NEW PATIENT FORM

Patient Full Name: Soc. Sec #:

Address:

City: State: Zip:

Home Phone: Mobile Phone: Yes Work Phone:

Date of Birth: Age: Gender: Marital Status:

Race:

Email Address (For access to our patient portal): Yes

Employer: Occupation:

Employer Address:

City: State: Zip:

SPOUSE OR PARENT'S INFORMATION (Provide parent or guardian information if patient is a minor):

Name: Date of Birth: Soc. Sec #:

Relationship to patient: Phone #:

Employer: Occupation:

Employer Address:

City: State: Zip:

PRIMARY COMPLAINT:

Why are you seeing the doctor today? Please specify Right or Left if applicable.

Date of accident or onset of symptoms: ☐ Auto Accident ☐ Worker's Comp

☐ Other:

Name of referring physician:

Are you currently in a Skilled Nursing Facility (Medicare patients only)? ☐ Yes ☐ No

PRIMARY INSURANCE:

Name of Insurance: Name of Insured:

Policy #: Insured's date of birth:

Group #: Insured's Soc. Sec.#: Relationship to Patient:

SECONDARY INSURANCE:

Name of Insurance: Name of Insured:

Policy #: Insured's date of birth:

Group #: Insured's Soc. Sec.#: Relationship to Patient

WORKER'S COMPENSATION INFORMATION:

Mail claim to: Verified By: Phone #:

I consent to examination and treatment as deemed appropriate by the attending physician. I authorize Legend Orthopedics to release to any insurance company or government agency any and all information necessary to process this claim, and I authorize payment of benefits directly to Legend Orthopedics. I understand that charges not covered by my insurance carrier are my responsibility.

Signature: _____ Date: _____

PATIENT MEDICAL HISTORY:

Date:

Name of your primary CARE PHYSICIAN:

Name of your CARDIOLOGIST (if any):

CHIEF COMPLAINT:

Why are you seeing the doctor today?

Have you been treated for this problem before: ☐ Yes ☐ No

Height: ft in Current Weight:

MEDICAL HISTORY:

Have you received treatment for any of the following conditions?

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Anemia	☐	☐	Heart Disease	☐	☐	Malignant. Hypothermia	☐	☐	Pulmonary Embolism
☐	☐	Asthma	☐	☐	Hepatitis	☐	☐	MRSA/Staph Infection	☐	☐	Thyroid Problems
☐	☐	Bleeding or Bruising	☐	☐	High Blood Pressure	☐	☐	Osteoporosis	☐	☐	Ulcer
☐	☐	Cancer	☐	☐	HIV/AIDS	☐	☐	Pacemaker	☐	☐	Type
		Type_____	☐	☐	Kidney Problems	☐	☐	Phlebitis	☐	☐	Are there any other medical problems we should know about?
☐	☐	Diabetes	☐	☐	Liver Disease	☐	☐	Peripheral Vascular Disease			
☐	☐	Defibrillator	☐	☐	Lung Problems	☐	☐	Psychological Problems			
☐	☐	DVT/Blood Clots	☐	☐	Lupus	☐	☐	Rheumatoid Arthritis			
☐	☐	Gout	☐	☐	Tuberculosis	☐	☐	Stroke/TIA			

Have you had a recent flu vaccination? ☐ Yes ☐ No Approximate Date: _____

Have you had a pneumonia vaccination? ☐ Yes ☐ No Approximate Date: _____

For Females: Are you pregnant? ☐ Yes ☐ No ☐ Uncertain

SURGERIES AND HOSPITALIZATIONS:

Please list prior surgeries/hospitalizations, with approximate dates

SOCIAL HISTORY (Smoking Status):

☐ Current Every day smoker ☐ Current Someday smoker ☐ Smoker, Current Status Un known ☐ Heavy Tobacco Smoker

☐ Light Tobacco Smoker ☐ Never Smoker (Start Date): _____

☐ Former Smoker (Quit Date):_____ ☐ Unknown if ever smoker (Packs Per day): _____

Do you drink alcoholic beverages? Do ☐ Yes ☐ No Amount & Frequency:

you use recreational drugs? ☐ Yes ☐ No Type & Frequency:

Do you exercise regularly? ☐ Yes ☐ No Type & Frequency:

Are you right or left hand dominant? ☐ Right ☐ Left

Occupation:

Education: ☐ Elementary School ☐ High School ☐ College ☐ Post-Graduate

Do you live alone? ☐ Yes ☐ No Do you have children: ☐ Yes ☐ No If yes, how many?

FAMILY HISTORY

Have you parents, grandparents, brothers or sisters been treated for the following conditions?

- ☐ Alzheimer's
- ☐ Arthritis
- ☐ Cancer
- ☐ Stroke
- ☐ Diabetes
- ☐ Gout
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Malignant Hypothermia
- ☐ Osteoporosis
- ☐ Other:

REVIEW OF SYSTEMS:

Please check any of the following symptoms that you have experienced on a regular basis.

GENERAL
- ☐ Fever
- ☐ Weight Change
- ☐ Other
- ☐ None

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Fluid/Selling of Extremities
- ☐ Other
- ☐ None

KIDNEY/BLADDER
- ☐ Painful Urination
- ☐ Incontinence
- ☐ Other
- ☐ None

EYES
- ☐ Glasses or Contacts
- ☐ Glaucoma
- ☐ Other
- ☐ None

RESPIRATORY
- ☐ Shortness of Breath
- ☐ Sleep Apnea
- ☐ Other
- ☐ None

BLOOD/LYMPHATIC
- ☐ Anemia
- ☐ Blood Clots
- ☐ Other
- ☐ None

GASTROINTESTINAL
- ☐ Diarrhea/Constipation
- ☐ Abdominal Pain
- ☐ Nausea/Vomiting
- ☐ None

SKIN
- ☐ Rashes
- ☐ Lumps
- ☐ Other
- ☐ None

EAR, NOSE, THROAT
- ☐ Difficulty Swallowing
- ☐ Seasonal Allergies
- ☐ Hard of Hearing
- ☐ Other
- ☐ None

NEUROLOGICAL
- ☐ Numbness
- ☐ Weakness
- ☐ Other
- ☐ None

PSYCHOLOGICAL
- ☐ Anxiety
- ☐ Depression
- ☐ Other
- ☐ None

EMERGENCY CONTACT

Alternate contact person's name: _____ Phone #: _____

May we discuss your care with alternate contact person or other caregivers? ☐ Yes ☐ No

Patient Signature: _____ Date: _____

PATIENT MEDICATION LIST

Medication Allergies (Reactions)

☐ No, known drug allergies

Latex allergy? ☐ Yes ☐ No

Tape/Adhesive Allergy? ☐ Yes ☐ No

☐ **Retail Pharmacy** ☐ **Mail Order Pharmacy**

Name:	Name:
Phone:	Phone:
Location:	

PLEASE LIST YOUR CURRENT MEDICATIONS (or provide a list of medications):

Name of Medication/Dosage

PATIENT ACKNOWLEDGEMENT:

I have provided the most accurate list that I can provide of my current medications. If I have any questions about my medications, I will call the doctor who prescribed them.

I authorize Legend Orthopedics to request and use my prescription medication history from other healthcare providers or third-party benefit payors for treatment purposes. I understand that my medication list may be shared with my other physicians unless I decline. ☐ Decline

Patient Signature: _____ Date:

Orthopaedic Associates of Augusta, P.A. D/B/A Legend Orthopedics Financial Policy

Our practice is committed to providing you with the finest and most comprehensive care available. We believe that full disclosure of our financial policy is important in this relationship. Please read carefully and be sure that any questions you might have are answered before signing this agreement.

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All co-payments required by your insurance company are due at the time of service and will be collected before you see the physician. If you are unable to pay, we will be happy to reschedule your appointment.

Our physicians are members of the Premier Health Network and our office will gladly file health insurance claims on your behalf. Patient balances remaining after your insurance company has processed your claim will be due and payable within thirty (30) days of your insurance company's payment or their notice of non-payment. We utilize the services of an outside collection agency for past due accounts.

For elective surgical procedures, all deductibles required by your insurance company must be paid in advance of your procedure, no later than the date of your pre-operative visit. If no pre-operative visit is required by your physician, payment must be received in our office at least three days before the scheduled procedure. This will allow our scheduling staff adequate time to reschedule your procedure if necessary.

Monthly payment plans are available for patient balances of $500 or more and may be set up through our business office (this does not include co-payments or deductible amounts that are payable before an elective procedure is performed). The minimum monthly payment required is 20% of the total patient balance.

Patients with no insurance coverage will be expected to pay the total balance in full at each visit or in advance of any scheduled procedure.

For your convenience, payments may be made by cash, personal check, Money Order, MasterCard or Visa, Discover or American Express. Please contact our billing office at 706-722-1197 if you have any questions.

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I acknowledge that I have read and understand the financial policy of Legend Orthopedics and agree to the terms outlined in this policy. I further understand that I am financially responsible for all amounts not covered by my insurance company.

Signature of Patient or Guarantor:	Date:

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.*PLEASE REVIEW IT CAREFULLY.*

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. We must obtain your authorization before the use and disclosure of any psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosure that constitute a sale of PHI. Uses and disclosures not described in this Notice of Privacy Practices will be made only with authorization from the individual.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the Practice may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the Practice or the hospital. For example, we may disclose medical information about you to people outside the Practice who may be involved in your medical care, such as family members, clergy or other persons that are part of your care. We may make your medical information available electronically through health information exchange services which help make your medical information available to other healthcare providers who may need access to it in order to provide care or treatment to you. Participation in health information exchange services also allows us to see health information about you from other participants in the healthcare exchange.

For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the Practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other Practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts WHO WILL FOLLOW THIS NOTICE. This notice describes our Practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other Practice personnel POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the Practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the Practice, whether made by
Practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; public health risks; and worker's compensation

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy at any time.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances

Right to Amend. If you feel that medical information, we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by. or for, the Practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer, and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer

Right to Request Removal from Fundraising Communications. You have the right to opt out of receiving fundraising communications from the Practice Right to Restrict Disclosures to Health Plan You have the right to restrict disclosures of PHI to a health plan if the disclosure is for payment of health care operations and pertains to a health care item or service for which the individual has paid out of pocket in full.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing, and you must specify how or where you wish to be contacted.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the Practice's waiting room. COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services, Office of Civil Rights, Hubert
H. Humphrey Building, 200 Independence Ave., Washington, DC 20201. To file a complaint with the Practice, contact Privacy Officer, Legend Orthopedics, 811 13th St., Suite 20, Augusta, GA 30901. All complaints must be submitted in writing. You will not be penalized for filing a complaint. You will not be penalized for filing a complaint. OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.

I have received or been offered a copy of this Notice of Privacy Practices.

Signature:	Date:

Print Print Reset