

## PATIENT DEMOGRAPHICS

GEORGIA BONE & JOINT SURGEONS, P.C

PATIENT INFORMATION					
Patient's Last Name:		First:		Middle:	
Street Address:					
City, State, Zip:			Email:		
Date of Birth:		SSN:		Gender: <input type="checkbox"/> M <input type="checkbox"/> F	
Home Phone:			Cell Phone:		
Preferred Pharmacy:				Phone:	
Primary Physician:		Who Referred You To Our Office:			
EMERGENCY CONTACT					
Name:		Relationship to Patient:			
Phone:		Address:			
EMPLOYER INFORMATION					
Current Employer:				Phone:	
Address:					
GUARANTOR INFORMATION					
<b>Person Responsible For Bill (please leave blank if same as patient)</b>					
Name:		Date of Birth:		Phone:	
Address:					
INSURANCE INFORMATION (please leave blank if attaching insurance card)					
<b>Primary Insurance Name:</b>					
Subscriber's Name:		Policy #		Co-pay \$	
Subscriber DOB:		Group #		Group Name:	
Subscriber SSN:					
Patient's Relationship to Subscriber	Self ( )	Child ( )	Spouse ( )	Other ( )	
<b>Secondary Insurance Name:</b>					
Subscriber's Name:		Policy #		Co-pay \$	
Subscriber DOB:		Group #		Group Name:	
Subscriber SSN:					
Patient's Relationship to Subscriber	Self ( )	Child ( )	Spouse ( )	Other ( )	
Patient Signature		Date		Legal Guardian / Relationship to Patient	
				Date	

## INTAKE AND CONSENT

GEORGIA BONE & JOINT SURGEONS, P.C

Date:	Patient Name:	Acct: (office only)
1. Please describe injury or problem for which you are being seen today. Include "right" or "left" if applicable:		Date symptoms first occurred:
2. Have you been treated previously for this injury / problem: Yes <input type="checkbox"/> No <input type="checkbox"/>		When:
Doctor's Name / Facility:		
Please describe treatment:		
Were X-Rays taken? Yes <input type="checkbox"/> No <input type="checkbox"/>		If yes, do you have a copy with you today? Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Is condition the result of injury/ accident? <input type="checkbox"/> Work <input type="checkbox"/> Place of Business <input type="checkbox"/> Home <input type="checkbox"/> School <input type="checkbox"/> Auto State: Other: _____		Brief description of how injury occurred:
4. Is there any insurance, liability coverage, or third party responsible (other than your own group health insurance) for payment of treatment related to this injury / accident / condition: Yes <input type="checkbox"/> No <input type="checkbox"/>		
5. Do you have an attorney for this accident: Yes <input type="checkbox"/> No <input type="checkbox"/>		
Attorney Name _____ Attorney Phone _____		
<b>6. AUTHORIZATION FOR TREATMENT ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION</b>		
<p>I authorize Georgia Bone &amp; Joint Surgeons, P.C./Center For Orthopedic Surgery/Center for Physical Therapy and Sports Medicine and providers thereof, to render treatment and to release any medical information (including information related to psychiatric care, drug/alcohol abuse, and HIV/AIDS) necessary to process claims, for any utilization review or quality assurance activities, or if and when applicable, as requested by subpoena, request for production of documents, or other court order, whether released verbally, written, or by fax. I assign all medical and/or surgical benefits including major medical benefits to which I am entitled for this or any other claim filed related to treatment received at Georgia Bone &amp; Joint Surgeons, P.C, Center for Orthopedic Surgery/Center for Physical Therapy and Sports Medicine. This assignment and authorization shall remain in effect unless revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that, even though I may have some type of insurance coverage, I am responsible for payment of services. I further understand that as the person authorizing treatment for a minor child, I am responsible for the charges incurred regardless of other agreements in place. By signing below, I am affirming that I have completed this form fully and that the information furnished is correct to the best of my knowledge. I am also affirming that I have read and understand the contents of the authorization above and my responsibilities therein. If I am insured by Medicare, I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier, any information needed for this or a related Medicare claim whether verbal, written, or by fax. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who accepts assignment. Regulations pertaining to Medicare assignments of benefits apply. I also verify that I have received a copy of the Notice of Privacy Practices.</p>		
Patient Signature	Date	Legal Guardian / Relationship to Patient
		Date

## PRESCRIPTION INFORMATION

GEORGIA BONE & JOINT SURGEONS, P.C

Important Information Regarding Prescription Refills Effective 10/6/2014, hydrocodone pain medications can no longer be phoned in to the pharmacy. The DEA has changed the classification of the drug to Schedule II which means it must be a written, signed prescription. No hydrocodone pain medication products will be able to be called in, refilled electronically, or faxed after 10/13/2014.

1. As a general rule, the doctors will be unable to prescribe Class II pain medications unless a patient has had (or will be having) orthopedic surgery or has a serious fracture (broken bone). This includes hydrocodone or any product that contains hydrocodone.
2. The doctors will be unable to prescribe any medications for patients after hours, on the weekend, holidays, or any other time the office is closed.
3. Due to the changes, you may experience a delay in obtaining a pain medication refill as they can only be processed on days the physician is seeing patients in the office. Accordingly, please call at least 3 business days ahead of needing a refill.
4. The patient (if age 18 or older), must call personally to request the refill or be available by phone to confirm the request.
5. Prescription refill request hours are Monday-Thursday 8am-5pm. Please call 770-386-5221 during these office hours for refills. If the refill requires a written prescription, someone from our office will call you when it is ready to pick up.
6. Written prescriptions may be picked up during regular office hours Monday-Thursday 8am-5pm and Friday 8am- Noon.
7. Anyone (including patient) picking up a prescription must show picture ID and sign for the prescription.
8. If anyone other than the patient is picking up the prescription, they must be on the contact list in the patient's medical record. Prescriptions will not be released to anyone not listed in the patient's medical record.
9. Anyone prescribed narcotic pain medications may be subject to drug testing (at the patient's expense) or other pain management monitoring and compliance measures that are required by state or federal regulations.
10. A follow-up visit may be required in order to obtain a refill.
11. The doctors will not refill prescriptions that have been lost, stolen, or misplaced.
12. Giving, trading, or selling medications is grounds for immediate dismissal.
13. Obtaining narcotics from any other physician without notifying Georgia Bone & Joint Surgeons is grounds for immediate dismissal.
14. Altering or forging of a prescription is a felony and will be reported.
15. Medication history, if available, will be verified electronically for inclusion in the medical record.

We thank you for your cooperation and assistance in adhering to the new regulations. Please sign below indicating that you have read and understand the above.

\_\_\_\_\_  
 Patient Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Legal Guardian / Relationship to Patient

\_\_\_\_\_  
 Date

# REVIEW OF SYSTEMS Part 1 of 2

GEORGIA BONE & JOINT SURGEONS, P.C

**Office Use Only**

<b>Date:</b>	<b>Patient Acct:</b>	<b>BP</b>	<b>Pulse</b>	<b>Ht</b>	<b>Wt</b>
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**To Be Completed By Patient**

Patient Name:	Date Of Birth:
Reason For Your Visit Today:	Date Problem Began:
Primary Care Physician:	Referred By:

<p><b>Your Allergies</b></p> <p>1.Are you allergic to any medications? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>2.If yes, please list:</p> <p>3.List any other allergies:</p>	<p><b>Your Medications</b></p> <p>1.Do you currently take any blood thinners? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>2.List all current medications including dosage and how often taken</p>
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**Your Past Surgical History** 1.Please list any surgeries you have had and date of surgery:

2.Do you have any implants or metal of any type? Yes No 3.If yes, type:

**Your Past Medical History** 1.Please circle if you have / have had any of the following:

If NONE, initial here: Lung Disease Heart Disease Heart Attack High Blood Pressure

A-Fib Seizures Diabetes Hepatitis Liver Disease Rheumatoid Arthritis

Osteoarthritis Anemia Blood Clots HIV/AIDS Kidney Disease Psychiatric Disorder

Stroke Pacemaker Parkinson's Disease Stomach Ulcer Cancer \_\_\_\_\_

Dementia Asthma Hyperthyroid Hypothyroid Anesthesia Reaction

**Your Past Family History** 1.Please circle if there is any family history of:

If NONE, initial here: Lung Disease Heart Attack Pacemaker High Blood Pressure

Diabetes Stomach Ulcer Hepatitis Liver Disease Anemia Psychiatric Disorder

Blood Clots HIV/AIDS Kidney Disease Seizures Stroke Rheumatoid Arthritis

Cancer \_\_\_\_\_ Anesthesia Reaction Asthma Hyperthyroid Hypothyroid

1. Occupation:

2.MaritalStatus: Married Single Divorced Widowed 3.Are You: Right Handed Left Handed

**Your Social History**

1.Do you currently smoke? Yes No  5.Do you use alcohol? Yes No  7. Any history of drug abuse? Yes No

2.If yes, number of packs per day \_\_\_\_\_ 6.If yes, how much, how often: \_\_\_\_\_ 8.If yes, type of drug? \_\_\_\_\_

3.Year quit if former smoker \_\_\_\_\_ 9.Any current drug abuse? Yes No

4.Do you use smokeless tobacco? Yes No 10. If yes, type of drug? \_\_\_\_\_

1.Has anyone ever told you that you have diminished kidney function? Yes No

2.If required during surgery, would you object to receiving a blood transfusion? Yes No

3.Have you had a flu vaccine within the last 12 months? Yes No

4.Are you currently under the care of Pain Management? Yes No

# REVIEW OF SYSTEMS Part 2 of 2

GEORGIA BONE & JOINT SURGEONS, P.C

1. Please circle if you are currently having any of the following symptoms or conditions: Circle all that apply						
If you are not currently having any of the symptoms below, please initial here: _____						
General	Head	Eyes	Ears	Nose	Neck	Psych
<input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Night Sweats <input type="checkbox"/> Fatigue <input type="checkbox"/> Weight Gain <input type="checkbox"/> Weight Loss <input type="checkbox"/> Loss of Appetite	<input type="checkbox"/> Headache <input type="checkbox"/> Dizziness	<input type="checkbox"/> Vision changes <input type="checkbox"/> Pain Double <input type="checkbox"/> vision Blurred <input type="checkbox"/> vision	<input type="checkbox"/> Earache <input type="checkbox"/> Discharge <input type="checkbox"/> Decreased hearing <input type="checkbox"/> Ringing <input type="checkbox"/> Deafness	<input type="checkbox"/> Bleeding <input type="checkbox"/> Discharge <input type="checkbox"/> Sinus <input type="checkbox"/> Pain	<input type="checkbox"/> Pain	<input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Insomnia <input type="checkbox"/> Agitation <input type="checkbox"/> Hallucinations <input type="checkbox"/> Disorientation
Mouth & Throat	Nodes	Breasts	Respiratory	Cardiac	Skin	
<input type="checkbox"/> Sore Throat <input type="checkbox"/> Sores Bleeding <input type="checkbox"/> Gums <input type="checkbox"/> Hoarseness	<input type="checkbox"/> Enlargement <input type="checkbox"/> Tenderness	<input type="checkbox"/> Lumps <input type="checkbox"/> Pain	<input type="checkbox"/> Cough <input type="checkbox"/> Wheezing <input type="checkbox"/> Bloody Sputum <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Congestion <input type="checkbox"/> Chest Pain	<input type="checkbox"/> Chest Pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Swelling <input type="checkbox"/> Sweating <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Chest discomfort	<input type="checkbox"/> Glands swelling <input type="checkbox"/> Rashes <input type="checkbox"/> Leg ulcer <input type="checkbox"/> Itching	
Urinary (GU)	Blood Disorders	Musculoskeletal	Gastrointestinal (GI)	GYN	Neurological	
<input type="checkbox"/> Painful urination <input type="checkbox"/> Burning <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequency <input type="checkbox"/> Urine leaking <input type="checkbox"/> Hesitancy <input type="checkbox"/> Nighttime urination <input type="checkbox"/> Incomplete emptying of bladder <input type="checkbox"/> Testicular masses	<input type="checkbox"/> Anemia <input type="checkbox"/> Bruising <input type="checkbox"/> Easy bleeding	<input type="checkbox"/> Back pain <input type="checkbox"/> Radiating pain <input type="checkbox"/> Joint pain <input type="checkbox"/> Joint swelling <input type="checkbox"/> Injury <input type="checkbox"/> Muscle aches <input type="checkbox"/> Bone pain	<input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Heartburn <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Swelling <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Blood in stool <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Jaundice	<input type="checkbox"/> Excessive menstrual bleeding <input type="checkbox"/> Irregular periods <input type="checkbox"/> Hot flashes <input type="checkbox"/> Discharge <input type="checkbox"/> Post menopausal bleeding	<input type="checkbox"/> Memory loss <input type="checkbox"/> Confusion <input type="checkbox"/> Weakness <input type="checkbox"/> Dizziness <input type="checkbox"/> Tremors <input type="checkbox"/> Numbness <input type="checkbox"/> Paralysis	

**Completed By Office**  
**Reviewed by Provider:** \_\_\_\_\_

**Date:** \_\_\_\_\_

## **Patient Financial Policy:**

We are committed to providing you with high-quality healthcare services and ensuring transparency in all financial matters. To facilitate a clear understanding of our payment procedures and your responsibilities, we have outlined the following Patient Financial Policy. Please review this policy before your appointment.

### **Payment at the Time of Visit:**

Payment for all services, including co-payments, coinsurance, deductibles, and payments for non-covered services, is required at the time of your visit. We accept Cash, Checks, Mastercard, VISA, Discover, and American Express for your convenience.

### **Insurance and Referrals:**

- **Insurance Information:** It is your responsibility to provide accurate and current insurance information to our staff at the time of your appointment, and this includes providing us with any updates that may have been retroactive and may impact on your claims from being adjudicated. This includes notifying our staff if you are enrolled with a Medicare Advantage Plan.
- **Copays/Coinsurance/ Deductibles:** Your policy with your insurance company represents a contract between you and the insurer. Copayments, coinsurances, and deductibles are your responsibility and will not be waived. You are required to arrange payment for these costs before scheduling an appointment, and this includes knowing the applicable copayment for office visits and procedures. You must also verify that we are in-network with your insurance before your appointment. This includes both the office and the ambulatory surgery center if you are scheduled for a procedure. We encourage you to alert us immediately if you see that our doctors or the facility are not listed under your plan so we can investigate this further.
- **Specialist Referrals:** If your insurance policy mandates a referral to see our specialists, it is your obligation to obtain and provide this referral before your appointment. Failure to do so may result in appointment rescheduling, subject to the rescheduling fee. Primary Care Doctors will not “back-date” referrals.
- **Claim Submission:** If you are covered by an insurance policy with which we have a contract, we will submit a claim to your insurance company for reimbursement.
- **Non-Covered Services:** You are responsible for any services not covered by your insurance.
- **Payments made to the patient directly:** In the event your insurance company erroneously pays you directly, you are obligated to endorse the payment to Georgia Bone & Joint Surgeons, PC 15 Medical Drive Ste 101 Cartersville, GA 30121 along with an Explanation of Benefits (EOB) from your insurance provider.

### **Appointment Policy:**

- **Cancellations and “No-Show” Fees:** To provide the best services for our patients, we require a minimum of 48 hr. notice for cancellations or rescheduling of your appointments. Failure to provide timely notification may result in a fee of \$50. If you have an emergency or are sick, please notify us immediately. We will evaluate our fee on a case-by-case basis.

We understand that from time to time, extenuating circumstances are out of your control, but please understand that 3 No-shows may result in you being discharged from the practice.

### Self-Pay Patients

- If you do not have insurance coverage, payment is due at the time of service. We offer a self-pay rate and payment plans upon request. A deposit may be required prior to procedures, injections, casting, durable medical equipment (DME), or surgery scheduling.

### Minor Patients

- The parent or legal guardian accompanying a minor is responsible for payment at the time of service. In cases of divorce or custody agreements, the accompanying adult remains financially responsible.

### Workers' Compensation / Personal Injury Cases

- We will bill the appropriate carrier if claim information is provided. If the claim is denied or delayed, you are responsible for the balance. We do not bill attorneys unless prior arrangements are made.

### Miscellaneous Fees:

- Returned Check Fee: A fee of \$40 will be charged for checks that are returned due to insufficient funds.
- Collections Fees: If your account is referred to a collection agency, you will be responsible for any additional interest, collection, and attorney fees associated with collecting the outstanding balance. Additionally, this may affect your credit and potentially result in your discharge from the practice. Failure to Maintain Payment
- Plans: If you sign up for a payment plan using your credit card, you will be expected to pay your balance in full within 6 months. Additionally, you are responsible for updating us if any information related to your credit card changes. This includes the expiration date, the CVV, CVC, or CID number. If your credit card is rejected for any reason, the payment plan will be considered null and void, and payment in full will be required before being seen again.

I acknowledge and agree to the terms outlined in this Patient Financial Policy by seeking care at Georgia Bone & Joint. I recognize the importance of complying with these policies for the mutual benefit of all parties involved. Misusing insurance proceeds constitutes insurance fraud, and I am committed to upholding all relevant regulations and ethical standards.

- I understand that I am responsible for all charges incurred. This includes non-covered services, exclusions, coverage lapses, coverage termination, or services denied when policy maximums have been reached.
- I authorize the release of any information concerning my or my dependent's medical record and treatment for the purpose of evaluating and adjudicating payment for claims incurred.
- I authorize that payments can be made directly to my provider.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Guardian/Representative (If applicable): \_\_\_\_\_

Please retain a copy of this policy for your records.