

Name:  
Chart:  
Date:



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**Southeastern Orthopaedic Specialists, PA**  
**Financial & Insurance Policies**

**Murphy Wainer Orthopedics, Sports Medicine and Joint Replacement Center,  
Guilford Orthopaedics & Sports Medicine Center, Piedmont Orthopedics**

**Insurance co-pays are due at the time of your appointment and will be collected at check in.** Your insurance policies may require you to make a copayment for an office visit and/or medical service, therefore payment is required on the date of service.

**A \$20.00 service fee will be charged if the co-pay is not paid at the time of service.**

The payment collected at the time of service is an estimate based on the information available to us at the time of service. Any remaining balance after the patient's insurance processes and pays the claim is the responsibility of the patient.

**No show fee of \$25.00** may be charged for a missed appointment not cancelled 24hrs in advance of appointment.

**Urgent Care Visits: \$50.00 fee** will be charged to your insurance which may or may not cover this fee. You will be responsible for any portion not covered by your insurance.

We are contracted with most major insurance carriers. **It is the patient's responsibility to verify benefits/limitations and physician participation with their carrier.** Many insurance companies require authorization for visits. If required, please obtain authorization prior to your visit. **Failure to provide authorization may result in the rescheduling and/or cancellation of your appointment.** There may be services provided that your insurance carrier will not cover. Please verify and understand your benefits. **You agree to pay any portion not covered by your insurance carrier.**

**Payment requirements if you have NO insurance:** A minimum deposit of \$250.00 is required at check in of the initial visit. All other charges are due at time of service unless other arrangements are approved by us in advance in writing.

**Patient Balances:** When you receive a statement from our facility, payment is due upon receipt of the statement, unless other arrangements have been approved by the facility in writing.

**A \$25.00 service fee will be charged for returned checks. This charge will be applied to your account and is due immediately.**

**Collection Agencies:** Patients who do not respond to our efforts to collect an overdue balance may be turned over to an outside collection agency. If this becomes necessary, we will attach a 25% collection fee.

**All patients are required to present with a valid Photo ID at check in.** A minor child (under 18) must be accompanied by a parent or legal guardian who will present their Photo ID. **NEW PATIENTS UNDER THE AGE OF 18 MUST BE ACCOMPANIED AT THE FIRST VISIT WITH PARENT OR LEGAL GUARDIAN.** At the follow up appointment the MINOR may attend themselves **WITH A WRITTEN STATEMENT PROVIDING AUTHORIZATION TO TREAT MINOR WITHOUT PARENT OR GUARDIAN. This would be required at each visit.**

**Divorce:** In cases of divorce or separation, the parent authorizing treatment for the child/children will be the parent responsible for charges. If the divorce decree requires the other parent to pay all or part of the treatment cost, **it is the authorizing parent's responsibility to collect from the other parent.**

**I have read this Financial Policy and understand that I am ultimately responsible for the charges incurred.**

**Patient Name:** \_\_\_\_\_

**Parent/Guarantor Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Name:

Chart:

Date:



**GUILFORD  
ORTHOAEDIC**  
AND SPORTS MEDICINE CENTER  
A Division of Southeastern Orthopaedic Specialists, P.A.

Account # \_\_\_\_\_



**GUILFORD  
ORTHOAEDIC**  
AND SPORTS MEDICINE CENTER  
A Division of Southeastern Orthopaedic Specialists, P.A.

## Meaningful Use Documentation

**Language:**

English

Spanish

American Sign

French

Japanese

Other

**Race:**

American Indian

Asian

African American

Native Hawaiian

White

Type Unknown

**Ethnicity:**

Hispanic Origin

Non-Hispanic Origin

Type Unknown

**Decline:** \_\_\_\_\_

**\*\*\*\* Must update in C&S \*\*\*\***

**Updated by:** \_\_\_\_\_

Name:

Chart:

Date:



## ePrescribing

Guilford Orthopaedic and Sports Medicine, A Division of Southeastern Orthopaedic Specialists are in the process of implementing ePrescribing in each of our offices.

ePrescribing is a federally mandated initiative that requires all physicians prescribe in this manner by 2011.

ePrescribing software sends prescriptions over the internet to your pharmacy in a safe secure way, through the same technology used by credit card companies. This helps protect the privacy of your personal information.

ePrescribing software also lets your doctor see important information-like drug interactions and your prescription history.

The benefits to you:

- Less confusion over handwritten prescriptions or unclear phone calls.
- Reduced possibility of medical errors.
- Less chance of adverse drug reactions.
- Fewer trips to drop off at the pharmacy.
- A safer, faster, easier way to get your prescriptions filled.

### Patient Consent:

I agree that Guilford Orthopaedic and Sports Medicine, A Division of Southeastern Orthopaedic Specialists may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

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Patient Signature

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Date

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Printed Name

Name:  
Chart:  
Date:



**GUILFORD  
ORTHOPAEDIC**  
AND SPORTS MEDICINE CENTER  
A Division of Southeastern Orthopaedic Specialists, P.A.

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Authorization to release PHI (Personal Health Information)

I hereby authorize Southeastern Orthopaedic Specialists, P.A. to release my PHI to:  
(EXCLUDES PHYSICIANS & ATTORNEYS)

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Name of person that information may be released to:  
(i.e. spouse, parent, guardian, sibling, etc.)

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Address

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Type of information that may be released:  
(financial, medical information, information for a specific problem)

Expiration Date: \_\_\_\_\_

To revoke this authorization, it must be submitted in writing to Southeastern Orthopaedic Specialists, P.A.

There is potential for re-disclosure once this information is disclosed. SOS cannot control what the other entity does with your PHI (Personal Health Information).

Name:

Chart:

Date:



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**Guilford Orthopaedic and Sports Medicine Center**  
**A Division of Southeastern Orthopaedic Specialists**  
**1915 Lendew Street**  
**Greensboro, NC 27408**

Patient's Name: \_\_\_\_\_

Patients Ins: \_\_\_\_\_

Date of First Service: \_\_\_\_\_

During the past three years, have you had treatment by an Orthopaedic Surgeon in Greensboro?

Yes \_\_\_\_\_

No \_\_\_\_\_

If yes, please indicate the name of the physician and/or practice below:

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Name of Doctor and/or Practice

Date of Service

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Patient Signature

Date

\* \* Please fill out and bring to your appointment. Thank you! \* \*

Name:

Chart:

Date:



**Welcome To Our Office**

New Patient Information

Date \_\_\_\_\_

PATIENT'S NAME (PLEASE PRINT) (FULL NAME)		NICKNAME	S.S.#	Age	SEX M F	DOB
STREET ADDRESS			CITY AND STATE		ZIP	
HOME PHONE	CELL PHONE	E-MAIL			MARITAL STATUS S M W D	
PATIENT'S EMPLOYER		OCCUPATION (INDICATE IF STUDENT)		BUS. PHONE EXT		
EMPLOYER'S STREET ADDRESS			CITY AND STATE		ZIP	
CONTACT PERSON'S NAME IN CASE OF EMERGENCY			PHONE			

SPOUSE OR PARENT'S NAME		SPOUSE OR PARENT'S NAME S.S.#	BIRTHDATE
SPOUSE OR PARENT'S EMPLOYERS		EMPLOYER'S STREET ADDRESS	BUS. PHONE EXT
SPOUSE'S STREET ADDRESS		CITY AND STATE	ZIP

NAME AND ADDRESS OF REFERRING PHYSICIAN	NAME AND ADDRESS OF PRIMARY CARE PHYSICIAN (FAMILY DR.)
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PERSON RESPONSIBLE FOR PAYMENT	STREET ADDRESS, CITY, STATE	ZIP	HOME PHONE
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PRIMARY INSURANCE CO. NAME	CERTIFICATE #	GROUP #
POLICYHOLDER'S NAME	POLICYHOLDER'S BIRTHDATE	
SECONDARY INSURANCE CO. NAME	CERTIFICATE #	GROUP #
SECONDARY INS. POLICYHOLDER'S NAME	SECONDARY INS. POLICYHOLDER'S BIRTHDATE	

WHAT ARE YOU SEEING THE DOCTOR FOR TODAY?	DATE OF ONSET	DESCRIPTION OF PROBLEM OR INJURY
IF THIS IS A WORK RELATED INJURY (PLEASE FILL OUT THIS SECTION)		BRIEF DESCRIPTION OF HOW ACCIDENT HAPPENED
NAME OF EMPLOYMENT WHERE INJURY HAPPENED?		COMPLETE ADDRESS OF THAT EMPLOYER
WAS AN AUTOMOBILE INVOLVED? <input type="checkbox"/> YES <input type="checkbox"/> NO STATE _____	DATE OF ACCIDENT	NAME OF ATTORNEY

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES AND COPAYMENTS REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR OFFICE PERSONNEL.

**VERY IMPORTANT:**  
PLEASE BRING INSURANCE CARDS, XRAY'S, MRI AND ANY OFFICE NOTES RELATING TO TODAY'S VISIT.

Name: \_\_\_\_\_  
Chart: \_\_\_\_\_  
Date: \_\_\_\_\_



**Southeastern Orthopaedic Specialists**

Date: \_\_\_\_\_ Chart # \_\_\_\_\_ Provider \_\_\_\_\_

Patient Name (Please Print) \_\_\_\_\_

BP _____ / _____	Pulse _____
Temp _____	H _____ / _____ W _____

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

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_  F  M Height \_\_\_\_ / \_\_\_\_ Weight \_\_\_\_

Who requested that you visit this office?  Doctor (Name)  Self-Referral  Attorney

Primary Care Physician: \_\_\_\_\_ Your Occupation: \_\_\_\_\_

\* What is the main reason for this visit?  Pain  Numbness  Weakness  Other \_\_\_\_\_ (Chief Complaint)

\* 

What body part is involved?							(Location)	
Neck <input type="checkbox"/>	Shoulder <input type="checkbox"/> R <input type="checkbox"/> L	Elbow <input type="checkbox"/> R <input type="checkbox"/> L	Hand <input type="checkbox"/> R <input type="checkbox"/> L	Pelvis <input type="checkbox"/> R <input type="checkbox"/> L	Knee <input type="checkbox"/> R <input type="checkbox"/> L	Foot <input type="checkbox"/> R <input type="checkbox"/> L		
Back <input type="checkbox"/> Mid <input type="checkbox"/> Lower	Arm <input type="checkbox"/> R <input type="checkbox"/> L	Wrist <input type="checkbox"/> R <input type="checkbox"/> L	Finger <input type="checkbox"/> R <input type="checkbox"/> L	Hip <input type="checkbox"/> R <input type="checkbox"/> L	ankle <input type="checkbox"/> R <input type="checkbox"/> L	Toe <input type="checkbox"/> R <input type="checkbox"/> L		

How long has this problem been present? \_\_\_\_\_  Days  Weeks  Months

Check the box which best fits how your problem started. Then answer the one question below the box you checked.  
Use as much space to the right as needed.

**NO INJURY (Onset was:**  Gradual or  Sudden) **ANSWER:**

Why do you think it started? \_\_\_\_\_

**INJURY - (NOT AUTO OR WORK)** \_\_\_\_\_

Date \_\_\_\_\_, Where and How did it Happen? \_\_\_\_\_

**INJURY AT WORK** \_\_\_\_\_

Date \_\_\_\_\_, Where and How did it Happen? \_\_\_\_\_

**WORK RELATED - (BUT NO INJURY)** \_\_\_\_\_

Date \_\_\_\_\_, Where and How did it Happen? \_\_\_\_\_

**AUTO ACCIDENT - Date / Details -** \_\_\_\_\_

Driver / Passenger taken to ER? \_\_\_\_\_

Please check the box below which best describes your problem:

**The pain is**  Constant  Comes and goes (Intermittent) (Duration)

**Severity of pain**  Mild  Moderate  Severe  Extremely Severe (Severity)

What is the **quality** of the pain?  Sharp  Dull  Stabbing  Throbbing  Aching  Burning  
 Other: \_\_\_\_\_ (Quality)

Are these associated symptoms?  Swelling  Numbness  Weakness (Assoc Symp)

Since my problem started, it is:  Getting better  Getting worse  Unchanged (Context)

Does your pain wake you from sleep?  Yes  No (Timing)

What makes your symptoms **worse**?  Activity  Exercise  Work  Other \_\_\_\_\_ (Modify)

Which make you feel better?  Rest  Heat  Ice  Elevation  Other \_\_\_\_\_ (Modify)

What medications have you taken or been prescribed for this problem? \_\_\_\_\_ (Modify)

Check which treatments you have tried: Injection  Y  N Brace  Y  N Therapy  Y  N  
Cane/Crutch  Y  N (Modify)

Name:  
Chart:  
Date:



### Health History New Patient

I certify that the following information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may make in the completion of this form.

**Patient Name** (Print: First, Middle, Last)

**Patient Signature**

**Date**

What is your age?

What hand do you write with?

Right  Left

List ALL your **Diagnosed Medical Problems** (not just those related to your current office visit)

**If true** I have no known medical problems.

**Medications:** list ALL that you are currently taking.

**Allergies:** list ALL medications and foods allergies.

**If true** I take no medications currently.

**If true** I have no known allergies.

List ALL prior **operations or surgeries** you have had (include dates if known).

**If true** I have not had any surgery in the past.

List ALL medical problems in your family or blood relatives: (list the member affected by the medical problem).

**If true** There are no known medical problems in my family.



Name:  
Chart:  
Date:



Please answer the following questions	✓ yes	✓ no
Do you smoke cigarettes?		
If so, how many packs per day?		
How many years have you been smoking?		
Do you smoke a pipe or cigars?		
Do you dip snuff or chew tobacco?		
Do you drink alcohol?		
How often and how much alcohol do you drink?		
Do you use any street drugs?		
If so, which drugs do you use?		
Who do you live with?		

REVIEW OF SYSTEMS (ROS) Please ✓ symptoms you currently have or have had in the past year			
General	Eye, Ear, Nose, Throat	Musculoskeletal	Psychiatric
Fevers or Chills	Difficulty swallowing	Joint pains	Anxiety
Dizziness	Hearing loss	Muscle aches	Depression
Fainting spells	Hoarseness	Ankylosing spondylitis	Psychiatric hospitalization
Fatigue	Nose bleeds	Weak bones	Panic attacks
Frequent headaches	Ringing in ears	Rheumatoid arthritis	Suicidal thoughts
Insomnia	Sinus problems	Osteoarthritis	Psychiatric drugs
Sweats	Vision-blurred	Bone cancer	Memory loss
Weight changes	Poor vision	Bone infections	Other:
Other:	Other:	Other:	<b>MEN only</b>
Cardiovascular	Gastrointestinal	Genito-Urinary	Breast lumps
Ankle swelling	Poor appetite	Bladder control	Enlarged prostate
Chest pains	Bowel changes	Blood in urine	Erectile dysfunction
Enlarged heart	Constipation	Frequent urination	Penis discharge
Heart attack	Diarrhea	Kidney stones	Prostate cancer
Heart murmur	Excessive thirst	Painful urination	Other:
Heart palpitations	Heartburn	Urgent urination	<b>WOMEN only</b>
High blood pressure	Nausea	Weak stream	Abnormal Pap Smear
Shortness of breath	Rectal bleeding	Other:	Breast Lumps
Irregular heart beat	Stomach pain	Neurological	Vaginal Discharge
Prolonged bleeding	Ulcers	Loss of fine motor control	Severe menstrual pain
History of blood clots	Vomiting	Weakness	Hot flashes
Other:	Other:	Paralysis	Other:
Endocrine	Skin	Poor balance	Date of last period:
Blood sugar problem	Bruise easily	Seizures	Age periods began:
Use of steroids	Foot ulcers	Speech difficulties	Age of menopause:
Over Active Thyroid	Rashes	Tremors	Are you pregnant?
Under Active Thyroid	Sores that won't heal	Muscle wasting	# of pregnancies:
Other:	Other:	Other:	# of live births:

Height  Weight

For office use only			
Reviewed for completeness by _____	Date ____ / ____ / ____	Reviewed by MD _____	Date ____ / ____ / ____
Reviewed by MD _____	Date ____ / ____ / ____	Reviewed by MD _____	Date ____ / ____ / ____