

Name:
Chart:
Date:



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

Southeastern Orthopaedic Specialists, PA
Financial & Insurance Policies

Murphy Wainer Orthopedics, Guilford Orthopaedics and Sports Medicine Center

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 \$50.00 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 \$400.00 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 a valid Government Issued 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
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Account # _____

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:



**GUILFORD
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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.

Patient Signature

Date

Printed Name

Name:
Chart:
Date:



**GUILFORD
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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)

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

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:

Name of Doctor and/or Practice

Date of Service

Patient Signature

Date

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

Name:
Chart:
Date:



**GUILFORD
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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 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: _____



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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:
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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			
<i>General</i>	<i>Eye, Ear, Nose, Throat</i>	<i>Musculoskeletal</i>	<i>Psychiatric</i>
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	Ringling 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:	MEN only
<i>Cardiovascular</i>	<i>Gastrointestinal</i>	<i>Genito-Urinary</i>	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	WOMEN only
High blood pressure	Nausea	Weak stream	Abnormal Pap Smear
Shortness of breath	Rectal bleeding	Other:	Breast Lumps
Irregular heart beat	Stomach pain	<i>Neurological</i>	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:
<i>Endocrine</i>	<i>Skin</i>	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 ____ / ____ / ____