CARY ORTHOPAEDIC SPORTS/SPINE SPECIALISTS AND PERFORMANCE PHYSICAL THERAPY

PATIENT INFORMATION RECORD

OUR DOCTOR _____ **DATE** _____ **CHART NO.** _____

LAST NAME	FIRST NAME	MIDDLE INITIAL	MAIDEN NAME	ARE YOU A MINOR? ☐ ARE YOU IN A NURSING FACILITY? ☐

MAILING ADDRESS	CITY	STATE	ZIP CODE

LOCAL ADDRESS ☐SAME AS MAILING ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE #	CELL PHONE #	PREFERRED CONTACT METHOD ☐TEXT ☐HOME ☐CELL ☐EMAIL	EMAIL ADDRESS

MARITAL STATUS (S M W D SEP)	AGE	SEX (M F)	DATE OF BIRTH	RACE	ETHNICITY	PREFERRED LANGUAGE

EMPLOYMENT STATUS (circle one) EMPLOYED / STUDENT / OTHER	PATIENT EMPLOYER	WORK PHONE #	SOCIAL SECURITY NUMBER

FAMILY DOCTOR	FAMILY DOCTOR PHONE #	PHARMACY NAME	PHARMACY LOCATION/INTERSECTION

EMERGENCY CONTACT NAME	RELATIONSHIP	EMERGENCY CONTACT'S BEST PHONE #

SPOUSE NAME	SPOUSE BEST PHONE #	SPOUSE DATE OF BIRTH

IF THE PATIENT IS A MINOR OR STUDENT, PLEASE COMPLETE BELOW:

MOTHER'S NAME	DATE OF BIRTH	BEST PHONE #

STREET ADDRESS, CITY, STATE, ZIP CODE	SOCIAL SECURITY #

FATHER'S NAME	DATE OF BIRTH	BEST PHONE #

STREET ADDRESS, CITY, STATE, ZIP CODE	SOCIAL SECURITY #

1. List Body Part(s)/ Briefly describe discomfort _____

Right ____ Left ____ Bilateral (both) ____

2. On a scale of 1-10 what is your pain right now?_____

3. What date did this problem/pain begin? (Approximately) MO/DAY/YEAR _____

4. Is this problem due to an injury? **YES** or NO **If yes go to 4a.**

4a. Where did the injury occur? (football field, grocery store, home, etc) _____

4b. What were you doing when the injury occurred? (walking, falling, playing) _____

4c. Was the injury due to the following? military activity__ volunteer __ student __ student athlete __ leisure activity __

5. Will you be filing though Workers Compensation, AUTO insurance, or Liability Insurance? **YES** or NO

5a. If **YES,** please give details (names, phone #'s, claim #'s, etc) _____

I hereby authorize the designated physician to release any information acquired in the course of my treatment to my insurance company for completion of claims. In consideration of the medical services to be rendered, I agree to pay to Cary Orthopaedic & Sports Medicine Specialists the regular charges for said services. I understand that I am responsible for all charges not paid by insurance. If applicable, I also request payment of government benefits either to myself or to the party who accepts assignment. I certify that I have read the above or had it explained to me and I agree to all of its terms and as evident of this fact sign my name below.

CONSENT FOR CARE: I, the undersigned, do hereby agree and give consent for Cary Orthopaedic Sports and Spine Specialists and/or Performance Physical Therapy to furnish medical care and treatment to _____ considered necessary and proper in diagnosing or treating his/her physical condition.
(Patient Name)

Signature of Patient/Guardian/Legal Representative Date Staff Initials

Cary Orthopaedics

PERFORMANCE physical therapy

Name _____ Date _____ Chart No. _____

Patient's Personal History

The following information is important to your health. Please take the time to fully and accurately fill out this form, it may be sent to a surgery center if surgery is ordered.

Previous Surgeries:
(Where, When, & Why)

Previous Injuries & Hospitalizations:
(Where, When, & Why)

Other Illnesses Not Hospitalized For:

Allergies (Please list all drug/seasonal/environmental/food allergies and reactions)**:**

Do you have a metal allergy? Circle **Y** **N**

Medications (Please list all current medications/vitamins/supplements):

Medication	Dose	Reason

Personal Habits:

Do you use any tobacco products?	**Y**	**N**	Every Day? _____ Some Days? _____ How much? _____
Are you a former tobacco user?	**Y**	**N**	
Do you drink caffeinated beverages?	**Y**	**N**	How many beverages per day/week? _____
Do you drink alcoholic beverages?	**Y**	**N**	How many drinks per day/week? _____

Additional Information:

Have you ever taken medicine for High Blood Pressure? **Y** **N**

Had an x-ray of the head or neck area as a child? **Y** **N**

Date of last EKG? _____

Date of last chest x-ray? _____

Date of last TB skin test? _____

Have you ever had an allergic reaction to latex? **Y** **N**
If YES, describe reaction _____

Have you ever had the flu shot? **Y** **N**
If YES, what was the date of your last flu shot? _____

Have you ever had the pneumococcal vaccine? **Y** **N**
If YES, what was the date of your last shot? _____

Review of Symptoms:
Have you had any of these symptoms in the **last SIX MONTHS?**

HEAD & NECK								
Visual disturbances	Y	N	Bloody/ black stools	Y	N	Fever/chills	Y	N
Hearing or ear problems	Y	N	Jaundice	Y	N	Night sweats	Y	N
Frequent headaches	Y	N	Ulcers	Y	N	Shortness of breath	Y	N
Dizziness	Y	N	Rectal bleeding	Y	N	OTHER ILLNESSES IN YOUR LIFETIME?		
Environmental allergies	Y	N	GEINTO-URINARY			Anesthesia problems	Y	N
Sinus troubles	Y	N	Urinary Tract Infection	Y	N	Asthma	Y	N
Painful swallowing	Y	N	Frequent urination during night	Y	N	Cancer	Y	N
Lump or swelling of neck	Y	N	Blood in urine	Y	N	Diabetes	Y	N
Sore throat without cold	Y	N	Kidney stones	Y	N	Hypertension/High blood pressure	Y	N
Enlarged tonsils	Y	N	BONES & JOINTS			High cholesterol	Y	N
Problems with teeth	Y	N	Cramps in legs	Y	N	History of blood clots	Y	N
Swelling of gums or jaw	Y	N	Broken bones	Y	N	Stroke	Y	N
Tongue sore or sensitive	Y	N	Swollen ankles	Y	N	Thyroid disorders	Y	N
Nosebleeds	Y	N	Back trouble	Y	N	*MEN ONLY		
CHEST			Arthritis	Y	N	Pain/swelling in testicles	Y	N
Heart attack/problems	Y	N	Cyst or growth	Y	N	Weak urine stream	Y	N
Pain in chest	Y	N	GENERAL SYMPTOMS			Prostate infection	Y	N
Chronic cough	Y	N	Bleeding problems	Y	N	*WOMEN ONLY		
Vomited/coughed blood	Y	N	Numbness	Y	N	Hot flashes	Y	N
Skipping or racing heart	Y	N	Convulsions/seizures	Y	N	Urination when cough/sneeze	Y	N
Heart murmur	Y	N	Unusual fatigue	Y	N	Lumps in breast	Y	N
ABDOMINAL/INTESTINAL			Worry/depression	Y	N	Complications of pregnancy	Y	N
Abdominal pain	Y	N	Insomnia	Y	N	ADDITIONAL INFO.		
Constipation	Y	N	Weight gain	Y	N	_____		
Change in bowel stools	Y	N	Weight loss	Y	N	_____		

HEIGHT _____ **WEIGHT** _____LBS

Family History:
Has anyone in your family (parents, grandparents, aunts/uncles, children) ever had……?

			Who?				Who?
Anesthesia problems	Y	N		Leukemia	Y	N	
Arthritis	Y	N		Mental illnesses	Y	N	
Asthma, hay fever, allergies	Y	N		Seizures/epilepsy	Y	N	
Cancer/type	Y	N		Sickle cell anemia	Y	N	
Diabetes	Y	N		Stroke	Y	N	
Glaucoma	Y	N		Thyroid disorders	Y	N	
Heart attack/problems	Y	N		Tuberculosis	Y	N	
High blood pressure	Y	N		Ulcers	Y	N	
High cholesterol	Y	N		Other:			
Kidney stones	Y	N					

I attest that the above information is true and correct to the best of my knowledge.

Signature of Patient/Guardian/Legal Representative Date Staff Initials
(may be used as re-attestation if surgery is less than 1 year later)

Cary Orthopaedics

PERFORMANCE physical therapy

Acknowledgement of the Use and Disclosure of Health Information for Treatment or Health Care Operations

Name _____ **Chart #** _____

This HIPAA form is designed to provide privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals and other health care providers.

I understand that as part of the delivery of my health care, COSMS (Cary Orthopaedic Sports Medicine Specialists) originates and maintains medical records describing my health history, symptoms, examination and test results, diagnoses, treatment and plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the health care professionals who contribute to my care.
- A tool for routine health care operations such as assessing quality and ensuring the continued competence of health care professionals involved in my care.
- I have been provided with a Notice of Information Practices that provides a more complete description of the uses and disclosures of my health information.
- I understand that COSMS reserves the right to change this notice and their practices as needed and will make a reasonable attempt to inform me.
- I understand that I have the right to request restrictions in the use or disclosure of my health information for treatment or healthcare operations and that COSMS are not required to agree to the restrictions requested.
- I understand that I may revoke this acknowledgement in writing except to the extent that COSMS has already taken action based on it.

☐ **I agree that COSMS can EMAIL me secured HIPPA protected information to my email address.**

☐ I agree that COSMS may leave a message on my voicemail whaen unable to reach me on my home or cell phone.

☐ I request that the following person(s) have **ACCESS** to my medical and financial records. (i.e. talk to the doctor on my behalf, pick up prescriptions/ medical records, make or change appointments)

_____

_____

☐ I request the following RESTRICTIONS in the use or disclosure of my health information.

_____

For COSMS use

Requested Restrictions: ACCEPTED _____ DENIED_____

_____

Signature of Patient/Guardian/Legal Representative Date Witness Initials

FINANCIAL POLICIES AND PROCEDURES

Thank you for choosing Cary Orthopaedics and Performance Physical Therapy as your orthopaedic and physical therapy providers. We are committed to the successful treatment and outcomes for all of our patients. The following is a statement of our financial policies and procedures which we require you to read and sign.

APPOINTMENTS

When scheduling an appointment, our patient services coordinators will ask you to arrive 30 minutes prior to your appointment time to update any paperwork that is more than six months old, or 15 minutes prior to your appointment time if all paperwork is up to date.

CO-PAYMENTS, DEDUCTIBLES, CO-INSURANCE, AND FEES

Co-payment, deductibles, co-insurance, and fees for services not covered by your insurance policy are due and will be collected at the time services are rendered. We accept personal checks, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, and CARECREDIT. We do NOT accept postdated checks. If you are having surgery or are scheduled for any in office procedure, your insurance benefits will be verified prior to the procedure, and an estimate of the cost will be provided to you. This estimate does not include charges for anesthesia, facility, facility related charges for DME or hardware, or rehabilitation services; you will be billed separately for these services by the facility or rendering provider. You will be expected to pay any co-payments, deducible, and/or co-insurance responsibility prior to your procedure.

REGARDING INSURANCE

Per our in-network contracts, we will automatically file your insurance for services rendered. Should you choose, our office will provide you with proper documentation to file your insurance on your own. Please remember that you will be responsible for any co-pay, deductible and/or co-insurance that your insurance company deems your responsibility.
NOTE: Some services provided may be deemed “non-covered services” or “not considered medically necessary” by your insurance carrier. You may be responsible for paying for these services. We will not file out-of-network insurance that requires authorization.

We **DO NOT** file third party insurance and, we do not wait until settlement for payment.

INSURANCES REQUIRING AUTHORIZATION OR REFERRAL (HMO’s, WC, etc)

Many insurance companies require referrals or authorizations for services rendered by an in-network provider. It is the responsibility of the patient to ensure that all required referrals and authorizations are in place prior to their appointment being scheduled. Any services denied by your insurance company for lack of referral or authorization will be billed to and deemed the responsibility of the patient.

PAST DUE AND COLLECTION ACCOUNTS

Cary Orthopaedics and Performance Physical Therapy require that all accounts with **Past Due or Collection** balances be paid in full prior to scheduling any appointment, including surgical or in office procedures. Any fees associated with checks returned by the bank for insufficient funds will be charged to the patient and are required to be paid before any appointment including, surgical or in office procedures, are scheduled.

MISSED APPOINTMENTS/CANCELLATIONS

Our policy is to charge for missed appointments or appointments canceled with less than 24 hours notice at a rate specific to the appointment type. This charge is not billable to your insurance company and will be the patient’s responsibility to pay.

MINOR PATIENTS

The adult parent or guardian accompanying the minor is responsible for payment of the minor patient’s account regardless of who the insurance policyholder is. For unaccompanied minors, non-emergency treatment will be denied until the parent or guardian is present or we have written permission for treatment and payment of the account.

COMPLETION OF FORMS

A fee of $25 per form will be charged for completion of forms and must be paid prior to the release of the form, including the following but not limited to: Disability and FMLA. This charge is not billable to your insurance company and will be the patient’s responsibility to pay.

I have read and understand Cary Orthopaedics and Performance Physical Therapy’s financial policies and procedures. I understand that I am responsible for paying the deductible, co-payment, co-insurance, and any charges for non-covered services as determined by my insurance carrier. In addition to charges collected at the time of service, COSMS may bill me for additional serviced provided (ie, x-ray, MRI, medical equipment), and /or balance remaining on my account after my insurance carrier has responded to the claims.

Signature of Patient/Guardian/Legal Representative Date