

Patient Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Home #: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: ☐ Male ☐ Female

Email Address: \_\_\_\_\_

Marital Status: ☐ Single ☐ Married ☐ Divorced For X-ray purposes, are you pregnant? ☐ Yes ☐ No

Patient's Employer: \_\_\_\_\_ Employer Phone #: \_\_\_\_\_

Employer's Address: \_\_\_\_\_  
Street City State Zip

Spouse's Name or if Minor, Parent/Guardian's Name: \_\_\_\_\_

SSN and Birth Date of Spouse or Parent/Guardian: \_\_\_\_\_

Name and Phone # of Emergency Contact: \_\_\_\_\_

Reason for Today's Visit: \_\_\_\_\_

Is this a work-related injury? If Yes, Give Date Occurred: \_\_\_\_\_

Did you go to the emergency room? ☐ Yes ☐ No If Yes, Give Hospital Name: \_\_\_\_\_

Date of Treatment: \_\_\_\_\_ Were X-rays taken? ☐ Yes ☐ No

If you were referred by another doctor for today's problem, give doctor's name: \_\_\_\_\_

Are you seeking a second opinion for today's problem? ☐ Yes ☐ No

Name and Address of Family Doctor: \_\_\_\_\_

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### INSURANCE INFORMATION - PLEASE PRODUCE YOUR INSURANCE CARD FOR US TO SCAN TO OUR FILES

Primary Insurance Company: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Employer of Insured: \_\_\_\_\_

SSN and Birth Date of Insured: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Employer of Insured: \_\_\_\_\_

SSN and Birth Date of Insured: \_\_\_\_\_

Acceptance of financial responsibility: I understand that I am responsible for all medical expenses regardless of insurance coverage and whether or not there is an accident with another person at fault. Authorization to treat and to release medical information: I hereby authorize medical treatment and the release of medical information requested from my insurance company. Authorization to pay: I hereby authorize payment directly to Carolina Orthopaedic & Sports Medicine Center.

Signature of Patient or Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_



Patient Name: \_\_\_\_\_

Date of Accident: \_\_\_\_\_

Type of Accident: ☐ Auto ☐ Work-Related ☐ Other: \_\_\_\_\_

If Work-Related, Give Name of Employer, Phone #, and Name of Person Who Will Verify: \_\_\_\_\_

\_\_\_\_\_

How and when did the accident happen? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Guidelines for Prescription Refills

1. Our office requires a **48-hour notice for prescription refills.**
2. Medications will be refilled between **9 a.m. and 4 p.m., Monday – Friday.** **No refills on the weekends or holidays. The “on-call” doctor will not refill medications.**
3. Safety of your prescriptions is YOUR responsibility. **LOST PRESCRIPTIONS WILL NOT BE REFILLED.** Lock up your prescriptions and keep them away from children.
4. Our doctors may not refill prescriptions for pain medicine if you are receiving similar medicines from another doctor.
5. Be aware of the effect of other medications you may be taking. Ask your doctor or your pharmacist whether you can take them along with pain medication.
6. Do not drink alcoholic beverages while taking pain medication. Obey warnings regarding sedation of certain medicines.
7. Follow the prescribed dose of the medication. Do not give your medications to other people and do not take medication from others.
8. Carolina Orthopaedic & Sports Medicine Center may request and use your prescription medication from other healthcare providers or third-party pharmacy benefit payors for treatment.

I agree and will comply with the above guidelines.

Signature of Patient or Parent/Guardian: \_\_\_\_\_

## Acknowledgment of Receipt of Notice of Privacy Practices

Chart #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Patient Name (Please Print): \_\_\_\_\_

I have been offered a copy of the Notice of Privacy Practices for Carolina Orthopaedic & Sports Medicine Center.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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### Authorization for Release of Information

#### Name & Address of Covered Entity Authorized to Release Information:

**CAROLINA ORTHOPAEDIC & SPORTS MEDICINE CENTER  
2345 COURT DRIVE  
GASTONIA, NC 28054**

#### PERSONAL REPRESENTATIVE

A personal representative is anyone that you would like Carolina Orthopaedic & Sports Medicine Center to authorize as privileged to your information, including, but not limited to, prescription refills and/or samples, reasons for a particular visit, billing information, etc. If there are no names listed below, we are assuming that you are declining your option to choose a personal representative. Upon doing so, please keep in mind that our office will not give out any information, including prescription refills, to anyone other than the patient or parent/guardian.

Personal Representative: Initial Each Item That Is Subject to This Authorization.

\_\_\_\_\_ Leave Information on the Voice Mail

\_\_\_\_\_ Leave Information With My Spouse

\_\_\_\_\_ Leave Information With the Following Persons: \_\_\_\_\_

Description of Information to be Released.

☐ Information Results From Any Tests or X-Rays

☐ Other Information as Described: \_\_\_\_\_

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This authorization shall be in force and effect until revoked by the patient, representative, or representative signing the authorization.

The permitted use of the information is to inform the patient.

## Health History Form

Patient Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ ☐ Right-Handed ☐ Left-Handed

Primary Care Physician: \_\_\_\_\_

### Patient Medical History

- |   |   |  |  |  |
|---|---|--|--|--|
| <input type="checkbox"/> Stroke               | <input type="checkbox"/> Asthma             | <input type="checkbox"/> Acid Reflux         | <input type="checkbox"/> Liver Trouble         | <input type="checkbox"/> Infections      |
| <input type="checkbox"/> Heart Trouble        | <input type="checkbox"/> Kidney Failure     | <input type="checkbox"/> Lung Disease        | <input type="checkbox"/> Thyroid-Hyper/Hypo    | <input type="checkbox"/> Anxiety         |
| <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Kidney Stones/UTI  | <input type="checkbox"/> Tuberculosis        | <input type="checkbox"/> Depression            | <input type="checkbox"/> Other Illnesses |
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Lupus              | <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Sleep Apnea           |  |
| <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Cancer             | <input type="checkbox"/> COPD                | <input type="checkbox"/> AIDS/HIV              |  |
| <input type="checkbox"/> Irregular Heart Rate | <input type="checkbox"/> Osteoporosis       | <input type="checkbox"/> Phlebitis           | <input type="checkbox"/> Chronic Heart Failure |  |
| <input type="checkbox"/> Gout                 | <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Anemia              | <input type="checkbox"/> Hepatitis             |  |
| <input type="checkbox"/> Seizures             | <input type="checkbox"/> Alcoholism         | <input type="checkbox"/> Stomach Ulcers      | <input type="checkbox"/> MRSA                  |  |

### Past Surgical Procedures

### Personal History

Tobacco/vape/e-cig use? ☐ Yes ☐ No \_\_\_\_\_ packs per day for \_\_\_\_\_ yrs. Date started? \_\_\_\_\_ Date quit? \_\_\_\_\_  
 Alcohol use? ☐ Never ☐ Rare ☐ Occasional ☐ Moderate Drinks per single occasion: \_\_\_\_\_  
 Regular exercise routine? ☐ Yes ☐ No Describe: \_\_\_\_\_ Hobbies? \_\_\_\_\_

### Family Medical History (Please write beside diagnosis if this was Mother, Father, Sibling, Child, Family)

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Stroke _____              | <input type="checkbox"/> Diabetes _____  | <input type="checkbox"/> Seizures _____       | <input type="checkbox"/> Cancer _____            |
| <input type="checkbox"/> Heart Trouble _____       | <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Mental Illness _____ | <input type="checkbox"/> Bleeding Disorder _____ |
| <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Gout _____      | <input type="checkbox"/> Kidney Trouble _____ | <input type="checkbox"/> Alcoholism _____        |
| <input type="checkbox"/> Other Illnesses _____     |  |   |  |

### Medications

Allergies to medications? ☐ No ☐ Yes: \_\_\_\_\_

Current medications/dosages? ☐ No ☐ Yes: \_\_\_\_\_

Latex allergy? ☐ No ☐ Yes \_\_\_\_\_

Taking blood thinners? (Please Circle) Arixtra Aspirin Coumadin Eliquis Lovenox Plavix Pradaxa Other

### Review of Systems (Recent or Current Conditions)

- |   |  |  |  |  |
|---|--|--|--|--|
| <input type="checkbox"/> Weight Change  | <input type="checkbox"/> Hearing Changes       | <input type="checkbox"/> Shortness of Breath   | <input type="checkbox"/> Urinary Burning     | <input type="checkbox"/> Other Illnesses |
| <input type="checkbox"/> Fever/Chills   | <input type="checkbox"/> Ear Pain/Ringing      | <input type="checkbox"/> Cough                 | <input type="checkbox"/> Frequent Headaches  | _____                                    |
| <input type="checkbox"/> Night Sweats   | <input type="checkbox"/> Nosebleeds            | <input type="checkbox"/> Nausea/Vomiting       | <input type="checkbox"/> Seizures            | _____                                    |
| <input type="checkbox"/> Poor Appetite  | <input type="checkbox"/> Hoarseness            | <input type="checkbox"/> Stomach Pain          | <input type="checkbox"/> Numbness            | _____                                    |
| <input type="checkbox"/> Rash           | <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Frequent Diarrhea     | <input type="checkbox"/> Weakness            | _____                                    |
| <input type="checkbox"/> Insomnia       | <input type="checkbox"/> Tooth/Gum Trouble     | <input type="checkbox"/> Frequent Constipation | <input type="checkbox"/> Backache            | _____                                    |
| <input type="checkbox"/> Depression     | <input type="checkbox"/> Chest Pain            | <input type="checkbox"/> Blood in Stool        | <input type="checkbox"/> Joint Pain          | _____                                    |
| <input type="checkbox"/> Anxiety        | <input type="checkbox"/> Abnormal Heartbeat    | <input type="checkbox"/> Incontinence          | <input type="checkbox"/> Joint/Limb Swelling | _____                                    |
| <input type="checkbox"/> Visual Changes | <input type="checkbox"/> Blackouts             | <input type="checkbox"/> Urinary Frequency     | <input type="checkbox"/> Lumps/Masses        | _____                                    |

## Primary Injury or Condition

What makes it worse?

- ☐ Sitting ☐ Standing ☐ Lying Flat ☐ Doing Nothing ☐ Bending  
☐ Lifting ☐ Twisting ☐ Coughing ☐ Walking ☐ Sneezing

What makes it better?

- ☐ Sitting ☐ Standing ☐ Lying Flat ☐ Doing Nothing  
☐ Walking ☐ Exercise ☐ Heat ☐ Cold

Circle Your Pain Levels: (Least Pain ..... Most Pain)

At Worst 0 · 1 · 2 · 3 · 4 · 5 · 6 · 7 · 8 · 9 · 10

At Best 0 · 1 · 2 · 3 · 4 · 5 · 6 · 7 · 8 · 9 · 10

Today 0 · 1 · 2 · 3 · 4 · 5 · 6 · 7 · 8 · 9 · 10

Since the Start of the Problem, Are You:

- ☐ Improving ☐ Getting Worse ☐ Staying the Same

Whom have you seen for this problem?

\_\_\_\_\_

What test(s) have been done? When? Where?

X-Ray \_\_\_\_\_ CT Scan \_\_\_\_\_

MRI \_\_\_\_\_ Nerve Studies \_\_\_\_\_

Other \_\_\_\_\_

What treatment(s) have you had for this problem?

Medications \_\_\_\_\_ Helped? ☐ Yes ☐ No ☐ Not Sure

Physical Therapy Helped? ☐ Yes ☐ No When? \_\_\_\_\_ How many visits? \_\_\_\_\_

Injections (Type/Date) \_\_\_\_\_ Helped? ☐ Yes ☐ No ☐ Not Sure

Surgery (Type/Date) \_\_\_\_\_ Helped? ☐ Yes ☐ No ☐ Not Sure

Other \_\_\_\_\_ Helped? ☐ Yes ☐ No ☐ Not Sure

Have you ever had the same or similar problem before? ☐ Yes ☐ No ☐ Not Sure

Has anything helped? \_\_\_\_\_

Is this a work-related injury? ☐ Yes ☐ No If Yes, Name of Employer: \_\_\_\_\_

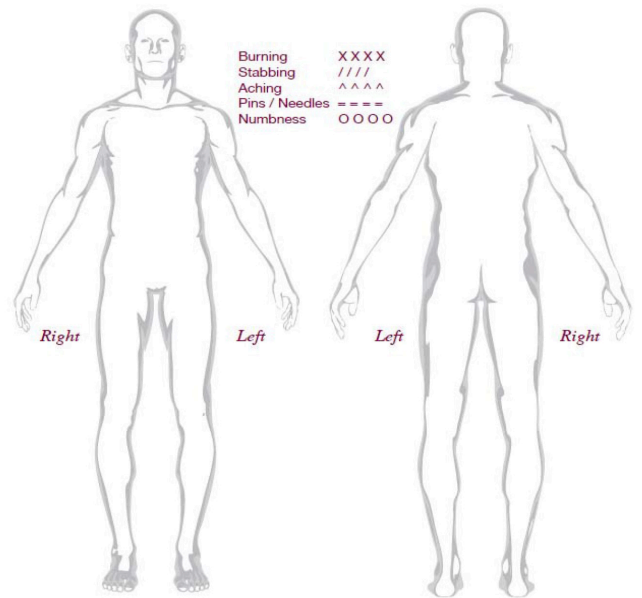
Date of Injury: \_\_\_\_\_

Patient Name (Please Print): \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician/PA Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Mark the areas on your body where you feel the described sensations.**  
**Use the appropriate symbol.**  
**Mark areas of radiation, include all affected areas.**



## Office & Financial Policies

We would like to thank you for choosing Carolina Orthopaedic & Sports Medicine Center as your medical provider. To keep you informed of our current office and financial policies, we ask that you read and sign the following acknowledgment.

**Late Appointments:** Arriving 15 minutes late for your appointment may result in rescheduling of your appointment.

**Cancelled Appointments:** We request a 24-hour notice if you are unable to keep a scheduled appointment so that we may offer that time to another patient. Please call our office so that we can reschedule your appointment. Carolina Orthopaedic & Sports Medicine Center reserves the right to charge a no-show fee. Excessive no-shows will result in possible termination from the practice.

**No Insurance:** We require patients without insurance to provide a deposit at the time of service, and the remaining balance is due at check out. If you are unable to pay your balance in full, you will need to make prior arrangements with a financial counselor.

**Liability Injury:** Carolina Orthopaedic & Sports Medicine Center does not provide deferred billing for liability cases. Payments for liability services are required at the time of service.

**Insurance:** Please bring your insurance card with you at the time of your appointment. Insurance plans with which we contract require that all co-pays be paid prior to any services being rendered. The co-payment requirement cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier. If you do not have your co-pay at the time of your visit, your appointment may be rescheduled.

You are responsible for any co-insurance, deductibles, or non-covered services as required by your insurance. You will receive a statement from our office indicating what your insurance has paid. Any remaining balance is due upon receipt of the statement.

**Medicaid Patients:** Medicaid patients must present a current Medicaid card and be prepared to pay any applicable co-payments. If you do not bring your current Medicaid card and applicable co-payment, your appointment will be rescheduled.

**Workers' Compensation:** Workplace injury care requires authorization from your employer's Workers' Compensation carrier before we can process any of your medical claims. Failure to properly report this injury to your employer may result in your claims being denied. Denied claims will be your responsibility.

**High Deductible Health Plans:** High Deductible Health Plans (HDHP) are consumer-driven health plans that have a minimum deductible and out-of-pocket limit that is set each year and adjusted for inflation, if necessary. If you have a HDHP, Carolina Orthopaedic & Sports Medicine Center requires a deposit fee to hold your surgical appointment. The deposit will be applied to whatever patient balance is not paid by your health insurance plan (such as deductibles, co-insurances, co-pays, and/or non-covered services).

**HMO:** For HMO insurance plans that we participate with, your insurance carrier requires that you obtain a referral from your primary care physician (PCP) before receiving services. Please bring that referral with you. Any services received without a referral or proper authorization will be your responsibility.

**UCR (Usual and Customary Rate):** We are committed to providing the best possible care for our patients, and we charge what is usual and customary for our area. If we do not have a contract with your insurance company, you are responsible for payment-in-full regardless of any insurance company's arbitrary determination of UCR.

**Delinquent Accounts:** Delinquent accounts may be assigned to a collection agency. All collections costs will be added to your outstanding balance. Failure to pay a delinquent account will result in you not being able to make an appointment and/or possible termination from the practice.

**Returned Checks:** A \$25.00 charge will be added to your account for any checks returned or ACH withdrawals rejected by your bank for any reason in addition to any fees that your financial institution may charge you.

## Office & Financial Policies

**Disability or Insurance Forms:** There will be a charge of \$15.00 for the completion of medical forms. Payment is due at the time that you pick up the forms. Please allow 7 – 10 business days for the completion of these forms. If you would like the forms mailed to you or your insurance company, payment will be due prior to mailing.

**Medical Records:** We will provide you with a copy of your medical records upon request. You will need to sign a letter of release at the time of pickup. Please allow 5 – 7 days for us to copy your records. If you wish for your records to be mailed, there may be an associated fee to cover the mailing costs. You may be charged for additional copies of your medical records. Rates charged are within North Carolina state statutes.

**X-Rays:** We will provide you with a copy of your X-rays upon request. You will need to sign a letter of release at the time of pick-up. Please allow 48 hours from the time of your request. There is a \$5.00 charge per CD containing your X-rays and is payable at the time of pickup.

**Consent for Medical Treatment:** I authorize Carolina Orthopaedic & Sports Medicine Center physicians and personnel to render medical treatment and evaluation if needed for this appointment and all appointments. I further authorize X-rays, injections, casting, or other diagnostic tests and treatments that may be necessary.

The authorization shall remain in effect until rescinded by the patient or authorized individual.

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Signed (Patient or Authorized Individual)

Date