Southern Orthopaedics & Sports Medicine, P.A.

****All office locations can be reached toll free (866) 432-3293****

Attached are our new patient information forms which we must have completed for your chart. If you have been in previously or are being seen for a new problem, we require that these forms be updated on a yearly basis.

Please complete these forms prior to your appointment and bring into the office with the following items:

1. Any x-rays concerning this condition.
2. Referral authorization number if you have any HMO insurance or Tricare Prime. (This authorization must come from your Primary Care Physician).
3. Any doctor's notes concerning this condition.
4. All insurance information:
    a) Insurance cards (we will need to copy them.)
    b) If auto related, we require your claim number, date of accident, policy holder's name, agent, insurance company name, address and phone number.
    c) If work related, we require worker's compensation carrier address and phone number with contact person, claim number, and date of accident, prior to the appointment being scheduled.
5. In order for the doctor to provide the best care possible he needs to know what has previously been done for your condition. If you fail to bring in any of the needed information it will be necessary to reschedule your appointment for another time when you have gathered all of the required information.
6. Please bring in a list of all current prescribed medications and dosages.
7. We will collect all insurance co-payments at the time of the visit.
8. If you have no insurance, we will require full payment at time of visit unless you have made prior arrangements with our billing office.
9. If you have any questions, please feel free to call 432-3293 or 866-432-3293.
10. Please come to our office with the above information 30 minutes earlier than your appointment time in order for our patient specialist to enter this information into the computer system and prepare your chart for your appointment thus preventing a delay in getting you in to see the doctor at your designated appointment time.

Thank you for your cooperation, and for choosing Southern Orthopaedics & Sports Medicine.

Southern Orthopaedics & Sports Medicine, P.A.

VISIT INFORMATION

Name (Last, first, middle initial	Date of Birth	Date

For what are you being seen today? ______________________________

Please Circle one: Symptoms are related to an Injury Symptoms are not related to an injury

Duration of Symptoms ____________________

What makes it worse? ____________________

What makes it better? ____________________

Treatment to date: Medicine____________________

Physical Therapy? Yes No Surgery for the same symptom or problem? Yes No

Severity 1 thru 10 (10 being the worst pain) --------

Additional symptom such as numbness, weakness, popping ETC ----------------

Date of Accident: __ __/__ __/__ __

If Injury related please circle one:

- ☐ Auto Accident
- ☐ Home Accident
- ☐ Work Accident
- ☐ Other Accident

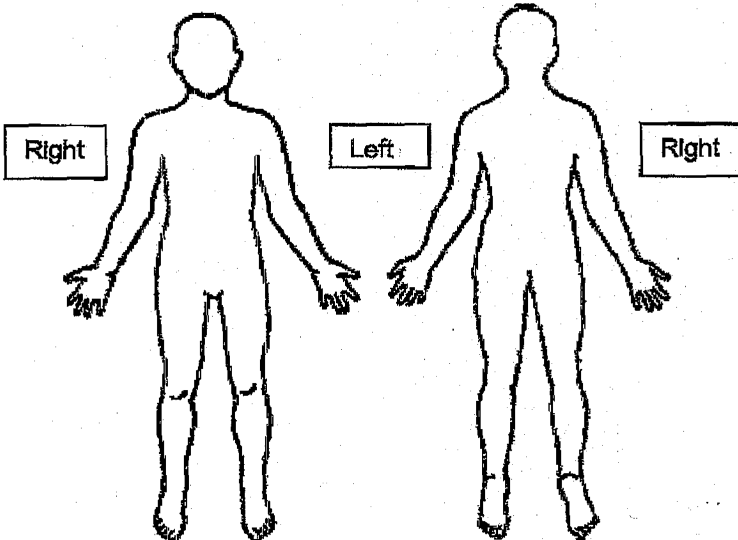


Figure 1 **Please Circle your Pain Area**

Please feel free to list any additional comments below:

____

____

____

____

____

____

How long has this been bothering you?

____

____

____

____

____

____

____

Doctor Comments:

____

____

____

Welcome to our practice. Please fill out the information below to the best of your ability.

Today's Date: ______________

Patient's Name ______________________________ Age ________ Date of Birth ______________ M / F

Chief Complaint ____

PAST MEDICAL HISTORY

Have you ever had any of the following? Please check all pertinent boxes.

- ☐ Aids or HIV+
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Trouble
- ☐ Bladder Infections
- ☐ Bleeding Tendency
- ☐ Blood Transfusions
- ☐ Bronchitis
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Mitral Valve Prolapse
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Ulcer

PAST SURGICAL HISTORY

Please list previous Hospitalizations / Surgeries / Serious Illnesses	When?	Hospital, City, State

MEDICATIONS

Please include non-prescription and Herbal Supplements

Drug Name	Dosage	Frequency	Drug Name	Dosage	Frequency

ALLERGIES

Medication	Reaction	Medication	Reaction

Tape Allergy ☐ Yes ☐ No **Latex Allergy** ☐ Yes ☐ No

FAMILY HISTORY

Things that members of your family have

- ☐ Back Pain
- ☐ Cancer
- ☐ Diabetes
- ☐ Drug/Alcohol Dependence
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Stroke
- ☐ Sudden Death
- ☐ Tuberculosis

PATIENT SOCIAL HISTORY

Marital Status
- ☐ Divorced
- ☐ Married
- ☐ Separate
- ☐ Single
- ☐ Widowed

Use of Alcohol
- ☐ Daily
- ☐ Moderate
- ☐ Never
- ☐ Rarely

Use of Tobacco
- ☐ Currently
- ☐ Never
- ☐ Previously, but quit

________ Packs per day

Living Situation
- ☐ Alone
- ☐ Other ____________
- ☐ With Family
- ☐ With Friends

Dominant Hand
- ☐ Right
- ☐ Left

Date	Date	Date	Date	Date	Date
Patient	Patient	Patient	Patient	Patient	Patient
Doctor	Doctor	Doctor	Doctor	Doctor	Doctor

PATIENT HISTORY

The following questions pertain to symptoms the patient is experiencing or experiences on a regular basis. These questions pertain to the patient only:

CONSTITUTIONAL

- Weight Loss ☐ YES ☐ NO
- Fever ☐ YES ☐ NO
- Night Sweats ☐ YES ☐ NO
- Problems with Anesthesia ☐ YES ☐ NO

EYES:

- Metal in Eye ☐ YES ☐ NO
- Cataracts ☐ YES ☐ NO

ENT:

- Nose Bleeds ☐ YES ☐ NO
- Ear Ringing ☐ YES ☐ NO
- Sore Throat ☐ YES ☐ NO
- Hearing Loss ☐ YES ☐ NO

CARDIOVASCULAR:

- Chest Pain ☐ YES ☐ NO
- Leg Swell ☐ YES ☐ NO
- High Blood Pressure ☐ YES ☐ NO
- Heart Murmur ☐ YES ☐ NO
- Irregular Beat ☐ YES ☐ NO
- Heart Attacks ☐ YES ☐ NO
- Stroke ☐ YES ☐ NO
- Blood Clot Lung/Legs ☐ YES ☐ NO

RESPIRATORY:

- Irregular ☐ YES ☐ NO
- Shallow ☐ YES ☐ NO
- Cough ☐ YES ☐ NO
- Shortness of Breath ☐ YES ☐ NO
- Asthma ☐ YES ☐ NO
- Emphysema ☐ YES ☐ NO

GASTROINTESTINAL:

- Nausea/Vomiting ☐ YES ☐ NO
- Change in Bowel Habits ☐ YES ☐ NO
- Distension ☐ YES ☐ NO
- Tarry Stools ☐ YES ☐ NO
- Bloody Stools ☐ YES ☐ NO
- Hepatitis ☐ YES ☐ NO

GENITOURINARY:

(Reproductive & Urinary Systems)

- Frequency in Urination ☐ YES ☐ NO
- Burning ☐ YES ☐ NO
- Frequent Urination at Night ☐ YES ☐ NO
- Frequent Infections ☐ YES ☐ NO
- Bloody Urine ☐ YES ☐ NO
- Inability to Control Bladder ☐ YES ☐ NO
- Inability to Urinate ☐ YES ☐ NO
- Prostate Problems ☐ YES ☐ NO

NEUROLOGICAL:

- Fainting Spells ☐ YES ☐ NO
- Seizures ☐ YES ☐ NO
- Amnesia ☐ YES ☐ NO
- Dizziness ☐ YES ☐ NO
- Headache ☐ YES ☐ NO
- Paralysis ☐ YES ☐ NO
- Stimulator Implant ☐ YES ☐ NO

MUSCULOSKELETAL:

- Back Pain ☐ YES ☐ NO
- Neck Pain ☐ YES ☐ NO
- Leg Pain ☐ YES ☐ NO
- Joint Swelling ☐ YES ☐ NO
- Fractures ☐ YES ☐ NO
- Arm Pain ☐ YES ☐ NO

ENDOCRINE

- Do you have diabetes? ☐ YES ☐ NO
- Do you take insulin? ☐ YES ☐ NO
- Hair Gain? ☐ YES ☐ NO
- Hypoglycemia ☐ YES ☐ NO
- Hyperglycemia ☐ YES ☐ NO

PSYCHIATRIC

- Anxiety ☐ YES ☐ NO
- Depression ☐ YES ☐ NO
- Hallucinations ☐ YES ☐ NO
- Difficulty Sleeping ☐ YES ☐ NO
- Compulsive Behaviors ☐ YES ☐ NO
- Impulsive Behaviors ☐ YES ☐ NO
- Suicidal Ideation ☐ YES ☐ NO

HEME-LYMPH

- Lightheadedness ☐ YES ☐ NO
- Easy Bleeding ☐ YES ☐ NO
- Easy Bruising ☐ YES ☐ NO
- Petechiae ☐ YES ☐ NO
- Purpura ☐ YES ☐ NO
- Lymph Node Enlargement ☐ YES ☐ NO
- Pica ☐ YES ☐ NO

ALLERGIC-IMMUNOLOGICAL

- Sinus Allergy Symptoms ☐ YES ☐ NO
- Allergic Dermatitis ☐ YES ☐ NO
- Frequent Illness ☐ YES ☐ NO

PLEASE USE THIS SPACE TO LIST ANY INFORMATION THAT HAS NOT BEEN MENTIONED ABOVE THAT YOU FEEL WOULD BENEFIT THE DOCTOR IN HIS TREATMENT OF YOUR CASE.

____

____

____

PATIENT INFORMATION

Date ____________________

Last Name ____________________ First ____________________ Middle ____________________

Preferred Name ____________________

Age ______ Date of birth ____________ Sex ☐ M ☐ F SS# ____________________

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Other ____________

Address ____________________

City ____________________ State ____________ Zip ____________

Home phone (____) ____________________ Work phone (____) ____________________

Cell Phone (____) ____________________ Email ____________________

Spouse Name ____________________ Phone Number ____________________

Who is your Primary Care Physician? ____________________

How did you hear about our practice? ____________________

Reason for today's visit: ____________________

Place of Employment: ____________________

If injury, give date ____________________ or date of first symptoms ____________________

Please circle where the Injury occurred:

JOB AUTO HOME OTHER

Have X-rays been taken? ☐ Yes ☐ No When? ____________ Where? ____________

PAYMENT INFORMATION

Name of person responsible for payment ____________________

Do you have insurance coverage? ☐ Yes ☐ No

PRIMARY INSURANCE ____________________

Policy holder ____________________

Policy holder's ID# ____________________

Policy holder's Group # ____________________

Policy holder's date of birth ____________________

Policy holder's Social Security Number ____________________

SECONDARY INSURANCE ____________________

Policy holder ____________________

Policy holder's ID# ____________________

Policy holder's Group # ____________________

Policy holder's date of birth ____________________

Policy holder's Social Security Number ____________________

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

FOR INSURANCE PURPOSES ONLY, WE MUST HAVE AN ORIGINAL SIGNATURE ON FILE. PLEASE SIGN AT BOX 12 AND BOX 13

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous)

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2			DO NOT COMPLETE, SIGNATURE ONLY					NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH #

Southern Orthopaedics & Sports Medicine, PA
1717 North 'E' Street, Tower III, 5th Floor, Ste 534
Pensacola, Florida 32501
(850) 432-3293 or (866) 432-3293
1427156827

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

ICMS-1500L

InHealth Record Systems (Div. of Professional Filing Systems, Inc.) To Order Call 1-800-477-7374, In Atlanta 770/935-5854

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD — FIRST FOLD

Southern Orthopaedics & Sports Medicine, P.A.

Please list the family member or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care):

____

Please list the family members or other persons, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY:**

Name:____________________ Phone#____________________

Name:____________________ Phone#____________________

Print the address of where you would like your billing statement and/or correspondence from our office to be sent IF other than your home:

____

Please print the telephone number where you want to receive calls about your appointments, or other health care information IF other than your home phone#

____

Do you have voicemail or an answering machine? YES:________ NO:________

Can confidential messages (such as appointment reminders) be left on your voicemail or answering machine? YES:________ NO:________

PATIENT NAME:______________________(guardian if patient is under 18 years old)

PATIENT/GUARDIAN SIGNATURE:______________________

DATE:______________________

SOUTHERN ORTHOPAEDICS & SPORTS MEDICINE
HIPAA POLICY MANUAL

HIPAA Privacy Policy

It shall be the policy of Southern Orthopaedics & Sports Medicineto protect and safeguard the Protected Health Information of its patients in accordance with the Privacy Regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 and applicable state laws.

The Privacy Rule protects all *"individually identifiable health information"* held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information "protected health information (PHI)."

"Individually identifiable health information" is information, including demographic data, that relates to:

- the individual's past, present or future physical or mental health or condition,
- the provision of health care to the individual, or
- the past, present, or future payment for the provision of health care to the individual,

and that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual. Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).

These Policies are intended to provide guidance to providers and employees in regard to the protection and enhancement of the privacy rights of patients by (a) establishing rules related to the internal and external Use and Disclosure of Protected Health Information; (b) affording patients access and information regarding the Use and Disclosure of their Protected Health Information; and (c) implementing administrative procedures intended to assist patients and staff to effectuate these Policies.

These Policies will apply to all Protected Health Information collected by our practice after April 14, 2003. The Policies apply to all physicians and staff of Southern Orthopaedics & Sports Medicine.

Southern Orthopaedics and Sports Medicine, P.A.

FINANCIAL POLICY

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care.

For your convenience, we have answered a variety of commonly asked financial policy questions below. If you need further information about any of these policies, please ask to speak with a Billing Specialist.

We file an insurance claim within 7 days of your date of service.

If your appointment is not cancelled within 24 hours, you will be charged a $25.00 no-show fee.

A billing statement covering medical services rendered will be mailed to you monthly.

If we do not receive a response from your insurance carrier within 90 days, you will receive a statement and will need to contact your insurance carrier regarding payment. **The balance due for medical services will be your responsibility.**

If you have financial problem, please ask to discuss a payment plan with our staff. Our minimum payment plan begins at $25.00 per month. We accept cash, checks, VISA, or Mastercard as payment. American General Financing is also available. In the event a personal check is returned unpaid from your bank, your account will be charged a $25.00 return check fee. Please note all co pays are due at the time of service. If we must bill you for two consecutive co pays, there will be a $5.00 charge added for billing.

AUTO RELATED INJURIES

Failure to inform us that the injury related to this appointment is a result of an auto accident could revert all financial responsibility to you the patient. Insurance information must be obtained before appointment date. Failure to provide us with this information will result in the rescheduling of the appointment.

NO INSURANCE

Payment is required at the time services are rendered.

(over)

Do I Need A Referral?

If you have an HMO plan with which we are contracted, you need a referral authorization from your primary care physician. If we have not received an authorization prior to your arrival at the office, we have a telephone available for you to call your primary care physician to obtain it. If you are unable to obtain the referral at that time, you will be rescheduled.

MINOR PATIENTS

The parent/guardian/adult accompanying a minor child is responsible for payment. Any child 18 or over is legally an adult and responsible for his/her bill, regardless of attending college, living at home, or being covered by parents insurance. If both parents have insurance, the parent with the first birthday in the year is most often the primary insurer. Please check your insurance policy to determine which company is primary before your appointment. In divorce cases, the parent who brings the child in for services is ultimately the responsible party.

If you had a previous collection balance or are presently in collection, the physician may use his or her discretion as to seeing you again. It may be required that you pay your previous balance in full prior to being seen. You will be responsible for payment of the office visit, co pay, deductible, etc., on the day of the visit.

Surgery

If your physician recommends surgery, one of our Surgery Coordinators will contact you. They will answer specific questions about the surgery scheduling process and complete all pre-certification/authorization if your insurance company requires it.

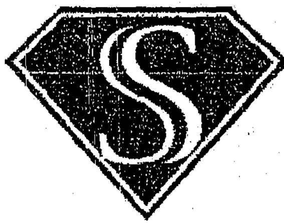
The Surgery Coordinator will request a pre-surgical deposit, the amount of which depends on your coverage and deductible amount. The Surgery Coordinator will explain a cost estimate, which shows your financial responsibility, based on the benefit levels and coverage of your insurance plan.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility.

I authorize my insurance benefits be paid directly to Southern Orthopaedics & Sports Medicine, P.A.

I authorize Southern Orthopaedics & Sports Medicine, P.A. to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

Date	Signature	Printed Name



Southern Orthopaedics & Sports Medicine, P.A.

NARCOTIC AGREEMENT

The purpose for this agreement is to prevent misunderstandings about certain medicines you will be taking for pain management. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals.

- I understand this agreement is essential to the trust and confidence necessary in a doctor-patient relationship and that my doctor undertakes to treat me based on this agreement.
- I understand that if I break this agreement, my doctor may stop prescribing these pain-control medications and/or release me from the practice. If this occurs, my doctor will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.
- I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life and how well the medicine is helping to relieve the pain.
- I understand that if I am being prescribed pain medication by another physician that I must notify that physician regarding medication prescribed to me by the physician listed below.
- I will not use any illegal controlled substances, such as marijuana and cocaine. I will not share, sell or trade my medication with anyone.
- I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or anti-anxiety medicines from any other doctor.
- I will safeguard my medicine from loss or theft. Lost or stolen prescriptions, written, or filled, **will not be replaced**.
- I agree that refills of my prescriptions for pain medicine will be made only at the time of an office visit or during regular office hours. **No refills will be available during evenings or weekends**.
- I authorize my doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including the State of Florida's Board of Pharmacy, in the investigation of any possible misuse, sale or other diversion of my pain medicine.
- I authorize my doctor to provide a copy of this agreement to my pharmacy.
- I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.
- I agree that I will submit to a blood or urine test if requested by my doctor to determine my compliance with my program of pain control medicine.
- I agree that I will use my medicine at a rate no greater than the prescribed rate and that the use of my medicine at a greater rate will result in my being without medication for a period of time.
- If requested by my doctor, I will bring all unused pain medicine to every office visit.

I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document will be given upon request.

I agree to use ____________________(pharmacy), located at______________________________(address) ____________________(telephone number), for filing prescriptions for all of my pain medications.

Patient Name: ____________________ DOB: __________ Date: __________

Patient Signature: ____________________ Witness: ____________________

Physician Name: William E. Smith Jr. M.D.

Physician Signature: ____________________