



**PATIENT & INSURANCE INFORMATION**

Patient Name: Last \_\_\_\_\_ First \_\_\_\_\_ Preferred Name \_\_\_\_\_

Sex:  Male  Female Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Mobile \_\_\_\_\_

Email Address \_\_\_\_\_ Contact Preference:  Home  Mobile

Marital Status:  Single  Married  Divorced  Widowed  Separated  Partner

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 (if different from above) \_\_\_\_\_ Phone \_\_\_\_\_

**IN CASE OF EMERGENCY PLEASE CONTACT:**

Last \_\_\_\_\_ First \_\_\_\_\_

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 \_\_\_\_\_

Policy Holder Employer \_\_\_\_\_

**Secondary Insurance** \_\_\_\_\_ ID# \_\_\_\_\_

Policy Holder Name: Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_

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 \_\_\_\_\_



**MEDICAL HISTORY**

**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_

**Allergies** (please list allergies & your reaction)

**No Known Drug Allergy**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medications** (please list all 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  Brother  Sister  M Grandmother  M Grandfather  P Grandmother  P Grandfather

**Cancer:**  Mother  Father  Brother  Sister  M Grandmother  M Grandfather  P Grandmother  P Grandfather

**Heart Disease /Heart Attack:**

Mother  Father  Brother  Sister  M Grandmother  M Grandfather  P Grandmother  P Grandfather

**Osteoarthritis:**  Mother  Father  Brother  Sister  M Grandmother  M Grandfather  P Grandmother  P Grandfather

**Rheumatoid Arthritis:**  Mother  Father  Brother  Sister  M Grandmother  M Grandfather  P Grandmother  P Grandfather

**Stroke:**  Mother  Father  Brother  Sister  M Grandmother  M Grandfather  P Grandmother  P Grandfather

**Blood Coagulation Disorder/Blood Clots:**

Mother  Father  Brother  Sister  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  Separated  Widowed  Partner

**Alcohol Intake:**  None  Occasional  Moderate  Heavy

**Caffeine Intake:**  None  Occasional  Moderate  Heavy

**Illicit Drugs:** \_\_\_\_\_

**Exercise Level:**  None  Occasional  Moderate  Heavy

**Sporting Activities:** \_\_\_\_\_



**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**

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

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

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

Other: \_\_\_\_\_

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

Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_



**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, American Express 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 \_\_\_\_\_



**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 may 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 \_\_\_\_\_