Name:
Chart:
Date:

Southeastern Orthopaedic Specialists, PA

Financial & Insurance Policies

Murphy Wainer Orthopedics, The Sports Medicine & Orthopaedics 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:** __________

Account # ____________

A Division of Southeastern Orthopaedic Specialists, P.A.

"We work to keep you playing"

- Vincent E. Paul, MD
- Peter G. Dalldorf, MD
- Dominic W. McKinley, MD
- Justin W. Chandler, MD
- Frank J. Rowan, MD
- John L. Graves, MD
- Hao Wang, MD
- Mark L. Dumonski, MD

Meaningful Use Documentation

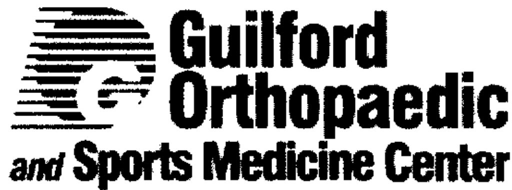
Language:	**Race:**	**Ethnicity:**
English	American Indian	Type-Unknown
Spanish	Asian	Hispanic Origin
American Sign	Black	Non-Hispanic Origin
French	Native Hawaiian	
Japanese	White	
Other	Type-Unknown	

Decline: ______________________________

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

Updated by: ______________________________

Account #________________



ePrescribing

Guilford Orthopaedic and Sports Medicine Center, A Division of Southeastern Orthopaedic Specialists is 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 benefit 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 prescription filled

Patient Consent

I agree that Guilford Orthopaedic and Sports Medicine Center, 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:

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: **GOSM, GOSM** ______________________ 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:

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 Orthopaedic and Sports Medicine Center

Welcome To Our Office

New Patient Information

Date ___________

PATIENT'S NAME (PLEASE PRINT) (FULL NAME) GOSM, GOSM	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.)

PERSON RESPONSIBLE FOR PAYMENT	STREET ADDRESS, CITY, STATE	ZIP	HOME PHONE

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? ☐ YES ☐ 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) ______________________________

Patient Signature ______________________________

BP ____ / ____	Pulse ______
Temp ______ H ____ / ____	W __

Date of Birth ___ / ___ / ___ Age ____ ☐ F ☐ M Height ___ / ___ Weight ______

Who requested that you visit this office? ☐ Doctor (Name) ____________ ☐ Self-Referral ☐ Attorney________

Primary Care Physician: ______________________________

* What is the main reason for this visit? ☐ Pain ☐ Numbness ☐ Weakness ☐ Other__________ (Chief Complaint)

*

What body part is involved?						(Location)
Neck ☐	Shoulder ☐ R ☐ L	Elbow ☐ R ☐ L	Hand ☐ R ☐ L	Pelvis ☐ R ☐ L	Knee ☐ R ☐ L	Foot ☐ R ☐ L
Back ☐ Mid ☐ Lower	Arm ☐ R ☐ L	Wrist ☐ R ☐ L	Finger ☐ R ☐ L	Hip ☐ R ☐ L	ankle ☐ R ☐ L	Toe ☐ R ☐ 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)

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* Minimum dictation required for New/Consult Level 3,4,5 or Established Level 3,4,5
Recommended for all dictation levels for New, Consult or Established 1-5

Name:
Chart:
Date:

Guilford Orthopaedic and Sports Medicine Center

REVIEW OF SYSTEMS: Do you have now, or have you ever had, any of the following health problems?

N2E3 (MS) **1) M/S** • Have you had a prior problem with this same Orthopaedic condition in the past? ☐ Y ☐ N (explain below) ______

• Have you had prior ☐ Back Pain ☐ Joint Swelling ☐ Prior Fracture ☐ Arthritis ______

N3E4 (2-9) **2) ARE YOU ALLERGIC TO ANY MEDICATIONS?** ☐ Y ☐ N If yes, please list ______

3) ARE YOU A DIABETIC? ☐ Y ☐ N TREATMENT: ☐ Insulin ☐ Oral Meds ☐ Diet ☐ None

3.1) DO YOU HAVE HIGH CHOLESTEROL? ☐ Y ☐ N MEDICATION: ______

N4,5 E5 (14)

(Please check all that apply, or mark None)

						None	Year	Explain Details/Comments
4) CON	☐ weight loss	☐ Loss of appetite	☐ Fever	☐ Cancer		☐	___	___
5) EYE	☐ Glasses	☐ Contacts	☐ Double Vision	☐ Cataract		☐	___	___
6) ENT	☐ Hearing Loss	☐ Hoarseness	☐ Ringing in Ears			☐	___	___
7) CV	☐ High blood pressure	☐ Heart attack	☐ Blood clots			☐	___	___
8) RS	☐ Asthma	☐ Cough	☐ Pneumonia	☐ Short of Breath	☐ TB	☐	___	___
9) GI	☐ Stomach ulcer	☐ Hepatitis	☐ Blood in Stool			☐	___	___
10) GU	☐ Pain with urination	☐ Blood in urine	☐ Kidney disease			☐	___	___
11) SK	☐ Skin Ulcers	☐ Rash	☐ Lumps			☐	___	___
12) NEU	☐ Seizures	☐ Stroke	☐ Balance Problem	☐ Headaches		☐	___	___
13) PSY	☐ Depression	☐ Nervousness	☐ Sleep disorder	☐ Sleep Apnea		☐	___	___
14) HEM	☐ Easy bleeding	☐ Easy bruising	☐ Anemia			☐	___	___

PAST MEDICAL HISTORY

LIST MEDICAL PROBLEMS: ______

N3/E4 (1) * **WHAT MEDICATIONS DO YOU TAKE?** ☐ None Please list with dosage: ______

Have you ever taken blood thinners? ☐ Y ☐ N Medication: ______

N4,5 E5 (1) **Are you currently taking blood thinners?** ☐ Y ☐ N Medication: ______

PAST HOSPITALIZATIONS (Not for surgery) ☐ **None** ______

PAST SURGICAL HISTORY: What operations have you had? When? ☐ None ______

Have you ever had a reaction to anesthesia? ☐ Y ☐ N

N4,5 E5 (1) **FAMILY HISTORY: Have any direct relatives had any of the following disorders? If so, which relative?**

* Any direct relative with the same Orthopaedic condition you are being seen for today? ☐ Y ☐ N ______

Diabetes ☐ Y ☐ N ______ High Blood Pressure ☐ Y ☐ N ______ Heart disease ☐ Y ☐ N ______ Arthritis ☐ Y ☐ N ______

N4,5 E5 (1) **SOCIAL HISTORY:**

* Do you use tobacco? ☐ Y ☐ N **Packs per day** ______ Alcohol use? ☐ Y ☐ N How often? ☐ Daily ☐ Other ______/week

Marital History: M S D W How many people live with you? ______

Occupation: ______ ☐ Student Employer: ______

Are you currently working? ☐ Y ☐ N **If no**, how long have you been off work? ______

For office use only

Reviewed for completeness by ______ Date / / Reviewed by MD ______ Date / /

Reviewed by MD ______ Date / / Reviewed by MD ______ Date / /

N3E4=Minimum dictation for New/Consult Level 3 or Estab. Level 4 N4,E5= Minimum dictation for New/Consult Level 4,5 or Estab. Level 5