cause: ______________	Cause: ______________	Cause: ______________	Cause: ______________

REVIEW OF SYSTEMS

Are you CURRENTLY experiencing any of these conditions/symptoms?

Constitutional
- ☐ Y ☐ N Fever
- ☐ Y ☐ N Chills
- ☐ Y ☐ N Weight Loss

Cardiovascular
- ☐ Y ☐ N Chest pain
- ☐ Y ☐ N Irregular Heartbeat

Gastrointestinal
- ☐ Y ☐ N Abdominal pain
- ☐ Y ☐ N Reflux (GERD)
- ☐ Y ☐ N Difficulty swallowing

Skin
- ☐ Y ☐ N Unusual bruises
- ☐ Y ☐ N Rashes

Musculoskeletal
- ☐ Y ☐ N Joint Swelling
- ☐ Y ☐ N Joint Pain

Neurologic
- ☐ Y ☐ N Numbness/Tingling
- ☐ Y ☐ N Migraines
- ☐ Y ☐ N Weakness

Genitourinary
- ☐ Y ☐ N Incontinence

Hematologic
- ☐ Y ☐ N Excessive Bleeding

Respiratory
- ☐ Y ☐ N Shortness of Breath

Psychiatric
- ☐ Y ☐ N Mental illness

Other ______________________________
____
____
____

Patient's Name (Please Print): ____

Patient's Signature: ____ **Date:** _______________

Patient Name(Print):______________________________Patient DOB:____________

HIPAA Notice of Privacy Practices:

Carolina Orthopaedics, LLC

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for the purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and relates to your past, present, future physical, or mental health condition and or related health care services.

- Uses and disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law. I understand that as a part of my electronic health record, Carolina Orthopaedics will transmit my prescriptions electronically as permitted, to the pharmacy that I designate as my primary pharmacy provider. Additionally, Carolina Orthopaedics will obtain the history of all of my past and present prescriptions and I understand that those prescriptions will become a part of my electronic health record.

- Treatment:

We will use and disclose your protected health information to provide, coordinate, or manage your health care and related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred, to ensure that the physician has the necessary information to diagnose or treat you.

- Payment:

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

- Healthcare Operations:

We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse and Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement:Coroners,Funeral Directors, and Organ Donation:Research:Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates.

- Required Uses and Disclosures:

Under the law, we must make disclosures to you and when required by a Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164-500. Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

Patient Name(Print):_______________________________Patient DOB:_____________

You may revoke this authorization at any time in writing, except to the extent that your physician or the physician's practice has taken action in reliance on the use or disclosure indicated in the authorization.

- Your Rights:

The following is a statement of your rights with respect to your protected health information. You have the right to inspect or copy the following records: psychotherapy notes, information complies in reasonable anticipation of, or use in, a civil criminal, or administrative action or proceeding and protected health information that is subject to law that prohibits access to protected health information.
You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected healthy information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.
Your physician is not required to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.
You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.
You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We, Carolina Orthopaedics, LLC, reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and effective on or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individual with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our Compliance Officer in person or by phone.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

____ Date: ______/______/______
Print Name

____ Date: ______/______/______
Signature

As part of the Affordable Care Act, I understand I am entitled to electronic access to medical records, financial information (including Bill Pay online) and wish to participate in this patient portal provided by Carolina Orthopaedics, LLC.

My email address is: ______________________________
I authorized Carolina Orthopaedics, LLC to utilize my email for appointment and /or financial notifications. I understand I will be given a secure ID to participate in limited electronic information exchange with my provider, Carolina Orthopaedics, LLC.

Patient Name______________________________Patient Signature___________________________

Patient Name(Print):_____________________________Patient DOB:______________

Patient Information Considerations:
Carolina Orthopaedics, LLC strives at all times to protect the confidentiality of patient information. Please answer the following questions, so that we may protect your rights.

Where would you prefer our office to contact you in regards to appointment reminders, financial issues, or other information related to your care?

Home _____ Office _____ Other Phone Number ______________________________

May we leave messages on your answering machine/voicemail? _____Yes _____No

Is there anyone other than yourself that you would like our office to be able to discuss your test results, general health condition, financial issues, or who can pick up prescriptions on your behalf if you are not available? If so, please list below:

1. ____ ________________________________
Name Relationship to patient

2. ____ ________________________________
Name Relationship to patient

3. ____ ________________________________
Name Relationship to patient

Prescription Policy:
Carolina Orthopaedics, LLC has a 24-48 hour prescription policy on all medication refill requests. This is a universal policy and applies to all patients and on all medications. We ask that you do not wait until you are completely out of medication before you call or you will have to wait a day or more without medication. If your prescription can be called into a pharmacy, it is your responsibility to call your pharmacy to see if the prescription is ready to be picked up. We will not call you to let you know that it has been called in. Multiple phone calls to our office will not speed up the refill process.

If you are required to pick up your prescription at our office, you must provide us with a valid state issued picture ID, each and every time that you come to pick up your prescription. We will not be able to give you your prescription without proper identification.

Forms/X-rays:
There is a $15.00 fee for all patient requested forms and x-rays. This fee is to be paid up front. Forms may take up to 2-4 weeks to be completed by the physician. Requests for original x-rays will be honored within 48 hours of written request. Please be aware that any imaging disc(s) left in our office will be destroyed.

Carolina Orthopaedics reserves the right to re-schedule any appointment if you arrive 15 minutes after your scheduled appointment time.

____ __________________

Patient Signature **Date**

Patient Name(Print): ____ Patient DOB: _____________________

FINANCIAL POLICY

The intent of this document is to inform you of Carolina Orthopaedics, LLC Financial Policy. It is the philosophy of CO that all our patients receive the best possible care and service; therefore, your complete understanding of our Financial Policy, as it relates to your financial obligation, is an essential part of our philosophy. Please read this document thoroughly and sign and date the authorization page indicating that you have read, understand and agree to comply with these policies.

Payment, for all services by CO, is due in full at the time the services are rendered. Exclusion to this policy includes those patients who are members of a health plan in which CO participates with. If you are a member of a health plan that CO is in network with, we will file your services to that plan. Your estimated deductible, copayment, co-insurance or previous balance owed is due at the time you arrive for your appointment and prior to any surgery. If your health plan is one we do not participate with, we will file your services to them: however ALL amounts not paid by your health plan will be due from you. Medicaid is filed secondary to Medicare policies only.

You will receive a monthly statement itemizing the services rendered, claims submitted on your behalf; payments received and appropriate patient balance due. You will be billed in full for any services that your health plan deems to be non-covered or balances due after we have received payment from them. All patient balances are payable in full within 30 days after receipt of the statement. CO accepts cash, personal checks, money orders, MasterCard, Visa, and Discover as payment for services rendered.

It is the policy of CO that any patient, age eighteen years or older, will be financially responsible for all charges incurred. CO does not get involved with divorce or separation. For any patient under the age of eighteen, the person assigned guarantor on the new patient paperwork will be financially responsible for the account.

A $30.00 returned check fee will be assigned to your account for every check returned to CO as non-payable.

Refunds will be issued on a monthly basis. Refunds will be given in the form of a check, sent to last given address.

CO reserves the right to turn any patient over to an attorney and/or collection agency if it is deemed that their account has been in default of the payment obligations or compliance of this policy.

In the event you are unable to make your scheduled appointment, you must cancel at least 24 hours prior. If proper cancellation notice is NOT given, you will be charged a $25.00 fee for the missed appointment. If you are having a fluoroscopic procedure and do not give appropriate 24 hours notice, you will be charged a $100.00 fee.

If your injury is due to a work related accident, CO reserves the right to reschedule the appointment or change the appointment to self-pay at the time of service until Worker's Compensation benefits can be verified and authorization can be obtained from the Workers Compensation carrier. Any amount not paid for services rendered due to an accident will become the patient's responsibility unless otherwise specified by government insurance programs.

If your injury is due to a car accident, CO reserves the right to change the appointment to self-pay at the time of service. Any amount not paid for services rendered due to a car accident will become the patient's responsibility unless otherwise specified by government insurance programs. CO does not file to third party insurance companies, which includes all car insurance companies. Payment is due at the time of service for all self-pay services.

CO reserves the right to re-schedule any appointment if you arrive 15 minutes past your scheduled appointment time.

____ _______________________

Patient Signature **Date**