Patient Information

Name:			
Address:			Apt/Unit #:
City:		State:	Zip:
Date of Birth:	Sex:	Marital Status:	
Home Phone:		Cell Phone:	
Email Address:			
Employer: (Please disregard if you are a student)			
Occupation:		Work Phone:	

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

Cell Phone Home Phone Work Phone Email Text Message

Spouse's Information

Spouse's Name:	Is your Spouse Employed? YES NO
Spouse's Employer:	Work or Cell#:

Emergency Contact Person (Different household)

Emergency Contact Name:	
Relationship to Patient:	Phone Number:

Today's Visit: (Please complete all Information in this section)

What Body Part are we seeing you for today?			Right Left Bilateral
List Drug Allergies:		Who Referred you to our office:	
Referring Physician:	Phone:	City:	State:
Date of Injury/ Onset:	Auto Accident? YES NO	Work Related? YES NO	

How did the injury occur? If this is an ongoing issue, please indicate below:

**** If we are filing your Insurance, you <u>must</u> complete this section****

Parent/Guarantor Information (Must Be Filled out if the patient is a child)

Guarantor's Name:	Employer:	
Employer's Phone:	Guarantor's Email address:	

Insurance Information

Primary Insurance :	Policy Holder:	Policy Holder Date of Birth:
ID#:	Group#:	
Secondary Insurance:	Policy Holder:	Policy Holder Date of Birth:
ID#:	Group#:	

THE CENTER FOR ORTHOPAEDIC & SPORTS MEDICINE

The Center For Orthopaedics and Sports Medicine

CRAIG WEIL, M.D. ERIC STEENLAGE, M.D.

Craig E. Weil, M.D.
Board Certified

Eric S. Steenlage, M.D.
Board Certified

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 non-covered/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 t 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 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 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.

Collection Fees:

If an unpaid account is turned over to a collection agency, you are then responsible for your balance, collection fees, attorney fees, and court cost 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.

_____ **Date:** _____

Print Full Name of Patient/ Guarantor

_____

Signature of Patient/ Guarantor

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

Injury Questionnaire

Patient Name: _____ Date: _____

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

What are you being seen for today?

Body Part	Left	Right		Body Part	Left	Right
Shoulder				Hip		
Upper Arm				Upper Leg		
Elbow				Knee		
Lower Arm				Lower Leg		
Wrist				Ankle/ Foot		
Hand/ Fingers				Other		

Did the problem start gradually or suddenly?_____

When did this happen? Circle one (Please be as specific as possible on the date when this started)

Specific date: (please indicate) _____ **Weeks ago** **Months ago** **Years ago** **Unknown**

What caused the Problem? Circle one

Work **Auto Accident** **Sports** **Unknown** **Old Injury** **Other (Please describe in the box below**

What were you doing when you were injured or first noticed the problem? Describe in the box below

Have you been seen by any type of provider for this problem? YES NO If so, who?_____

List any previous surgery or medical treatment obtained on the involved body part. Also, indicate date below

_____ **Date:**_____

Signature

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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 by mail or asking for one at the time of my next appointment.

If you wish to have the any specific restrictions or instructions in the use or disclosure of my health information, please indicate in the box below.

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 of revoking this consent, gives this organization the right to refuse treatment as permitted by Section 164.506 of the Code of Federal Regulations. this consent or revoking this consent, this organization may refuse to treat me as permitted by**

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 disclose for these permitted uses, including disclosures via fax.

My medical and billing information may be discussed with the following people: Circle all that Apply

Spouse Immediate Family Children Other (please indicate)_____

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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