MIDLANDS
orthopaedics, p.a.
Advanced Options. Caring Specialists.

AUTHORIZATIONS AND ACKNOWLEDGEMENTS

*Name:*_____ *Chart#:*_____

1. ***ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICIES****:* I have received a copy of the Midlands Orthopaedics, P.A. (MOPA) Notice of Privacy Policies detailing how my protected health information (*PHI*) may be used and disclosed as permitted under federal and state law. I understand that MOPA is permitted to disclose my PHI without my authorization to facilitate treatment, payment and health care operations. As permitted by HIPAA, I request the following restriction(s) to the release of my PHI for those specific purposes: _____
_____
_____
I understand that I will be notified by MOPA if my restriction request is denied. If the lines above are blank, I have not requested a restriction to the disclosure of my PHI for purposes of treatment, payment or health care operations.

2. ***ASSIGNMENT OF BENEFITS:*** I assign to Midlands Orthopaedics, PA (MOPA), any insurance or other third party benefits available for health care services provided to me. I understand that MOPA has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to MOPA, I agree to immediately forward to the practice upon receipt all health insurance and other third-party payments that I receive for services rendered to me by MOPA.

3. ***MEDICATIONS AND REFILL REQUESTS:*** I understand that the providers of Midlands Orthopaedics, PA (MOPA) will not address requests for medications or refills of currently prescribed medications after regular business hours or on weekends. Requests for refills and/or changes to medications must be made during the normal business day. We apologize for the inconvenience, but "on-call" or "after-hours" staff members do not have access to the medical records needed to make decisions regarding medication changes or additions.

I _____ *acknowledge receipt and understanding of the items described on this Authorization and Acknowledgement form.*

_____ _____
Patient/Guardian Signature *Date*

Patient ID: _____

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HIPAA PRIVACY AUTHORIZATION FORM

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1. I hereby authorize Midlands Orthopaedics, PA to use and/or disclose the protected health information described below to _____.
   [Name of Individual, Address and Telephone Number]
2. Authorization for Release of Information:

   a. Covering the period of health care from:

   ☐ _____ to _____ **OR** ☐ all past, present and future periods.

   b. Covering the following protected health information:

   ☐ I hereby authorize the release of my complete health record.

   OR

   ☐ I hereby authorize the release of my complete health record with the exception of the following information: _____.

3. This authorization shall be in force and effect until _____, at which time this authorization expires.
   [Date or event]

4. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

5. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned upon signing this authorization.

6. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Name of Patient or Personal Representative Relationship to Patient

MIDLANDS orthopaedics, p.a.

FINANCIAL POLICY

Thank you for choosing Midlands Orthopaedics, PA (MOPA). We are committed to the success of your medical treatment, and we strive to offer excellent care in a patient friendly environment. We recognize that healthcare is expensive, insurance requirements are frustrating and discussing payment arrangements when you don't feel well may be unpleasant. Nevertheless, prompt payment of charges helps us expedite your care so we ask you to review our financial policies. As your health care provider, our relationship is with you…our patient and not with your insurance company. Your insurance plan is a contract between you, your insurance company and/or your employer. Our office is not a party to that contract or any possible restrictions imposed by it. While we will make every effort to obtain appropriate payment from your insurance carrier, payment for services rendered is ultimately your responsibility.

Insurance

You will be required to update your insurance information at least once each year, but we may ask you to provide your insurance card more frequently. Please notify our office immediately if you change insurance carriers, drop coverage, receive new cards or in any way experience a change to your coverage. Failure to do so may result in insurance claim denials that cause all charges to become your full responsibility. Please know the benefits, limitations and responsibilities of your insurance plan.

Referrals and Authorizations

If your plan(s) require a referral from your primary care physician (family or regular doctor), please make sure one has been provided prior to your appointment. We must have a current referral to prevent your insurance carrier from denying payment for services you receive with us.

Co-pays, Deductibles, Co-insurance and Pre-determination of Benefits

We participate with many health plans and file charges with those plans as a courtesy. Most health plans require us to collect charges they deem to be patient responsibility in the form of co-pays, deductibles and co-insurance. We must also collect payment directly from the patient for services the plan does not cover. If MOPA does not participate with your insurance plan, payment-in-full is required at the time of service.

Our charges are usual and customary for our area. If your insurance ultimately denies responsibility for services you receive, you are responsible for payment. If you have a Health Savings Account (HSA), Health Reimbursement Account (HRA) or a Flexible Spending Account, we will provide all documentation necessary for you to receive appropriate reimbursement; however, payment is still required at the time of service.

Uninsured Patients

Payment is due at the time services are provided. A minimum deposit of $100.00 - $300.00 (determined by services required) will be required *prior to* the appointment. This payment will be applied toward your total balance due upon check-out. We do offer a Prompt Pay Discount to uninsured patients who pay their entire balance at the time of service. If you are unable to pay your entire balance, an Account Specialist will assist you in establishing a payment plan.

Past Due Balances

Balances that are not paid within 30 days from the date of service are considered past-due. If your insurance company has not responded to our request for payment within 30 days, we will ask for your assistance in obtaining payment from the carrier and/or to make a payment on the balance. Balances that are not paid within 90 days of the date of service will be forwarded to a collection agency. Collection agency and any associated legal fees may be added to the account. Patients with past-due balances will be required to make payment arrangements before additional services will be scheduled.

No-Show and Late Cancellation Fees

Because cancelled appointment slots for surgeries, MRI and other procedures are difficult to fill without adequate notice, the following fees will be charged for appointments that are not cancelled at least 24 hours prior to the appointment time.

- MRI appointments: $100.00
- Appointments for ESI (epidural steroid injection), ESWT (extracorporeal shock wave), EMG (electromyography), or surgical procedures: $150.00

I acknowledge receipt and understanding of the Midlands Orthopaedics Financial Policy outlined above.

_____ _____

Patient/Guardian Signature Date Printed name of Patient/Guardian Date

MIDLANDS
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Patient Account No. _____ Doctor _____ Date _____

Is this visit due to any accident? ☐ YES ☐ NO If yes: _____ Motor Vehicle ____ Work Related ____ Other? _____

Method of Payment Today: Cash ☐ Check ☐ Visa/MC ☐ Insurance ☐ SELF PAY ☐

(PATIENT INFORMATION) EVER SEEN UNDER OR KNOWN BY OTHER NAME _____

LAST NAME	FIRST NAME	MIDDLE INITIAL
GENDER ☐ M ☐ F	DATE OF BIRTH -- --	SS # -- --	MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOW
ADDRESS	CITY, STATE, ZIP CODE	HOME PHONE ( ) --
PATIENT'S EMPLOYER	PATIENT'S OCCUPATION	☐ FULLTIME ☐ PART TIME	WORK PHONE ( ) --
IS THE PATIENT A STUDENT? ☐ YES ☐ NO	IF YES, NAME AND CITY OF SCHOOL	CELL PHONE ( ) --
IN CASE OF EMERGENCY (SOMEONE NOT LIVING WITH YOU)	RELATIONSHIP TO PATIENT	HOME PHONE	WORK / CELL

(INSURANCE INFORMATION) * COPIES OF YOUR INSURANCE CARDS ARE REQUIRED

INSURANCE #1 (PRIMARY INSURANCE)	INSURANCE #2 (SECONDARY INSURANCE)
INSURED'S NAME RELATIONSHIP TO PATIENT	INSURED'S NAME RELATIONSHIP TO PATIENT
SOCIAL SECURITY # OF INSURED (IF DIFFERENT FROM PATIENT)	SOCIAL SECURITY # OF INSURED (IF DIFFERENT FROM PATIENT)
DATE OF BIRTH OF INSURED -- --	DATE OF BIRTH OF INSURED -- --
INSURED'S EMPLOYER (IF DIFFERENT FROM PATIENT)	INSURED'S EMPLOYER (IF DIFFERENT FROM PATIENT)

(GUARANTOR) PERSON RESPONSIBLE FOR THE BILL IF PATIENT IS A MINOR OR STUDENT

FULL NAME RELATIONSHIP	HOME ADDRESS CITY, STATE, ZIP			
HOME PHONE	WORK PHONE	CELL PHONE	DOB	SS#

HAS PATIENT SEEN AN ORTHOPAEDIST / NEUROSURGEON FOR THIS PROBLEM?
☐ YES ☐ NO

HAS PATIENT HAD X-RAYS FOR THIS PROBLEM?
☐ YES ☐ NO IF YES*, WHERE _____
*IF **YES*** – MUST BRING WITH YOU TO YOUR APPOINTMENT*

REFERRED BY	PRIMARY CARE DOCTOR
ADDRESS	ADDRESS
PHONE #	PHONE #

PHARMACY NAME	LOCATION	PHONE #

I herby acknowledge that by providing insurance information, I have asked and promised to pay for services provided in exchange for this information. I understand that fees for services provided by Midlands Orthopaedics are my responsibility and I agree to pay any balance left unpaid by any insurance company or third party entity immediately upon notification of said balance. If I do not have insurance, I understand that I am responsible for any incurred expenses in their entirety.

_____ Patient or Guarantor

_____ Date

MIDLANDS orthopaedics, p.a.

GENERAL MEDICAL INFORMATION

Revised 2010-1-15

Patient's Full Name_____ Chart#_____
First Middle Last

What is the purpose of your visit today?
Body Part: _____ ☐ Right ☐ Left ☐ Both Sides

Date of Onset/Injury: _____

How did the Injury Occur? _____

Previous Treatment:
What (xrays, injections):_____
When: _____
Where: _____
By Whom: _____

Referring Physician_____ **Regular Physician**: _____
Address:_____ _____
City, State, Zip:_____ _____
Phone#:_____ _____

Current Medications that you are taking (Over the Counter and Prescription):

_____
_____
_____
_____

List All Surgical Procedures and any Hospitalizations in your lifetime with the year of occurrence:

_____
_____
_____

SOCIAL HISTORY	(CHECK ALL THAT APPLY)	FAMILY HISTORY
☐ 01. Alcohol 1-2 drinks/day	☐ 14. Tobacco- Chew	☐ 01. Arthritis
☐ 02. Alcohol more than 1-2 Drinks/day	☐ 15. Cigar/Pipe	☐ 02. Asthma
☐ 03. Alcohol-None	☐ 16. Cigarettes <1 PPD	☐ 03. Bleeding Disorders
☐ 04. Alcohol-Occasional	☐ 17. Cigarettes > 1 PPD	☐ 04. Cancer
☐ 05. Children-None	☐ 18.Cigarettes >2 PPD	☐ 05. Diabetes
☐ 06. Children-Yes	☐ 19. Non-Smoker	☐ 06. Heart Disease
☐ 07. Marital Status-Divorced	☐ 20. Previous Smoker	☐ 07. High Blood Pressure
☐ 08. Married	☐ 21. Work History-Disabled	☐ 08. High Cholesterol
☐ 09. Significant Other	☐ 22. Homemaker	☐ 09. HIV/AIDS
☐ 10. Single	☐ 23. Retired	☐ 10. Kidney Disease
☐ 11. Widowed	☐ 24. Student	☐ 11. Mental Disorders
☐ 12. Special Diet-No	☐ 25. Unemployed	☐ 12. Sickle Cell Trait
	Right or Left Hand Dominance (please circle)	☐ 13. Stroke
☐ 13. Special Diet-Yes _____ (specify)	**Occupation**:_____ **Employer**:_____ Type of Work:_____	

Illnesses (past and present): I HAVE NONE OF THE PROBLEMS LISTED BELOW: ☐

☐ 01. Acid Reflux	☐ 13. Gallbladder trouble	☐ 25. Liver Disease
☐ 02. Anemia	☐ 14. Glaucoma	☐ 26. Mental Disorders
☐ 03. Asthma	☐ 15. Gout	☐ 27. Panic Attacks
☐ 04. Bleeding disorder	☐ 16. Heart Attack	☐ 28. Phlebitis
☐ 05. Blood Transfusion	☐ 17. Heart Disease	☐ 29. Poor Circulation
☐ 06. Cancer	☐ 18. Hepatitis: A, B, C (please circle)	☐ 30. Reflux
☐ 07. Chronic Bronchitis	☐ 19. Hiatal Hernia	☐ 31. Sickle Cell Anemia/Treatment
☐ 08. Diabetes	☐ 20. High Blood Pressure	☐ 32. Sleeping Disorders
☐ 09. Eating Disorder	☐ 21. HIV/AIDS	☐ 33. Strokes
☐ 10. Elevated Cholesterol	☐ 22. Kidney Failure	☐ 34. Thyroid Problems
☐ 11. Emphysema	☐ 23. Kidney/Bladder Infection	☐ 35. Tuberculosis
☐ 12. Epilepsy	☐ 24. Kidney Stones	☐ 36. Ulcers

Additional Illnesses not listed above: _____

_____

******ALLERGIES to any medications? ☐ NO ☐ YES**

Please List: _____

_____

Review of Systems: I HAVE NONE OF THE PROBLEMS LISTED BELOW: ☐

Please check any symptoms or conditions that apply to you.

☐ 01. Significant weight change	☐ 20. Eczema	☐ 39. Anemia
☐ 02. Loss of appetite	**GI**	☐ 40. Take a blood thinner
☐ 03. Recent Fever	☐ 21. Frequent heartburn or indigestion	**ANESTHESIA**
Eyes, Ears, Nose & Throat	☐ 22. Frequent nausea or vomiting	☐ 41.I have had problems with anesthesia
☐ 04. Recent bad cold or sinus infection	☐ 23. Constipation	☐ 42. My family members have had problems with anesthesia
☐ 05. Frequent hay fever symptoms	☐ 24. Diarrhea	☐ 43. No previous problems
☐ 06. Seasonal/year round	☐ 25. Blood in stool or black stools	☐ 44. Nausea or vomiting
☐ 07. Vision Trouble	☐ 26. Jaundice	☐ 45. Difficulty opening mouth
☐ 08. Hearing Trouble	☐ 27. Liver problems	☐ 46. Difficulty waking up from surgery
☐ 09. Frequent nose bleeds	**URINARY**	☐ 47. Malignant hyperthermia
RESPIRATORY	☐ 28. Painful urination?	☐ 48. I have had surgery at Midlands before
☐ 10. Shortness of breath	☐ 29. Blood in urine or dark urine	**GYNECOLOGICAL (females only)**
☐ 11. Frequent cough	☐ 30. Loss of bladder control	☐ 49. Menstrual problems
☐ 12. Wheezing	**NEUROLOGICAL**	**PSYCHIATRIC**
☐ 13. CPAP machine	☐ 31. Frequent Headaches	☐ 50. Depression
CARDIAC	☐ 32. Loss of balance	☐ 51. Hyperactive ADD
☐ 14. Chest pain	☐ 33. Seizures	☐ 52. Anxiety
☐ 15. Heart murmur	☐ 34. Fainting spells	☐ 53. Other
☐ 16. Palpitations/irregular heart beat	☐ 35. Claustrophobia	
☐ 17. Dizziness/light headedness	☐36. I have been diagnosed with fibromyalgia, RSD or pain syndrome	**Height:**_____ **Present Weight:**_____
SKIN	**HEMATOLOGIC**	
☐ 18. Rash	☐ 37. Easy bruising or bleeding	
☐ 19. Psoriasis	☐ 38. Severe blood loss with previous surgery	☐ 54. I have had MRSA

IS THERE ANY ADDITIONAL HEALTH INFORMATION YOUR PROVIDER SHOULD KNOW?

_____

_____

_____

_____