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

EMAIL ADDRESS

HOME PHONE #	CELL PHONE #	Appointment Reminders through a third-party ☐ YES ☐ NO	PREFERRED CONTACT METHOD ☐ TEXT ☐ HOME ☐ CELL ☐ EMAIL

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

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

REFERRING MD:	REFERRING DOCTOR PHONE	FAMILY DOCTOR

PHARMACY NAME	PHARMACY LOCATION / INTERSECTION / ROAD

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

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 is 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 HIPAA 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

Cary Orthopaedics

Financial Policy

Thank you for choosing Cary Orthopaedic for your orthopaedic care needs. We are committed to providing you with the highest quality care in a transparent and cost effective manner. We feel that a clear understanding of our financial policies will help foster this goal and maintain the quality of customer service we strive to provide our patients. Please do not hesitate to contact us if you have questions regarding our policies.

Insurance Card: As a courtesy to our patients, we will gladly file your insurance. In order to do this, we require a current copy of the patient's insurance card at each visit. We will scan your card(s) and photo ID for our files. If you do not have proof of insurance at the time of your visit, and wish to be seen by one of our providers, you will be required to pay for any incurred expenses during that visit at the time you check out.

Co-Payments/Co-Insurance /Deductibles: Cary Orthopaedic requires our patients to leave a bank card or credit card on file for payment of all co-payments, co-insurance, deductibles and outstanding balances. **If you are having surgery or are scheduled for an 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, DME or hardware, or rehabilitation services: you will be billed separately for these service by the facility or rendering provider.** We gladly accept **Visa, Mastercard, Discover** and **American Express**. If you choose not to leave your card on file, you will be required to pay for your visit in full at the time of service, when you check out. As an added convenience, Cary Orthopaedic does accept **Care Credit**, checks** and **cash** as a form of payment.

Insurance Claims: Your insurance benefits are a contract between you and your insurance company, but we will be happy to file your insurance for you. In order to properly bill your insurance company for the services we provide, we require that you disclose all insurance information including primary, secondary, and tertiary insurances, as well as any recent changes in your insurance information or status. As noted above, if you do not have proof of active insurance at the time of your visit, but wish to be seen by one of our providers, you may pay out of pocket for any expenses incurred on that visit. Payment is due at time of service. Although we will always provide a good faith estimate of the amount that your insurance may or may not cover, it is the insurance company that makes the final determination regarding your eligibility and benefits for service. We **do not** file third party insurance, such as automobile or liability insurance.

Referrals/Authorizations: If your insurance company requires a referral and/or preauthorization for any services we provide, please inquire about how to obtain this approval from our business office staff or our billing department, and we will be happy to guide you. Lack of required authorization may result in a denial of payment by your insurance company, and the balance would become the patient's personal responsibility.

Self-Pay Accounts: Self-pay accounts are patients without insurance coverage, patients covered by an insurance plan Cary Orthopaedic does not participate with, or patients without an active insurance card on file with us. As noted above, Cary Orthopaedic requires our patients to leave a bank or credit card on file for payment of all balances. If you choose not to leave your card on file, you will be required to pay for your visit in full at the time of service, when you check out. As an added convenience, Cary Orthopaedic does accept **Care Credit*, checks** and **cash** as a form of payment.

Missed or Cancelled Appointments: Cary Orthopaedic will add a $50.00 charge for any no-show or cancelled appointment for office visits that are not cancelled within 24 hours of the appointment time. We will add a charge of $75.00 for any no-show or cancellation of an in-office procedure without a 24 hour notice.

Divorced/Separated Parents of Minor Children: The responsibility for payment of services rendered to any dependent children whose parents are legally separated or divorced lies with the parent who physically brings the minor to the appointment. Payment is due at time of service.

Returned Checks: Cary Orthopaedic will charge a patients account $25.00 for any returned check by your bank. This will be payable by cash or money order only. This fee will be in addition to any previously accrued expense.

Collection Accounts: Cary Orthopaedic makes every attempt to avoid turning a patients account over to an outside collection agency. In the event the account is sent to outside collections, the person who is financially responsible for the account will be responsible for all collection costs, including attorney fees and court cost. Patients accounts who have been sent to collections cannot schedule an appointment until the collection balance is paid in full.

Bankruptcy: Any patient whose account is written off due to bankruptcy will not be allowed to continue to receive services from a Cary Orthopaedic. Upon your written permission, we will be happy to provide you or those you designate a copy of your medical records.

Account Refunds: Cary Orthopaedic makes every attempt to provide a good faith estimate of the cost of services we provide. In the event that we over collect for these services, we are happy to provide a timely refund after all services have been properly adjudicated by your insurance company and the balance of the account has been paid in full. Cary Orthopaedic writes refunds checks once monthly as necessary.

Lost/Expired/Damaged Refund Checks: Cary Orthopaedic will charge a $25.00 fee for all lost, expired, or damaged refund checks that have to be re-written. This fee will come out directly from the amount of the original refund check and will be re-written during the course of the monthly refund process. Cary Orthopaedic writes refunds checks once monthly as necessary.

I have read and understand the Cary Orthopaedic & Sports Medicine Specialist financial policy. I hereby authorize Cary Orthopaedic & Sports Medicine Specialists and its providers to bill my insurance as given. I understand that I am responsible for paying the deductible, co-insurance, copay and any non-covered services as determined by my insurance company and the above financial policy.

_____ _____

Signature of Patient or Guardian **Date**

**CareCredit is the healthcare credit card designed exclusively for healthcare services with special financing options.* With CareCredit, you can use your card for all of your follow-up care as well as annual checkups. Convenient Monthly Payment Plans[1] from CareCredit allows you to pay over time, with no annual fees or pre-payment penalties.

Learn more by visiting www.carecredit.com or contacting our office. Ready to apply? Apply Online for your CareCredit card today. **Subject to credit approval. Minimum monthly payments required. Ask us for details.*

Credit Card on File
Program Overview and FAQS

Effective November 5, 2018 Cary Orthopaedics & Sports Medicine Specialists will offer **Credit Card on File** to our patients. This is a new way for you to pay your balance without receiving paper statements from us. You will still receive your Explanation of Benefits (EOB) from your insurance company showing what you owe, according to your insurance contract.

Why the Change? With the changing environment of healthcare, more financial responsibility is being placed on patients. As a result, healthcare providers are seeing unprecedented levels of unpaid balances due primarily to increased deductibles. As a private practice, unfunded by the state or federal government, we cannot afford to write off higher and higher balances on a consistent basis. In addition, patients are often confused by their coverage and unprepared for the balances left by their policy. This leads to long, confusing and complicated collections processes often ending with their accounts being sent to an outside collection agency. This process is expensive for both the patient and the practice. The goal of **Credit Card on File** is to simplify the collection process and reduce the number of longstanding accounts being sent to collections.

What is Credit Card on File (CCOF)? CCOF is a system where we keep credit card information on file with a PCI compliant third party to process account balances. The credit card information is NOT kept on file in our office, or on any of our computers. We use a gateway that is completely HIPAA compliant as required by law. Once we receive the EOB for service rendered, we will process the balance owed to us. We will access the third party to process the payment.

Here is how it works: At check-out, we will still collect payment for your regular copay or deductible/ co-insurance amounts. We will not usually know the exact amount that you will owe us, until we receive the EOB from your insurance company. This usually takes several weeks. However, we will provide you with an **estimate** based on your insurance plan coverage. Once we receive the EOB from your insurance company, we will charge your card for the balance owed, if any. The amount we will collect is the same amount you would normally receive a bill for in the mail. The difference is that you will not have to call into the office or write a check for payment. It will not cost you a stamp to mail the payment, or the time to make a call.

How will I know how much you are going to charge me? You will receive your EOB in the mail from your insurance company that explains the cost for the visit, how much they paid, and how much your financial responsibility will be, according to the terms of your insurance plan. We receive the same letter that you do. It usually arrives within 15-30 days from the time we file the claim. We look at each EOB carefully and see what your insurance company has assigned as your patient responsibility. This is the same way we would determine how much to bill you via mail.

What if I cannot afford the whole balance? Cary Orthopaedics & Sports Medicine Specialists will be happy to set your account up on a payment plan. If you need to make partial payments over several months, CCOF will conveniently provide this option. You will be required to sign a CCOF payment plan authorization that will be applied to your patient account using the card on file. Payment plans will be set up for a maximum of six months and in the amount specified by the Cary Orthopaedic Payment Plan Policy.

How can I trust that you will keep my credit information safe? We do not keep any credit card information on file in our office or on any of the computers we have. We use a secure gateway that is compliant with encryption standards as required by law.

I have two insurances and am covered at 100%, so I will never have a charge. Do I still need to give you a credit card? Even with multiple insurances, there are often times a patient still has some financial responsibility. Please keep in mind that we will not charge your card if you do not owe anything.

What if I need to dispute my bill? We always work with our patients to help them understand their EOB. We will refund your account based on the Cary Orthopaedic refund policy, via the same credit or bank card you have on file. We will only charge your card the amount we are instructed to collect by your insurance company.

What if I chose not to participate? Any patient who chooses not to participate will be required to pay the balance in full at the time of the visit. Our staff will make every effort to provide an **estimate** of the charges due for that day based on information provided by your insurance carrier. Patients who cannot pay the balance and do not participate in the **Credit Card on File** program will be required to pay all balances prior to making any future appointments.

I have read and fully understand Cary Orthopaedics & Sports Medicine Specialists Credit Card on File program and my options regarding this program. My signature below designates my understanding of the program and is not consent to participate.

_____	_____	_____
Name of Responsible Party	**Signature of Responsible Party**	**Date**

Payment Authorization Form

Schedule your payment to be automatically deducted from your Visa, MasterCard, American Express or Discover Card is a convenient way to pay your medical bills, and in most cases will reduce the cost of mailing a payment. Just complete and sign this form to get started!

Here's How Automatic Payments Work:
You authorize Cary Orthopaedic to charge your bank card or credit card for any copay, coinsurance or deductible expenses incurred for treatment received by one of our healthcare providers. You will be charged the amount deemed your responsibility by your insurance company for each visit. You agree that no prior-notification will be provided, other than the EOB you receive from your insurance company. You understand that you will receive an email notification telling you the date of the transaction and the amount that was charged to your account.

Please complete the information below:

I _____ authorize Cary Orthopaedic to
(Full Name)
charge my bank/credit card indicated below for any copay, deductible or coinsurance balance on the following account/accounts:

Acct#_____ Acct#_____

Acct#_____ Acct#_____

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Bank/Credit Card

☐ Visa ☐ MasterCard

☐ Amex ☐ Discover

Card Holder Name_____

Last 4 digits of the Card Number_____

Expiration Date_____

SIGNATURE _____ DATE _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Cary Orthopaedic in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non Sufficient Funds (NSF) I understand that Cary Orthopaedic may at its discretion attempt to process the charge again within 30 days, and agree to an additional $25.00 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.

Office Use Only:
ID verified by: _____

Updated 10/4/18-mlw

CARY ORTHOPAEDIC
sports medicine specialists
spine specialists

PHYSIATRIST CLINICAL PAPERWORK

Patient Name: _____ Account Number: _____ Date: _____

Age:_____ Height:_____ Weight:_____ Occupation:_____ How Long?_____

Are you: ❑ Right Handed or ❑ Left Handed

Date of last Flu Vaccine _____ Date of last Pneumonia Vaccine_____

What is your chief complaint? (describe your problem and any treatment)_____

_____

_____

_____

_____

The symptoms are mainly in the: ❑ Back ❑ Neck ❑ Legs ❑ Arms

Please rate your pain in the following body parts on a scale of 0-10 with 10 being the worse pain:

Back_____ Neck_____ Legs_____ Arms_____

When did your symptoms begin?_____

Are your symptoms due to a work injury? ❑ Yes ❑ No

Are your symptoms due to an auto accident? ❑ Yes ❑ No

Have your symptoms changed since they began? ❑ Yes ❑ No

If so, how?_____

Have you ever had any similar symptoms? ❑ Yes ❑ No

Check the following words which best describe your symptoms:

❑ Sharp ❑ Numbness ❑ Dull ❑ Tingling ❑ Electrical
❑ Burning ❑ Spasms ❑ Aching ❑ Skin Sensitivity
❑ Weakness ❑ Erectile Dysfunction
❑ Incontinence ❑ Changes to your bowel/bladder pattern
❑ If yes, please specify: _____

Which factors make the pain **BETTER**:

❑ Sitting ❑ Standing ❑ Lying Down ❑ Flexing Forward ❑ Overhead Activity
❑ Extending Backwards ❑ Walking ❑ Reaching ❑ Neck Motion

Which factors make the pain **WORSE**:

❑ Sitting ❑ Standing ❑ Lying Down ❑ Flexing Forward ❑ Overhead Activity
❑ Extending Backwards ❑ Walking ❑ Reaching ❑ Neck Motion

MEDICATIONS

Please list all current medications and doses:

Medication	Dose	Reason

ALLERGIES

Are you allergic to any medications or food that you know of? ☐ Yes ☐ No

If yes, please list: _____

Are you allergic to iodine or contrast dye? ☐ Yes Reaction: _____ ☐ No

Are you allergic to shellfish or seafood? ☐ Yes Reaction: _____ ☐ No

Are you allergic to latex? ☐ Yes Reaction: _____ ☐ No

SOCIAL HISTORY

Education Level: ☐ Elem / Middle School ☐ High School ☐ College ☐ Masters/Doctorate

Employment Status: ☐ Full time ☐ Part time ☐ Unemployed ☐ Disabled ☐ Modified Duty

Occupation: _____ If disabled, for what problem? _____

_____

Marital Status _____

Last date of employment _____

What is your caffeine intake each day: _____

Have you ever used recreational drugs and/or misused prescription medication? ☐ Yes ☐ No

Do you or did you ever smoke? _____ ☐ Yes ☐ No

If yes, how much/how long? _____ If previous smoker, when did you stop smoking? _____

Do you use alcohol? ☐ Yes ☐ No If so, amount/frequency _____

FAMILY HISTORY

	Age	Living	Deceased	Medical Problems
Father	_____	☐	☐	_____
Mother	_____	☐	☐	_____

Siblings ☐ Yes ☐ No How many? _____ Ages _____

ILLNESSES

Please check the following conditions, illnesses, or problems you have had:

☐ Heart: **Specify** _____ ☐ Hepatitis: **Specify** _____

☐ Lung: **Specify** _____ ☐ Colon/GI: **Specify** _____

☐ Kidney: **Specify** _____ ☐ Bleeding: **Specify** _____

☐ Cancer: **Specify** _____ ☐ Blood Clot: **Specify** _____

☐ Stroke: **Specify** _____ ☐ Liver: **Specify** _____

☐ Mental Illness: **Specify** _____ ☐ Thyroid: **Specify** _____

☐ Asthma	☐ Diabetes	☐ Anxiety/Depression	☐ Migraines/Headaches	☐ Anemia
☐ Seizure Disorder	☐ HIV/AIDS	☐ High Blood Pressure	☐ High Cholesterol	☐ Nerve Disorder
☐ Fibromyalgia	☐ Osteoarthritis	☐ Osteoporosis	☐ Rheumatoid Arthritis	☐ Tuberculosis
☐ Scoliosis	☐ Ulcers	☐ Lupus	☐ Other _____	
☐ Vascular disease	☐ Acid Reflux	☐ Multiple Sclerosis		

SURGICAL HISTORY

Please list any surgeries you have had on the lines provided:

_____

_____

_____

_____

Neck Surgery: Type _____ Date: _____ Performing Physician _____

Back Surgery: Type _____ Date: _____ Performing Physician _____

PROCEDURES/TESTS

Which of the following has been done? If you have had any of these procedures, please bring in the imaging with you.

	When	Where
X-RAYS	_____	_____
CT Scan	_____	_____
MRI	_____	_____
EMG/NCS	_____	_____
Spinal Injections	_____	_____
Physical Therapy	_____	_____
Chiropractic	_____	_____

REVIEW OF SYSTEMS

General
- ☐ Fever
- ☐ Chills
- ☐ Weight loss > 10 lbs.
- ☐ Weight gain > 10 lbs.
- ☐ Generally feeling ill
- ☐ Extreme Fatigue
- ☐ Excessive Thirst

Heart
- ☐ Chest Pain
- ☐ Racing Heart

Genito-Urinary
- ☐ Blood in urine
- ☐ Burning with urinations
- ☐ Frequent urination
- ☐ Difficulty controlling urine
- ☐ Loss of urine control with coughing or sneezing
- ☐ Change in menstrual cycle
- ☐ Unusual vaginal bleeding

Vision
- ☐ Blurred Vision
- ☐ Red itchy eyes

Lungs
- ☐ Shortness of Breath
- ☐ Chronic Cough
- ☐ Wheezing
- ☐ Pleurisy

Musculoskeletal
- ☐ Joint Cramping
- ☐ Joint Stiffness
- ☐ Joint Swelling
- ☐ Warm red joints

Psychological
- ☐ Unusual Stress
- ☐ Anxiety
- ☐ Depression

Neurologic
- ☐ Headaches
- ☐ Easily Confusion
- ☐ Seizures / Tremors
- ☐ Poor balance or walking
- ☐ Trouble starting arm or leg motion

ENT
- ☐ Difficulty Swallowing
- ☐ Difficulty Hearing
- ☐ Sinus Trouble
- ☐ Sore Throat

Gastrointestinal
- ☐ Acid Reflux
- ☐ Loss of Appetite
- ☐ Trouble with bowel habits
- ☐ Black tarry stools
- ☐ Ulcer pain
- ☐ Nausea / Vomiting
- ☐ Constipation / Diarrhea

Skin
- ☐ New skin sores
- ☐ New skin lumps
- ☐ Skin discoloration
- ☐ Easy bruising / bleeding
- ☐ Swollen lymph nodes

CARY ORTHOPAEDIC
sports medicine specialists
spine specialists

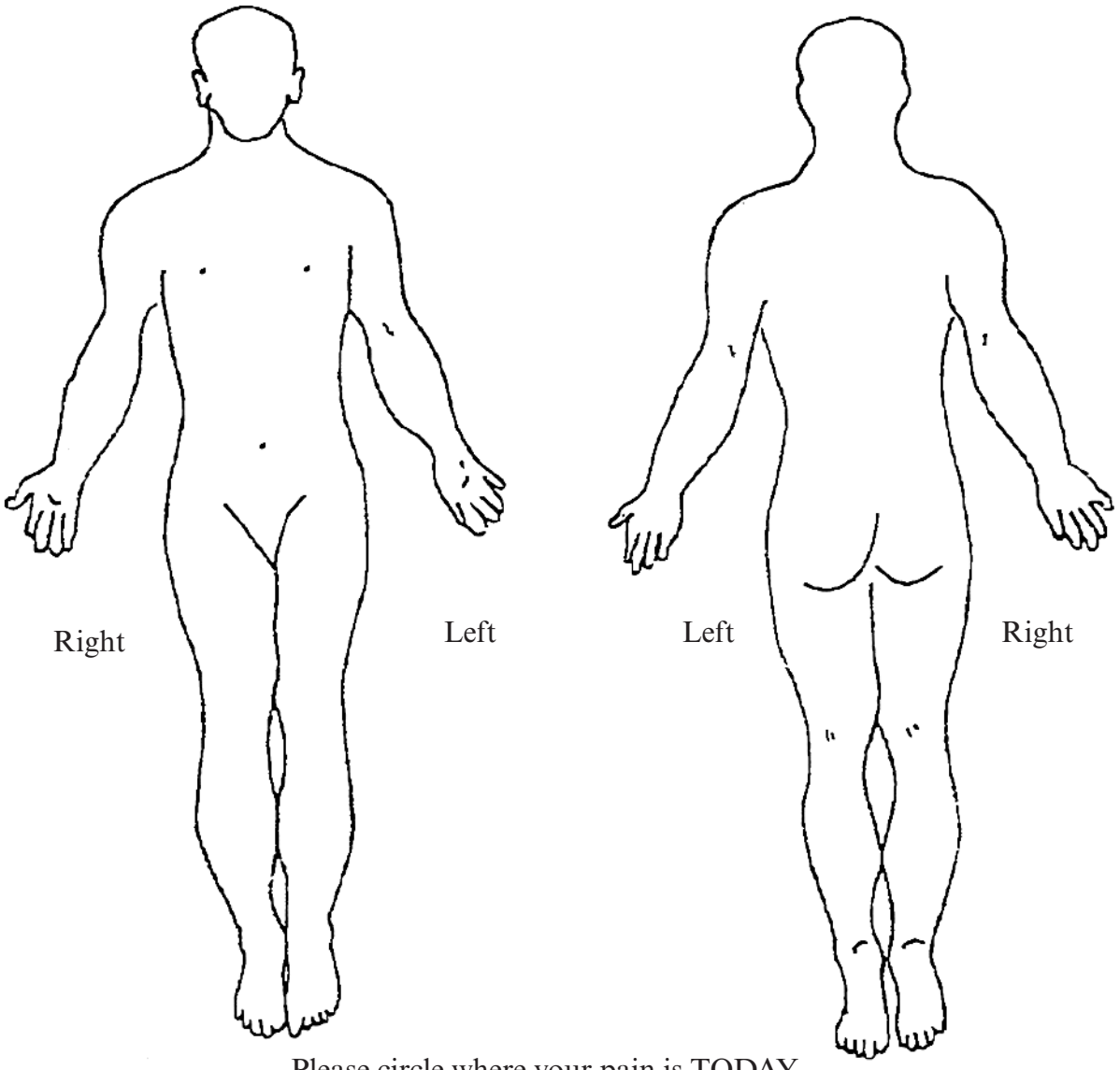
Pain Diagram

DATE

Patient Name:_____

- - - Pins and - - - Needles	z z z Stabbing z z z	B B B Burning B B B
x x x Numbness x x x	/// /// /// Aching and /// /// /// Cramping	O O O Other O O O Sensations

Mark the location(s) of your pain on the body outlines using the symbols



Please circle where your pain is TODAY

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain ever)

Please circle where your pain has been on average over the LAST WEEK

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain ever)