

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 <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH -- --	SS # -- --		MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOW	
RACE		ETHNICITY		PREFERRED LANGUAGE	
ADDRESS		CITY	STATE	ZIP CODE	HOME PHONE () --
PATIENT'S EMPLOYER		PATIENT'S OCCUPATION		<input type="checkbox"/> FULLTIME <input type="checkbox"/> PART TIME	WORK PHONE () --
IS THE PATIENT A STUDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, NAME AND CITY OF SCHOOL			CELL PHONE () --	
E-MAIL ADDRESS	-----@-----.				
IN CASE OF EMERGENCY (SOMEONE NOT LIVING WITH YOU)		RELATIONSHIP TO PATIENT	HOME PHONE () --		WORK / CELL PHONE () --

(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# -- --		

(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)	

I hereby 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

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. **ePrescribe:** I understand that Midlands Orthopaedics, PA (MOPA) utilizes electronic health record software which incorporates ePrescribing technology. I understand that MOPA may access and use my prescription history through ePrescribing software for purposes of providing me appropriate treatment.
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 Items described on this Authorization and Acknowledgement form.

Patient/Guardian Signature

Date

Patient ID: _____

HIPAA PRIVACY AUTHORIZATION FORM

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

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

GENERAL MEDICAL INFORMATION

Patient Name: _____ Chart #: _____

What is the purpose of your visit today? _____

Affected body part: _____ Right Left Both sides

Date of Onset/Injury: _____ How did the injury occur? _____

Previous Treatment Type (x-rays, injections, etc): _____

When: _____ Where: _____ By Whom? _____

Referring Physician Name: _____ Address, City, State, Zip, Phone: _____

Regular Physician (if different): _____ Address, City, State, Zip, Phone: _____

Medications you are currently taking (over the counter and prescription):

Allergies: _____

Social History

Alcohol intake: None Occasional Moderate Heavy

Number of Children: _____

Marital Status: Married Single Divorced Separated Widowed Domestic Partner

Diet: No restrictions Vegetarian Vegan Gluten Low Carb Other: _____

Chewing Tobacco: none 1/day 2-4/day 5+/day

Cigar/Pipe Use: YES NO

Smoking: None: 1 pack per week (PPW) 2 PPW ¼ pack per day (PPD) ½ PPD 1 PPD 1.5 PPD 2 PPD 3+PPD

Smoking Status: Never smoked Formerly smoked Current smoke every day Currently smoke some days each week

Work History: Disabled Homemaker Retired Student

Are you currently employed? YES NO

Occupation: _____ Employer: _____ Type of Work: _____

Family History: Have your family members experienced the following problems? Please check any that apply.

Illness	Mother	Father	Sibling	Other Family Member
Arthritis				
Asthma				
Bleeding Disorders				
Cancer				
Diabetes				
Heart Disease				
High Blood Pressure				
High Cholesterol				
HIV/AIDs				
Kidney Disease				
Mental Disorders				
Sickle Cell Trait				
Stroke				

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

<input type="checkbox"/> Acid Reflux	<input type="checkbox"/> Gallbladder trouble	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Anemia	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Mental Disorders
<input type="checkbox"/> Asthma	<input type="checkbox"/> Gout	<input type="checkbox"/> Panic Attacks
<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Phlebitis
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Poor Circulation
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hepatitis: A, B, C (please circle)	<input type="checkbox"/> Reflux
<input type="checkbox"/> Chronic Bronchitis	<input type="checkbox"/> Hiatal Hernia	<input type="checkbox"/> Sickle Cell Anemia/Treatment
<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Sleeping Disorders
<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Strokes
<input type="checkbox"/> Elevated Cholesterol	<input type="checkbox"/> Kidney Failure	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Kidney/Bladder Infection	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Ulcers
Additional illnesses not listed above:		

Review of Systems: Please indicate if you are having any problems in the following areas.

Constitutional: fever night sweats weight gain weight loss difficulty exercising

Eyes: dry eyes irritation change in vision other: _____

Ears: difficulty hearing ear pain other: _____

Nose: frequent nosebleeds nose/sinus problems other: _____

Mouth/Throat: sore throat bleeding gums snoring dry mouth mouth ulcers oral abnormalities teeth problems

Cardiovascular: chest pain arm pain on exertion shortness of breath when walking shortness of breath when lying down
palpitations heart murmur

Respiratory: coughing wheezing shortness of breath coughing up blood

Gastrointestinal: abdominal pain vomiting loss of appetite diarrhea vomiting blood

Genitourinary: incontinence difficulty urinating painful urination blood in urine increased urinary frequency

Musculoskeletal: muscle aches muscle weakness joint pain back pain swelling in extremities

Skin: abnormal mole jaundice rash itching dry skin growth/lesions

Neurologic: loss of consciousness weakness numbness seizures dizziness headaches migraines restless legs

Psychiatric: depression sleep disturbance feeling unsafe in relationship(s) alcohol abuse

Endocrine: fatigue increased thirst hair loss increased hair growth cold intolerance

Hematologic/Lymphatic: swollen glands easy bruising excessive bleeding

Allergic/Immunologic: runny nose sinus pressure itching hives frequent sneezing

I HAVE NONE OF THE PROBLEMS LISTED ABOVE:

List all surgical procedures and any hospitalizations in your lifetime with the year they occurred:

Have you ever had problems with anesthesia? If so, please describe:

Is there any additional information your provider should know?
