PERFORMANCE
ORTHOPAEDICS • SPORTS MEDICINE

PATIENT & INSURANCE INFORMATION

Patient Name: Last_____First_____MI_____Today's Date_____

Sex: ☐ Male ☐ Female Date of Birth_____SS# _____

Address_____City_____State_____Zip _____

Home Phone_____Mobile_____Business_____

Email Address_____Contact Preference: ☐ Home ☐ Mobile ☐ Business

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated Race_____

Ethnicity_____Preferred Language_____

Employer_____School (if applicable) _____

Referring Doctor_____Ref Doctor Phone_____

Primary Care Physician_____PCP Phone_____

Pharmacy_____Pharmacy Location/Intersection/Road_____

Parent/Legal Guardian/Guarantor (if applicable): Last_____First_____

Address_____Phone:_____☐ same as above

IN CASE OF EMERGENCY PLEASE CONTACT:

Last_____First_____MI_____

Relationship to patient_____Home Phone_____Mobile_____

INSURANCE INFORMATION: (please list the Policy Holder information if it is NOT the patient)

Primary Insurance_____ID#_____

Policy Holder Name: Last_____First_____MI_____

Relationship to Patient_____Date of Birth_____Social Security #_____

Policy Holder Employer_____

Secondary Insurance_____ID#_____

Policy Holder Name: Last_____First_____MI_____

Relationship to Patient_____Date of Birth_____Social Security #_____

Policy Holder Employer_____

INSURANCE AUTHORIZATION:

I authorize Performance Orthopaedic Surgery & Sports Medicine, P.A. to release any information acquired in the course of my examination or treatment to my insurance company. I hereby authorize all insurance payments be paid directly to Performance Orthopaedic Surgery & Sports Medicine, P.A. I recognize and accept financial responsibility for any balance or fee not covered by my insurance. All information in this form is completed to the best of my knowledge.

Name_____Signature_____Date_____

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CURRENT INJURY INFORMATION

Briefly describe injury/pain and the body part we are treating today: Height_____Weight_____

_____

Please indicate if your Condition is ☐ Right ☐ Left ☐ Bilateral **Date of Injury** or **onset of symptoms:** _____

Did you previously receive treatment from an Emergency Room, Urgent Care, or another physician? ☐ YES ☐ NO

Name / Location_____

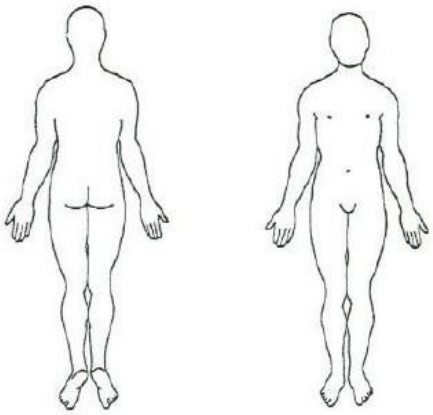
Have you had any prior images or testing for this Condition (X Ray, MRI, bone density, etc)? ☐ YES ☐ NO

Images/Test Location: _____

Condition related to: ☐ **Work Injury** ☐ **Auto Accident** ☐ **Other**

Body Chart:
Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:

Sharp, shooting pain
O Dull/aching pain
X Numbness
Tingling



My symptoms currently: ☐ Come and go ☐ Are constant ☐ Are constant, but change with activity

Aggravating Factors: identify up to 3 important positions or activities that make your symptoms worse:

_____

_____

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:

_____

_____

How are you currently able to sleep at night due to your symptoms?
☐ No problem sleeping ☐ Difficulty falling asleep ☐ Awakened by pain ☐ Sleep only with medication

When are your symptoms **worst**? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After exercise

When are your symptoms the **best**? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After exercise

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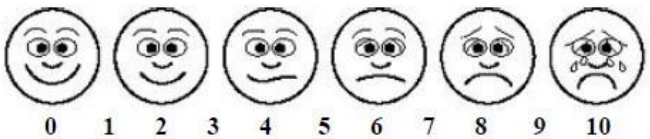
Using the 0 to 10 scale, with 0 being *"no pain"* and 10 being the *"worst pain imaginable"* please describe:



Your **CURRENT** level of pain while completing this survey:_____

The **BEST** your pain has been during the **past 24 hours**: _____

The **WORST** your pain has been during the **past 24 hours**: _____

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MEDICAL HISTORY

Allergies: (please list allergies & *your reaction*) ☐ **No Known Drug Allergy**

_____

_____

_____

Medications: (please list current medications, dosage, & frequency)

_____

_____

_____

Family History: (please list if any direct relative has had any of the below conditions) ☐ **No Current Problems or disabilities**

Diabetes: ☐ Mother ☐ Father ☐ Sibling ☐ M Grandmother ☐ M Grandfather ☐ P Grandmother ☐ P Grandfather

Cancer: ☐ Mother ☐ Father ☐ Sibling ☐ M Grandmother ☐ M Grandfather ☐ P Grandmother ☐ P Grandfather

Heart Disease /Heart Attack:

☐ Mother ☐ Father ☐ Sibling ☐ M Grandmother ☐ M Grandfather ☐ P Grandmother ☐ P Grandfather

Osteoarthritis: ☐ Mother ☐ Father ☐ Sibling ☐ M Grandmother ☐ M Grandfather ☐ P Grandmother ☐ P Grandfather

Rheumatoid Arthritis: ☐ Mother ☐ Father ☐ Sibling ☐ M Grandmother ☐ M Grandfather ☐ P Grandmother ☐ P Grandfather

Stroke: ☐ Mother ☐ Father ☐ Sibling ☐ M Grandmother ☐ M Grandfather ☐ P Grandmother ☐ P Grandfather

Blood Coagulation Disorder/Blood Clots:

☐ Mother ☐ Father ☐ Sibling ☐ M Grandmother ☐ M Grandfather ☐ P Grandmother ☐ P Grandfather

Other:_____

Social History

Smoking Status: ☐ Never Smoker ☐ Former Smoker ☐ Current Smoker # of packs _____ per day (or) per week
Occupation_____ **Retired** ☐ Yes ☐ No **Disabled** ☐ Yes ☐ No
Marital Status: ☐ Married ☐ Single ☐ Divorced
Alcohol Intake: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy
Caffeine Intake: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy
Illicit Drugs: _____
Exercise Level: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy
Sporting Activities: _____

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Past Surgical History: (please list any surgeries and dates) ☐ **NO Previous Surgery**

Surgery	**Date**	**Notes**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever been diagnosed with any of the following conditions? ☐ **NONE**

- ☐ **Pacemaker implanted**
- ☐ **Latex Sensitivity**
- ☐ **Currently or may be Pregnant**
- ☐ **Complications w/ Anesthesia**
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Clots (DVT)
- ☐ Cancer
- ☐ Coronary Artery Disease
- ☐ Claustrophobia
- ☐ Diabetes
- ☐ Dialysis
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Heart arrhythmia
- ☐ Heart attack (MI)
- ☐ Heart murmur
- ☐ Hiatal hernia
- ☐ HIV or AIDS
- ☐ Hypertension
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Leg/foot ulcers
- ☐ Liver disease
- ☐ Osteoporosis
- ☐ Other Lung disease
- ☐ Peripheral vascular problem
- ☐ Pulmonary embolism (PE)
- ☐ Reflux Disease
- ☐ Ulcers
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Urinary Tract Infections
- ☐ Other_____
  _____
  _____

Have you recently experienced any of the following symptoms? ☐ **NONE**

- ☐ Fever
- ☐ Fatigue
- ☐ Unexplained weight gain/loss
- ☐ Chest pain
- ☐ Palpitations
- ☐ Cough
- ☐ Shortness of breath
- ☐ Heartburn
- ☐ Nausea/vomiting
- ☐ Blood in stool
- ☐ Change in bowel habits
- ☐ Incontinence
- ☐ Difficulty urinating
- ☐ Increased urinary frequency
- ☐ Muscle aches/weakness
- ☐ Joint pains
- ☐ Back pain
- ☐ Bug bites
- ☐ Rashes
- ☐ Weakness
- ☐ Numbness/tingling
- ☐ Seizures
- ☐ Headaches
- ☐ Depression
- ☐ Anxiety/stress
- ☐ Heat/cold intolerance
- ☐ Swollen glands
- ☐ Easy bruising/bleeding
- ☐ Runny nose
- ☐ Itching/hives

Other: _____

All information on this form is completed to the best of my knowledge.

Name_____Signature_____Date_____

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NOTICE OF PRACTICE AND FINANCIAL POLICIES

Insurance: A current insurance card must be on file for each appointment. If you do not have your insurance card available, payment in full is expected before seeing your provider. If your injury is due to a motor vehicle accident, if you are uninsured, or if you have a legal case pending, payment is due in full before seeing your provider. If you change insurance carriers between appointments, you must bring in your new card so we can properly bill the visit. If you do not have your new insurance information, payment in full will be expected. Please note: we DO NOT accept any auto insurance as coverage for our service.

Workers Compensation: Workers Compensation patients must have an authorization and provide our office with the correct W/C Company and the adjuster/case manager name with phone number and fax number. Without this information, we will consider you as a self-pay patient and payment in full is expected. Once we have that information, we will submit the claim to your W/C provider and will issue you a refund after the claim has been paid.

Co-payments: Co-payments are due at each visit. We do not have authority to accept non-payment. This is a requirement that was agreed upon by the plan guarantor when the policy was chosen and is part of your contract with the insurance company. Failure on our part to collect copayments from patients can be considered fraud. Please help us uphold the law by paying your copay at each visit. Parents and/or guardians of patients under the age of 18 are responsible for the minor patient's account regardless of who holds the insurance policy. Be aware that some services or products may not be covered or may be considered not medically necessary by some insurance carriers. You will be responsible for those services or products at time of service. We accept cash, personal check, Visa, Mastercard, and Discover.

Account Balance: Our office will submit your claims on your behalf and will assist you in any way we can to help get your claims processed and paid. Your insurance company may request information to be supplied by you and it will be your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays on your account. Your insurance coverage is a contract between you and your insurance carrier; we are not party to that contract. If your insurance company does not pay your claim in 90 days, the full balance will automatically be billed to you.

Non-payment: Patients with an outstanding balance of more than 120 days must make arrangements for payment or the account will be turned over to a collection agency. Once the collection agency has received your account, you will be required to pay the agency directly according to their policies.

Refunds: In the case of an overpayment, we will issue a refund no later than 15th day of the month OR within 60 days. We may apply the credit to future balances per your request if your treatment is ongoing.

Surgery Policy: If you elect to undergo a surgery with our doctor, we will bill the surgeon fee only. There are 3 other entities involved: the facility, the anesthesiologist, and lab (if necessary). We do not have information on their fees or policies, but will give you contact information for those who will be involved in your case. After your surgery, you will not be billed a copay for 90 days. After that, insurance companies require us to collect your copay for any post-op or follow-up appointments.

Minor Patients: Any patient under 18 must be accompanied by a parent or guardian. If not, we may refuse non-emergency treatment until a parent or guardian arrives. We will accept a written, signed and dated letter authorizing us to evaluate and treat the minor patient. We do ask that a parent or guardian be available by phone to discuss the diagnosis, treatment, and prognosis.

Missed appointments / Late Cancellations: We strive to keep your appointment with our provider on time and will provide you with as much information regarding your injury and treatment as possible. In order to maintain our commitment, we ask that you keep your scheduled appointment or call to reschedule with at least 24 hours' notice. If you are running behind, we appreciate a quick phone call letting us know.

I have read and understand this information.

Name of Patient_____ Date_____

Signature of Patient or Parent / Legal Guardian_____

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CONSENT FOR CARE AND TREATMENT

I_____give permission for Performance Orthopaedic Surgery and Sports Medicine/Physical Therapy to give me medical treatment.

I allow Performance Orthopaedic Surgery and Sports Medicine to file for insurance benefits to pay for the care I receive.
I understand that:

- Performance Orthopaedic Surgery and Sports Medicine will have to send my medical record information to my insurance company.
- I must pay my share of the costs.
- I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

I understand:

- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my provider

Name of Patient_____Date_____

Signature of Patient or Parent / Legal Guardian_____

PRIVACY PRACTICES AND MEDICAL RELEASE

(Please ***initial*** each section and ***sign*** at the bottom)

_____I hereby give my consent for Performance Orthopaedic Surgery and Sports Medicine, P.A. (hereafter noted as POSSM) to use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment, and Health Care Operations (TPO). POSSM participates in an Organized Health Care Arrangement with providers in the UNC Health Alliance. POSSM may use your PHI for our own health care operations and for those of the Organized Health Care Arrangement in which we participate. I have the right to review the Notice of Privacy Practices prior to signing this consent. POSSM reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by contacting our office.

_____With this consent, POSSM may call my home or alternate contact number and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance inquires, and any calls pertaining to my clinical care, including but not limited to laboratory test results, imaging results, and patient questions.

_____With this consent, POSSM may mail to my home or alternate address any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

_____With this consent, POSSM may email my personal or alternate email address any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

_____I have the right to request that POSSM restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

_____By signing this form, I am consenting to allow POSSM to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, POSSM may decline to provide treatment to me.

_____With this consent, POSSM my obtain information about me directly from my pharmacy such as medication history, pharmacy insurance benefits, and covered formulary medications.

I authorize release of my medical information to the following individuals and/or entities:
(You may include your spouse, significant other, parent, child, friend, etc...)

Name_____Phone_____

Name_____Phone_____

Name_____Phone_____

I have read and understand this information. I understand I have full access to the Notice of Privacy Practices. I am the patient or am authorized to act on behalf of the patient to sign this document verifying consent to the above stated items.

Name of Patient_____Date_____

Signature of Patient or Parent / Legal Guardian_____