FIRST SETTLEMENT ORTHOPAEDICS

DEMOGRAPHIC FORM

First Name: ____________________ M. ________ Last ____________________ Suffix ______

DOB: __________ Age: ______ Social Security: ____________________ Marital Status: ❑ M ❑ S ❑ D ❑ W Sex: ❑ M ❑ F

Patient Address: ____

City: ____________________ State: ____________________ Zip Code: ____________

Email: ____________________ Preferred Phone: ____________________

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Employer: ____________________ Occupation: ______________ ❑ Full Time ❑ Part Time

Emergency Contact: ____________________ Relationship: ____________________

Emergency Contact Phone Number: ____________________

May we leave a voice mail: ❑ Y ❑ N May we speak with another resident: ❑ Y ❑ N ____________________

Preferred Pharmacy Name: ____

Pharmacy Location (street name & city): ____

____

Primary Doctor: ____

Referring Doctor: ____

Is your injury work-related: ❑ Y ❑ N If yes, date of injury: ____________________

Claim number: ____________________ MCO: ____________________

Employer: ____________________ Emp. Phone: ____________________

Responsible Party for Insurance & Bills: ❑ Self ❑ Spouse ❑ Parents ❑ Mother ❑ Father ❑ Other ______________

Resposible Party Address ____________________ Phone ______________

PRIMARY INSURANCE

Insurance Company: ____

Member ID: ____________________ Group ID: ____________________

Policy Holder Name: ____________________ DOB: ______________ SSN: ______________

Relationship to Policyholder: ❑ Self ❑ Spouse ❑ Parent ❑ Mother ❑ Father ❑ Other ______________

Person Responsible for Payment: ____

SECONDARY INSURER (If Applicable)

Relationship to Policyholder: ❑ Self ❑ Spouse ❑ Parent ❑ Mother ❑ Father ❑ Other ______________

Insurance Company: ____

Member ID: ____________________ Group ID: ____________________

Policy Holder Name: ____________________ DOB: ______________ SSN: ______________

❑ Yes ❑ No I understand and request that payment of authorized insurance company benefits be made directly to First Settlement Orthopaedics on my behalf for all rendered services. I authorize any holder of medical information about me to release information needed to determine these benefits or the benefits payable to related services. I am responsible for any co-pay, co-insurance, deductible and non-covered amounts.

❑ Yes ❑ No I authorize my healthcare provider and/or any entity authorized by my healthcare provider, including those using automated dialing systems, automated messages, email, text messaging or other electronic communication to contact me for any reason by using any telephone number, email address and/or mailing address provided.

**** Signature:** ____________________ **Date:** ______________

PLEASE COMPLETE OTHER SIDE

FIRST SETTLEMENT ORTHOPAEDICS

CONSENT TO THE USE/DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights and responsibilities with respect to your health care information.

The Notice of Privacy Practices provides more detailed information about how First Settlement Orthopaedics may use and disclose health information. I have the legal right to review the Notice of Privacy Practices before I sign this consent, and First Settlement Orthopaedics encourages reading it in full. My signature below verifies that I have received the Notice of Privacy Practices. I understand that the terms of the Privacy Notice may change, and I may obtain these revised notices by contacting the practice by phone or in writing. I have the right to request how my health information is used and disclosed. I also have the right to restrict how this information is disclosed, but the practice is not legally required to agree to these restrictions. First Settlement Orthopaedics must receive requests for any restriction of disclosure in writing.

I hereby authorize First Settlement Orthopaedics to release any information acquired in the course of my examination or treatment for the purposes of treatment, payment and healthcare operations. This information may be delivered in person, via regular mail, modem, telephone, or facsimile transmission. The information may be viewed by someone other than the intended recipient and I hereby release First Settlement Orthopaedics from any liability as a result of such transmission.

I have been informed and understand that First Settlement Orthopaedics will not bill third party payors (automobile/homeowners or other business insurances). I understand that all charges accrued by me must be submitted to my private health insurance, and third party payors must settle privately with these individuals. I further understand that any unpaid balance is my financial responsibility.

I understand that I may revoke this consent in writing, but the revocation will not apply to any services given before the revocation was signed. I also understand that by refusing to sign this consent or revoking this consent, this practice may refuse all services.

CHECK ONE:

❑ I authorize payment of surgical and/or medical benefits directly to First Settlement Orthopaedics. I understand I am financially responsible for all charges not covered and guarantee payment of this account

OR

❑ For the following reasons, I agree to be responsible for all bills incurred in the course of my examination and treatment

❑ No insurance coverage in force at this time.

❑ I do not wish to have First Settlement Orthopaedics bill my insurance company for me.

AUTHORIZATION TO DOWNLOAD MEDICATION HISTORY

By signing below, I am giving First Settlement Orthopaedics my consent to retrieve and use my medication history from our electronic prescription vendor.

________________________________ ____________________

Patient Name Date of Birth

________________________________ ____________________

Signature of Patient or Responsible Party Date

FIRST SETTLEMENT ORTHOPAEDICS

MEDICAL HISTORY FORM

Patient Name:____Today's Date:____________________________

Date of Birth:____________________________Age:_______________ Dominant Hand ❑ Left ❑ Right

Height:______ft._______in. Weight:_______lbs. Primary Care Physician:__________________________________

Race (Please Check):

❑ White ❑ Black/African American ❑ American Indian/Alaska Native ❑ Asian ❑ Native Hawaiian/other Pacific Islander ❑ Other

Did your primary care physician refer you? ❑ Yes ❑ No

May we release information to your primary care physician? ❑ Yes ❑ No Consult requested by ____________________

Reason for today's visit:____Date of injury:______________________

Body part being examined:____ ❑ Right ❑ Left ❑ Both

Was this the result of an accident? ❑ Yes ❑ No If yes, date of accident and please describe, how this happened:

____

Where did the injury occur? ❑ Work ❑ Auto ❑ Home ❑ Other____

Have you been previously seen for this condition? ❑ Yes ❑ No If so, please describe:______________________________

____

Have you had X-rays for this injury? ❑ Yes ❑ No Where:____

Date symptoms began:____ Severity of Pain: ❑ Mild ❑ Moderate ❑ Severe

When does pain occur: ❑ All the time ❑ Daytime ❑ Night time ❑ Morning ❑ w/Activity

Describe the pain: ❑ Sharp ❑ Stabbing ❑ Locking ❑ Clicking ❑ Other_____________________________________

CURRENT MEDICATIONS (Please include all prescription and over-the-counter medications):

Name / Dose / How Often **Name / Dose / How Often**

1.____ **4.**____

2.____ **5.**____

3.____ **6.**____

Allergies? ❑ Yes ❑ No List them:____

Do you have any metal allergies (e.g. nickel, etc.)? ❑ Yes ❑ No List them:____

Do you have a latex allergy? ❑ Yes ❑ No Do you have a poultry allergy? ❑ Yes ❑ No

FAMILY HISTORY (Please check any that have occurred in any blood relatives & who) (Maternal/Paternal):

❑ Y ❑ N Cancer Who__________ ❑ Y ❑ N Diabetes Who__________ ❑ Y ❑ N Heart disease Who__________

❑ Y ❑ N Stroke Who__________ ❑ Y ❑ N Bleeding tendencies Who__________ ❑ Y ❑ N DVT (blood clots) Who_________

❑ Y ❑ N High blood pressure Who__________ ❑ Y ❑ N Osteoporosis Who__________ ❑ Y ❑ N Other: Who__________

PERSONAL AND SOCIAL HISTORY

Do you use tobacco? ❑ Yes ❑ No If so, what type and how much?____

Do you drink alcohol? ❑ Yes ❑ No If so, how much and how frequently?____

Do you regularly participate in sports or physical activity? ❑ Yes ❑ No If so, how much and how frequently?_____________

Married Status ❑ Married ❑ Single ❑ Widowed ❑ Divorced ❑ Separated

Occupation: ____ ❑ Full-time ❑ Part-time

PLEASE COMPLETE OTHER SIDE

ORTHOPAEDIC REVIEW

Please mark any of the following you have had or now have:

❑ **None** ❑ Gout ❑ Neck Pain ❑ Osteoporosis ❑ Rheumatoid Arthritis

❑ Arthritis: Where:______________________________
❑ Back Pain: Where:______________________________
❑ Bone Infection: Where:__________________________
❑ Bursitis: Where:________________________________
❑ Degenerative Disc Disease: Where:_______________
❑ Dislocated Joint: Where:_________________________
❑ Fractured Bone: Where:__________________________
❑ Loss of Joint Motion: Where:____________________
❑ Tendonitis: Where:______________________________
❑ Torn Cartlidge/Meniscus: Where:________________
❑ Torn Muscle: Where:_____________________________
❑ Vertebral Fracture: Where:______________________
❑ Metal implants/plates/clips/screws: Where:____
❑ Other: Where:____

PAST SURGICAL HISTORY

	DATE OF SURGERY		DATE OF SURGERY
❑ None			
❑ Back Surgery	________________	❑ Cesarean Section	________________
❑ Knee Arthroscopy	________________	❑ Gallbladder Surgery	________________
❑ Rotator Cuff Repair	________________	❑ Hernia Repair	________________
❑ Total Joint Replacement	________________	❑ Hysterectomy	________________
❑ Angioplasty	________________	❑ Organ Transplant	________________
❑ Appendectomy	________________	❑ Tonsil/Adenoidectomy	________________
❑ Breast Surgery	________________	❑ Thyroid Surgery	________________
❑ Cardiac Surgery	________________	❑ Wisdom Teeth Removal	________________

❑ Other ____

PAST MEDICAL HISTORY

❑ Anemia/Low Blood Count
❑ Anxiety/Panic Attacks
❑ Asthma
❑ Blood Clots (Phlebitis)
❑ Bronchitis
❑ Colitis
❑ COPD
❑ Emphysema
❑ Insulin-Dependent Diabetes
❑ Cancer: Type:______________
❑ Gallbladder Problems
❑ Heart Attack
❑ Hepatitis
❑ Hiatal Hernia
❑ HIV/AIDS
❑ High Cholesterol
❑ High Blood Pressure
❑ Irregular Heart Beat
❑ Jaundice
❑ Kidney Disease
❑ Liver Disease
❑ Low Blood Pressure
❑ Migraines
❑ Mitral Valve Prolapse
❑ Pancreatitis
❑ Pneumonia
❑ Non-Insulin Diabetes
Other____________________________________
❑ Post-Menopausal
❑ Prostate Disease
❑ Siezures/Epilepsy
❑ Stomach Ulcers
❑ Stroke
❑ Thyroid Problems
❑ Tuberculosis

Have you ever received a pneumococcal vaccine? ❑ Yes ❑ No If yes, what date?__________________________

Do you suffer from sleep apnea? ❑ Y ❑ N If so, assisted by C-PAP? ❑ No ❑ Yes / Setting:_________
Have you had an influenza vaccine? ❑ Y ❑ N If so, date:__________________
Do you have cardiac stents? ❑ Y ❑ N If so, date:__________________
Do you have a pacemaker? ❑ Y ❑ N If so, date:__________________
Do you have a defibrillator? ❑ Y ❑ N If so, date:__________________

If you are age 65 or older or had a recent fracture…
Have you had falls resulting in a fracture? ❑ Yes ❑ No
Have you been screened (DXA scan) for osteoporosis since you turned 60 years old? ❑ Yes ❑ No
If yes, what was the result of the testing? ____
Have you been prescribed medication to prevent or treat osteoporosis? ❑ Yes ❑ No
If yes, what medication are you taking? ____

Patient's Name (Please Print) ____

Patient's Signature ____**Date**_____________________________

First Settlement Orthopaedics
&
Marietta Surgery Center

Authorization for Use or Disclosure of Protected Health Information

I, ____, authorize First Settlement Orthopaedics
(PATIENT NAME)
and Marietta Surgery Center staff to discuss the following with ________________________________
(NAME)
____________________________________ (parent, spouse, child, other).
(RELATIONSHIP)

PLEASE CHECK THE FOLLOWING THAT APPLY:

_____ Appointment information (leave message on machine or with person answering)

_____ Prescriptions

_____ Discuss Diagnosis

_____ Laboratory and/or X-ray results

_____ Question regarding treatment

_____ Billing/Insurance questions

_____ Other

____ SIGNATURE

__________________________ DATE

____ WITNESS

__________________________ DATE

This authorization expires on year from the date it was signed unless terminated before that time by the patient.

FIRST SETTLEMENT ORTHOPAEDICS

PATIENT FINANCIAL POLICY

We are committed to providing you with the best possible orthopaedic care, and will work with you to meet any special needs you may have. However, that requires that both the patient and the physician understand what is expected of the other, medically and financially.

The following information is an agreement between First Settlement Orthopaedics and Patient/Responsible Party named on the Demographic Form.

Insurance Participation

Our office participates with a variety of Insurance plans, and we will submit all claims to those carriers. However, there are some points we wish to emphasize:

- Your policy is a contract between you and the insurance company. While we will assist as much as possible, it is your responsibility to be familiar with your coverage and contact them directly if you have questions.
- You must bring your insurance card with you to every visit, and make us aware of any changes In your coverage.
- You are expected to pay for your co-payment at each visit. If you are not prepared to pay your co-payment at the time of the visit your appointment will be rescheduled.
- If you insurance card does not specify a co-pay amount the office will collect $25 to go towards the undisclosed co-pay or co-insurance assigned at the time of the insurance processing.
- If we do not participate with your insurance, you will likely have a higher out of pocket expense. It is the patient's responsibility to know If your insurance is in network.

Self-Pay Patients

If you do not have insurance, you will be asked to pay for your services at the time of your visit. Should you schedule an elective surgery 100% of the surgery fee Is required prior to scheduling the surgery.

Accident/Auto Injury

Payment in full is expected at the time of the visit, we do not bill third party insurance. If you have private insurance we will bill your insurance to establish timely filing guidelines with your health insurance company.

Workers' Compensation

If the claim can be verified there will be no payment required at the time of the visit. If the claim cannot be verified then payment in full is required at the time of your appointment. If your services are denied by Workers' Compensation the patient agrees to pay for services in full. If the patient has a private insurance we will bill the private insurance following any denial received.

Secondary Insurance

Our office will gladly bill your secondary Insurance but it Is the responsibility of the patient to follow up on any balance not paid by the secondary carrier. Any unpaid secondary balance will be the patient responsibility 90 days after the claim has been submitted.

Past Due Accounts

If your balance is not paid in a timely manner, we reserve the right to forward your account to an outside collection agency or attorney. All fees assessed by the agency or attorney will be charged to you and become part of your outstanding balance.

No-Show Charge

If you are unable to keep your appointment, and do not provide at least a 24 hour notice of cancellation, you may be subject to a $20 charge.

Minors

If the patient Is under 18, the parent or guardian must sign below. If the minor does not reside with both parents, and there is a dispute over which parent is responsible for any bills, we will ultimately rely upon the parent/guardian who brought the child to the office visit for financial responsibility.

Getting the Most Out of a Visit with Your Doctor

Your visit with an orthopaedic surgeon is an important meeting that can be most effective if you plan ahead. It's important that you give your doctor the information he or she needs and that you understand what your doctor is recommending. The following checklist will help you and your doctor discuss the issues most important for getting the most out of the visit.

Before you go

1. Find out the basics about the office. Where is it? What time should you arrive? If you're going to drive, where can you park? Do you need to bring your insurance card or a managed care medical referral?

2. Assemble your records such as results and copies of X-rays, MRI's with radiology reports, others imaging studies and lab tests and personally take the records to the doctor's office.

3. Make written lists of:

- Medications you are taking.
- Your medical history, such as prior treatments for heart or thyroid problems or operations, even those not related to your current problem.
- Your concerns about your condition (pains, loss of mobility or function).

4. Consider asking a friend or family member to accompany you. If you need a translator, ask another adult to come with you; don't rely on a child to translate.

5. Dress appropriately. For spine and many problems involving the arms and legs, you may be asked to disrobe. Wear loose clothing that's easy to take off and put on.

At the doctor's office

1. Arrive early so you can complete any required forms or tests before meeting with your doctor.

2. Be honest and complete in talking with your doctor. Share your point of view and don't hold back information about issues such as incontinence, memory loss, sex, or other issues that you might consider embarrassing.

3. Stick to the point. It might be fun to share news about the children, but keep it short to get the most out of your time with the doctor.

4. Take notes on what the doctor tells you, and ask questions if you don't understand the meaning of a word or the instructions for taking medication.

5. Ask what to expect from your treatment, what effect it will have on your daily activities and what you can do to prevent further disability.

6. Ask your doctor for handouts or brochures that you and your family members can review at home. Your doctor may refer you to an Internet web site for more information.

7. Talk to the other members of the health care team, too, such as physician assistants, nurses, and therapists (speech, physical, or occupational).

When you get home

1. Review the materials the doctor gave you. If you can't remember something, or if you don't understand your notes, call the office and speak to a member of your health care team.

2. Follow the doctor's instructions. Take the full course of medication and make sure you follow the prescribed diet or exercise routine. Remember, you're a part of your health care team, too.

3. Keep your doctor informed of any changes in your condition.

Questions to ask at the visit or later, if your doctor recommends surgery

- Why is this procedure being recommended? Are there alternatives?
- What are the benefits of this procedure in terms of pain relief and improvement of function and mobility? How long will the benefits last?
- What are the risks involved?
- What is the procedure called? How is it done?
- What percentage of patients improve following the procedure?
- What will happen if I don't have the surgery now?
- If I want a second opinion, whom can I consult?
- Will my doctor perform the operation or someone else? If someone else, when can I meet him or her? Is the doctor board certified?
- How many similar procedures have been done by my doctor (or whoever will perform the procedure)? What are the outcomes?
- Will I need any tests or medical evaluations prior to the surgery?
- What kind of anesthesia will be used? Are there possible after effects or risks?
- What kind of implant or prosthesis will be used? What are the outcomes using this device? How long will it last?
- Will I have pain following the procedure?
- How long will the recovery take? Will I need assistance at home afterwards? For how long?
- Will I have any disability following surgery? Will I need physical therapy?
- When can I return to work? When can I drive my car? When can I have sexual activity?
- Are there any written materials or videotapes about this surgery that I can review?

If you decide to go ahead with the surgery, check with your insurance company to see if your coverage requires you to obtain a managed care medical evaluation or clearance before the surgery. You should also verify that the surgery is covered by your policy and find out how your claim will be handled and paid.

Your orthopaedist is a medical doctor with extensive training in the diagnosis and nonsurgical and surgical treatment of the musculoskeletal system, including bones, joints, ligaments, tendons, muscles and nerves.