GEORGIA
BONE & JOINT
SURGEONS, P.C.

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: ☐ M 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			
Person Responsible For Bill (please leave blank if same as patient)			
Name:	Date of Birth:	Phone:	
Address:			
INSURANCE INFORMATION (please leave blank if attaching insurance card)			
Primary Insurance Name:			
Subscriber's Name:	Policy #	Co-pay $	
Subscriber DOB: Subscriber SSN:	Group #	Group Name:	
Patient's Relationship to Subscriber	Self ( )	Child ( )	Spouse ( )	Other ( )
Secondary Insurance Name:			
Subscriber's Name:	Policy #	Co-pay $	
Subscriber DOB: Subscriber SSN:	Group #	Group Name:	
Patient's Relationship to Subscriber	Self ( )	Child ( )	Spouse ( )	Other ( )

Patient Signature Date Legal Guardian / Relationship to Patient Date

GEORGIA BONE & JOINT SURGEONS, P.C.

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 ☐ No ☐		When:
Doctor's Name / Facility:		
Please describe treatment:		
Were X-Rays taken? Yes ☐ No ☐	If yes, do you have a copy with you today? Yes ☐ No ☐	

3.Iscondition the resultof injury/ accident?

☐ Work ☐ Place of Business

☐ Home ☐ School

☐ 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 (☐) No ☐

5.Do you have an attorney for this accident: Yes ☐ No ☐

Attorney Name________________________________ Attorney Phone ___________________________

6.AUTHORIZATION FOR TREATMENT ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I authorize Georgia Bone & 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 & 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.

Patient Signature   Date   Legal Guardian / Relationship to Patient   Date

GEORGIA
BONE & JOINT
SURGEONS, P.C.

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

GEORGIA BONE & JOINT SURGEONS, P.C.

REVIEW OF SYSTEMS Part 1 of 2

GEORGIA BONE & JOINT SURGEONS, P.C

Office Use Only

Date:	Patient Acct:	BP	Pulse	Ht	Wt

To Be Completed By Patient

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

Your Allergies

1.Are you allergic to any medications? ☐Yes ☐No

2.If yes, please list:

3.List any other allergies:

Your Medications

1.Do you currently take any blood thinners? ☐Yes ☐No

2.List all current medications including dosage and how often tak en

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	☐Hepatits	☐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 ◯

2.If yes, number of packs per day _______

3.Year quit if former smoker____________

4.Do you use smokeless tobacco? Yes No

5.Do you use alcohol? ◯Yes ◯No

6.If yes, how much, how often:

____

____

7.Any history of drug abuse? ◯Yes ◯No

8.If yes, type of drug?

9.Any current drug abuse? ◯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
☐ Fever ☐ Chills ☐ Night Sweats ☐ Fatigue ☐ Weight Gain ☐ Weight Loss ☐ Loss of Appetite	☐ Headache ☐ Dizziness	☐ Vision changes ☐ Pain Double ☐ vision Blurred ☐ vision	☐ Earache ☐ Discharge ☐ Decreased hearing ☐ Ringing ☐ Deafness	☐ Bleeding ☐ Discharge ☐ Sinus ☐ Pain	☐ Pain	☐ Anxiety ☐ Depression ☐ Insomnia ☐ Agitation ☐ Hallucinations ☐ Disorientation

Mouth & Throat	Nodes	Breasts	Respiratory	Cardiac	Skin
☐ Sore Throat ☐ Sores Bleeding ☐ Gums ☐ Hoarseness	☐ Enlargement ☐ Tenderness	☐ Lumps ☐ Pain	☐ Cough ☐ Wheezing ☐ Bloody Sputum ☐ Shortness of breath ☐ Congestion ☐ Chest Pain	☐ Chest Pain ☐ Palpitations ☐ Swelling ☐ Sweating ☐ Shortness of breath ☐ Chest discomfort	☐ Glands swelling ☐ Rashes ☐ Leg ulcer ☐ Itching

Urinary (GU)	Blood Disorders	Musculoskeletal	Gastrointestinal (GI)	GYN	Neurological
☐ Painful urination ☐ Burning ☐ Blood in urine ☐ Frequency ☐ Urine leaking ☐ Hesitancy ☐ Nighttime urination ☐ Incomplete emptying of bladder ☐ Testicular masses	☐ Anemia ☐ Bruising ☐ Easy bleeding	☐ Back pain ☐ Radiating pain ☐ Joint pain ☐ Joint swelling ☐ Injury ☐ Muscle aches ☐ Bone pain	☐ Difficulty swallowing ☐ Heartburn ☐ Nausea/Vomiting ☐ Abdominal pain ☐ Swelling ☐ Diarrhea ☐ Constipation ☐ Blood in stool ☐ Hemorrhoids ☐ Jaundice	☐ Excessive menstrual bleeding ☐ Irregular periods ☐ Hot flashes ☐ Discharge ☐ Post menopausal bleeding	☐ Memory loss ☐ Confusion ☐ Weakness ☐ Dizziness ☐ Tremors ☐ Numbness ☐ Paralysis

Completed By Office
Reviewed by Provider: ________________________________ **Date**:_____________________

SPINE PATIENT ENCOUNTER FORM

NAME:______________________________ DOB:______________ DATE:________________

1. WHAT KIND OF PAIN ARE YOU HAVING? (CHECK ALL THAT APPLY) | PLEASE DESCRIBE THE TYPE OF PAIN YOU ARE HAVING. (CHECK ALL THAT APPLY) | RATE SEVERITY FROM 1 TO 10 WITH 10 BEING THE WORST PAIN. (CIRCLE)

	Sharp	Dull	Aching	Stabbing	Throbbing	
❑ BACK PAIN	❑	❑	❑	❑	❑	1 2 3 4 5 6 7 8 9 10
❑ NECK PAIN	❑	❑	❑	❑	❑	1 2 3 4 5 6 7 8 9 10
❑ LEFT LEG PAIN	❑	❑	❑	❑	❑	1 2 3 4 5 6 7 8 9 10
❑ RIGHT LEG PAIN	❑	❑	❑	❑	❑	1 2 3 4 5 6 7 8 9 10
❑ LEFT ARM PAIN	❑	❑	❑	❑	❑	1 2 3 4 5 6 7 8 9 10
❑ RIGHT ARM PAIN	❑	❑	❑	❑	❑	1 2 3 4 5 6 7 8 9 10

2. HOW LONG HAVE YOU BEEN HAVING PAIN? ____DAYS ____WEEKS ____MONTHS ____YEARS

3. WHAT IS THE RATIO OF BACK TO LEG PAIN?

- ❑ 100% BACK/ 0% LEG PAIN
- ❑ 75% BACK/ 25% LEG
- ❑ 50% BACK/ 50% LEG PAIN
- ❑ 25% BACK/ 75% LEG PAIN
- ❑ 0% BACK/ 100% LEG PAIN
- ❑ NO BACK/LEG PAIN

WHAT IS THE RATIO OF NECK TO ARM PAIN?

- ❑ 100% NECK/ 0% ARM PAIN
- ❑ 75% NECK/ 25% ARM PAIN
- ❑ 50% NECK/ 50% ARM PAIN
- ❑ 25% NECK/ 75% ARM PAIN
- ❑ 0% NECK/ 100% ARM PAIN
- ❑ NO NECK/ ARM PAIN

4. ARE YOUR SYMPTOMS DUE TO AN INJURY? ❑ YES ❑ NO
IF THE ANSWER IS YES, PLEASE GIVE DATE AND EXPLAIN THE DETAILS REGARDING THE INJURY:

____

____

____

5. IF YOU ARE SUFFERING FROM BACK OR NECK PAIN, WHAT PERCENTAGE OF THE PAIN IS RELIEVED WHEN LYING DOWN IN YOUR MOST COMFORTABLE POSITION?

- ❑ 100% RELIEF WHEN LYING DOWN
- ❑ 75% RELIEF WHEN LYING DOWN
- ❑ 50% RELIEF WHEN LYING DOWN
- ❑ 25% RELIEF WHEN LYING DOWN
- ❑ 0% RELIEF WHEN LYING DOWN

6. WHAT POSITIONS AGGRAVATE YOUR SYMPTOMS? (CHECK ALL THAT APPLY)

- ❑ STANDING
- ❑ WALKING
- ❑ SITTING
- ❑ FORWARD BENDING
- ❑ BACKWARD BENDING
- ❑ SIDE BENDING
- ❑ GETTING OUT OF BED

7. PLEASE DESCRIBE YOUR WALKING TOLERANCE:

- ❑ I CAN WALK INDEFINITELY.
- ❑ I CAN WALK UP TO AN HOUR.
- ❑ I CAN WALK UP TO 30 MINUTES.
- ❑ I CAN WALK UP TO 15 MINUTES.
- ❑ I CAN WALK LESS THAN 5 MINUTES

8. HAVE YOU NOTICED ANY OF THE FOLLOWING SYMPTOMS? (CHECK ALL THAT APPLY)

- ☐ CLUMSINESS
- ☐ DROPPING OBJECTS MORE FREQUENTLY
- ☐ WORSENING HANDWRITING
- ☐ UNSTEADY WHEN WALKING
- ☐ NONE OF THE ABOVE

9. HAVE YOU NOTICED ANY CHANGE IN YOUR BODY SHAPE RECENTLY? ☐ YES ☐ NO
IF YES, THEN OVER WHAT TIME PERIOD? ____________________

10. WHAT TREATMENTS HAVE YOU HAD FOR YOUR CURRENT SYMPTOMS? (CHECK ALL THAT APPLY)

	DID THE TREATMENT HELP?
☐ HOME EXERCISE PROGRAM	☐ YES ☐ NO
☐ PHYSICAL THERAPY	☐ YES ☐ NO
☐ EPIDURAL STEROID INJECTIONS	☐ YES ☐ NO
☐ FACET BLOCKS	☐ YES ☐ NO
☐ NSAIDS (MOTRIN, IBUPROFIN, CELBREX, BEXTRA, VIOXX, LODINE, ETC.)	☐ YES ☐ NO
☐ NARCOTICS (LORTAB, DARVOCET, VICODIN, PERCOCET, OXYCONTIN, ETC.)	☐ YES ☐ NO
☐ ULTRA / ULTRACET	☐ YES ☐ NO
☐ CHIROPRACTOR MANIPULATION	☐ YES ☐ NO
☐ BRACES	☐ YES ☐ NO
☐ WEIGHT REDUCTION PROGRAM	☐ YES ☐ NO

11. HAVE YOU MODIFIED ANY ACTIVITIES? ☐ YES ☐ NO

12. HAVE YOU HAD ANY PREVIOUS SPINE SURGERIES? ☐ YES ☐ NO
IF YES, PLEASE LIST THE NAME OF THE PROCEDURE, THE DATE AND THE SURGEON:

____

____

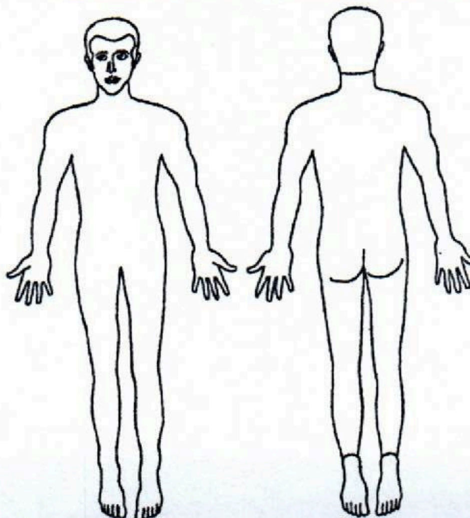
13. HAVE YOU HAD ANY OF THE FOLLOWING SYMPTOMS? (CHECK ALL THAT APPLY)

- ☐ FEVERS
- ☐ CHILLS
- ☐ NIGHT SWEATS
- ☐ WEIGHT LOSS
- ☐ NONE OF THE ABOVE

14. DOES THE PAIN WAKE YOU UP FROM SLEEP AT NIGHT? ☐ YES ☐ NO

15. HAVE YOU EVER LOST BOWEL OR BLADDER CONTROL? ☐ YES ☐ NO

16. PLEASE SHADE IN THE AREAS ON THE DIAGRAMS THAT CORRESPOND TO YOUR AREAS OF PAIN ON YOUR BODY.



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 you r 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.

- Iunderstand 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.
- Iauthorize 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.
- Iauthorize 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.