THE CENTER FOR ORTHOPAEDICS & SPORTS MEDICINE

J.F. Rick Hammesfahr, M.D.
Board Certified

Craig E. Weil, M.D.
Board Certified
CAQHS

New Patient Instructions:

Please fill out the attached paperwork and

- Bring it to the office at your appointment
- Or fax it to 770-565-9866 prior to your appointment
- Or email it to Summer@arthroscopy.com

If the necessary paperwork is not received by the time of your appointment, you will need to come to the office at least 20 minutes prior to your appointment to do the paperwork, prior to being seen. These forms help us to assist you in a more efficient and timely manner.

Forms to be filled out or signed:

- Patient information form
- HIPPA form (Consent to treatment)
- Injury form.
- Business Practices form

If you have any questions, please contact us at 770-565-0011.

At the time of your appointment, please bring your insurance card and photo ID with you.

1211 Johnson Ferry Road Marietta, Georgia 30068
Telephone 770-565-0011 Business Office 770-509-8498 Fax 770-565-9866
www.arthroscopy.com email: Summer@arthroscopy.com

PATIENT INFORMATION

Name:

Address:

City: State:

Zip: Sex:

Date of Birth: Martial Status:

Home Phone:

Work Phone:

Email Address:

Are You? A Student Employed

Occupation:

Employer:

Cell Phone:

EMERGENCY CONTACT PERSON (DIFFERENT HOUSEHOLD)

Emergency Name:

Relationship to Patient:

Phone Number of Contact Person:

SPOUSE'S INFORMATION

Spouse's Name:

Is Spouse? Employed

Spouse's Employer:

Spouse's Work or Cell Phone #:

TODAY'S VISIT
Please complete all information in this section.

Which body part?

Right Left

List Drug Allergies:

Who referred you to our office?

Referring Physician:

City: State:

Phone Number:

Date of Injury/Onset:

Auto Accident: Work Injury:

How did it happen?

PARENT/GUARANTOR INFORMATION (MUST BE FILLED IN IF PATIENT IS A CHILD)

Guarantor's Name:

Guarantor's Email Address:

Employer:

Employer's Phone:

Spouse's Name:

Spouse's Email:

Spouse's Employer:

Spouse's Employer's Phone:

INSURANCE INFORMATION

Primary Insurance:

Ins. Co. Address:

Ins. Co. City: State:

Ins. Co. Zip:

Phone Number on card For Provider Benefits:

Policy Holder:

ID #/Policy #:

Group #:

Policy Holder Date of Birth:

SECONDARY INSURANCE INFORMATION

Secondary Insurance:

Ins. Co. Address:

Ins. Co. City: State:

Ins. Co. Zip:

Phone Number on card For Provider Benefits:

Policy Holder:

ID #/Policy #:

Group #:

Policy Holder Date of Birth:

How would you like to be contacted concerning appointments? Select as many as necessary.

Cell Phone Text Message

Home Phone Email

Work Phone

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New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations as Mandated by Federal Law

I understand that as part of my health care, the Center for Orthopaedics & Sports Medicine originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I further understand that the Center for Orthopaedics & Sports Medicine reserves the right to change their Notice of Privacy Practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. I may obtain a revised notice of privacy practices by accessing the Center for Orthopaedics & Sports Medicine's website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I wish to have the following restrictions to the use or disclosure of my health information:

I understand that the Center for Orthopaedics & Sports Medicine is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. **I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.**

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

My medical and billing information may be discussed with the following people:
☐Immediate family ☐Spouse ☐ Children ☐ Other

I fully understand and accept the terms of this consent.

Patient / Guarantor Signature

Date

Code of Federal Regulations: Section 164.520

FOR OFFICE USE ONLY
☐ Consent refused by patient, and treatment refused as permitted.

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Business Practices

Information for Claim Filing:

- I hereby authorize the release of any medical information necessary to process the insurance claim.
- I authorize payment of medical benefits to the Center for Orthopaedics & Sports Medicine for services rendered. A photocopy of this authorization and assignment shall be considered as valid as the original.
- I understand that supplies may not be covered, and/or denied, by my insurance company, in which case I would be responsible for payment of the noncovered/denied supplies.

Settling of balances;

There are times when insurance companies process a claim in a manner different than expected. In these cases:

- A claim may be completely denied as not covered, with no payment made, making me completely responsible for the entire balance.
- A claim may pay differently than anticipated, making me responsible for a larger portion of the charges incurred than expected.
- Your insurance company may fail to process your claim correctly. In this case, we will ask your insurance company to reprocess and pay the claim correctly. If we do not receive payment within 45 days of your date of service, we will notify you of your insurer's failure to pay and of your resulting balance. At this point, you would need to contact your insurance company.

Insurance Company Look Back Periods

Insurance companies often perform audits of paid claims. These audits can be performed for up to 24 months after the date of service. This means that for up to 24 months from when the services are provided, your insurance company may reverse their decision. When an audit is performed and the insurer determines that the claim was paid in error, the insurance company will request a refund from us for the payment made. At that time, the remaining balance will become your financial responsibility. If this should occur, we will contact you for payment.

Interest on Unpaid Balances and Collection Fees

Patient balances over 30 days will be charged a $5.00 service charge or a 1.5% interest rate per month (for an annual rate of 18%), whichever is greater. You are then responsible for your balance, collection fees, attorney fees, and court costs associated with collection of the outstanding amount.

Patient / Guarantor Understanding

I fully understand the Business Practices policy of the Center for Orthopaedics & Sports Medicine regarding patient accounts and insurance policies. I understand that I am responsible for, and agree to pay any balance not covered/paid by my insurance company for any reason.

Signature

Date

Print Full Name

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Name: _____ Date: _____

Age: _____ Weight: _____ Height (inches): _____

What are you being seen for today?

	Left	Right		Left	Right
Shoulder			Hip		
Upper Arm			Upper Leg (Thigh)		
Elbow			Knee		
Lower Arm (Forearm)			Lower Leg (Tibia, Shin)		
Wrist			Ankle/Foot		
Hand/Fingers			Other		

Did the problem start gradually or suddenly? When did this happen?
(Be as specific as possible on the date when this started).

	Date of Onset	Days Ago	Weeks Ago	Months Ago	Years Ago	Unknown Date
Gradually						
Suddenly						

What caused the problem? (Circle answer)

Work ☐ MVA ☐ Sports ☐ Unknown Cause ☐ Old Injury ☐

Other (Please Describe): _____

What were you doing when you were injured or first noticed the problem?

_____

Have you been seen by a physician (Nurse practitioner or Physician's Assistant) for this problem?

☐ Yes No ☐

List any previous surgical procedures, or medical treatment obtained, on the involved joint (or arm or leg) and the date.

_____

_____

Signature

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Directions to Office:
1211 Johnson Ferry Rd, Marietta, Ga.

Directions from I-75 North (Kennesaw, Woodstock, Acworth, etc):

- Take I-75 going south to GA120 Loop E (exit 265)
- Turn Left on to North Marietta Parkway
- Take GA 120 ramp towards Roswell/Marietta.
- Turn left onto Roswell Rd (GA/120)
- Continue to Johnson Ferry Rd.
- Turn Right on Johnson Ferry Rd.
- Office is ½ mile on Right.

Directions from I-75 South (Downtown, Midtown, etc.)

- Take I-75 going North to GA/120 Loop East (exit 263) toward Marietta/Southern Poly/Roswell.
- Take GA120 east exit toward Roswell.
- Merge onto South Marietta Pkwy/GA120 Loop E.
- Take the GA/120 ramp toward Roswell/Marietta
- Turn Right onto Roswell Rd/GA120 NE
- Continue to Johnson Ferry Rd.
- Turn Right onto Johnson Ferry Rd.
- Office is ½ mile on Right.

Directions from I-285 East (Stone Mountain, Decatur, Lithonia, etc):

- Take I-285 West to Riverside Dr. (exit 24)
- Turn right onto Riverside Drive
- Continue North to Johnson Ferry Rd.
- Turn Left onto Johnson Ferry Rd. Go 2-3 miles
- Office will be on the left
- Make a U-turn at the light.

Directions from I-285 West:

- Take I-285 East to Riverside Dr. (exit 24)
- Turn left onto Riverside Drive
- Continue to Johnson Ferry Rd.
- Turn Left onto Johnson Ferry Rd. Go 2-3 miles
- Office will be on the left.
- Make a U-turn at the light.

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