Southeastern Orthopaedic Specialists

PATIENT INFORMATION

Patient Name: _____
Address: _____

(Include city, state and zip)

Telephone: ( ) _____ Cell: _____
Social Security Number: _____
Date of Birth: _____ Male __ Female __
Name of nearest relative: _____
Relationship: _____
Address: _____

(Include city, state and zip)

Married: _____ Single: _____

Patient Employer: _____
Address: _____

(Include city, state and zip)

Telephone: ( ) _____
Is this the result of an accident? Yes ____ No____
If so, where? _____
When? _____ Date of injury: _____
Is this a work-related injury? Yes ____ No____
Is this injury the result of an accident involving another party? Yes ____ No____
If patient is a minor, does responsible party have legal custody? Yes ____ No____

INSURANCE INFORMATION

Insurance Carrier Name: _____
Address: _____

(Include city, state and zip)

Attention To: _____
Group Name: _____
Group #: _____
Policy # or Individual ID #: _____
Policy Holder DOB: _____

AUTHORIZATION:

I hereby authorize Southeastern Orthopaedic Specialists, P.A. to use or disclose confidential information for treatment, payment, or other healthcare operations, and authorize payment directly to SOS, or the surgical and/or medical benefits, if any, otherwise payable to me for their services. I understand I am financially responsible for all charges not covered by this authorization and guarantee payment of this account.

Signature _____
Date _____

Release of Information:

I give permission to Southeastern Orthopaedic Specialists Sports Medicine Center to release information to my insurance company, attorney, assignee and/or beneficiaries.

Assignment of Benefits:

I authorize payment directly to Southeastern Orthopaedic Specialists Sports Medicine Center for services I receive. I understand I am financially responsible for all charges not covered by this authorization / guarantee payment of this amount.

_____
Signature Date

AUTHORIZATION TO RELEASE PHI (Personal Health Information)

I hereby authorize Southeastern Orthopaedic Specialists, P.A. to release my PHI to: Name of person ie. spouse, parent, guardian, sibling, etc.

_____

Signature: _____

To revoke the PHI Authorization, it must be submitted in writing to Southeastern Orthopaedic Specialists, P.A. There is the potential for re-disclosure once this information is disclosed. SOS cannot control what the other entity does with your PHI (Personal Health Information).

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Patient Medical History Form

Name:_____ Sex: Male:_____Female_____Age:_____

School Name if enrolled:_____

Email address (for appointment reminders only):_____

EXERCISE: Do you exercise beyond normal daily activities and chores? Yes_____No_____

If yes, describe the exercise:_____

On average, how many days per week do you exercise or do physical activity?_____

MEDICAL/SURGICAL HISTORY- Check if you have had:

___Arthritis
___Broken bones / fractures
___Osteoporosis
___Blood disorders
___Circulation / vascular problems
___Heart problems
___High blood pressure
___Lung problems
___Stroke
___Other:_____

___Diabetes/high blood sugar
___Low blood sugar/hypoglycemia
___Head injury
___Infectious disease i.e. TB, hepatitis
___Multiple Sclerosis
___Muscular Distrophy
___Parkinson's Disease
___Pregnancy
___Seizures / Epilepsy
___Development of Growth Problems

___Alleries___Latex
___Thyroid problems
___Cancer
___Skin Disease
___Depression
___Kidney problems
___Repeated infections
___Pacemaker
___High cholesterol
___Rheumatoid Athritis

List previous surgeries:_____Month_____Year_____

_____Month_____Year_____

_____Month_____Year_____

CURRENT CONDITION(s) / CHIEF COMPLAINTS:

Describe the problem(s) for which you seek physical therapy:_____

_____

On what date did the problem(s) begin?_____What happened?_____

Have you ever had the problems(s) before? Yes_____No_____

If yes, what did you do for the problem(s)?_____

About how long did the problem(s) last?_____

How are you taking care of the problem(s) now?_____

_____

What makes the problem(s) better?_____

What makes the problem(s) worse?_____

What are your goals for physical therapy?_____

List of current medications below or please attach a list if you have one already documented.

List all tablets, patches, drops, ointments, injections, etc. Include prescription, over the counter, and supplements. Also list any medicine you only take on occasion (albuterol, nitroglycerin).

Medication	**Dose (mg)**	**Frequency (1x daily etc.)**	**Review all with PT Y / N**

Welcome to Southeastern Orthopaedic Specialists Sports Medicine Center. Our staff is dedicated to providing the highest level of quality services and medical care for all of our patients. We want to do everything possible to make your rehabilitation a pleasant one. The following information is provided to prevent any misunderstandings regarding our financial policy, scheduling policy, and childcare policy. Thank you for choosing Southeastern Orthopaedic Specialists as your healthcare provider. Following are policies, which we require that you read, agree to, and sign prior to any treatment.

SCHEDULING POLICY:

Following your first visit to physical therapy, appointments are scheduled one week in advance. ***Cancellations must be made 24-hours ahead of your scheduled appointment.*** The number to call is 375-2301. A **$25.00** fee will be charged for not canceling 24-hours ahead of time or failing to show up for your scheduled appointment. We realize there may be times when you are unable to meet your scheduled appointment and by canceling 24-hours in advance, we are able to schedule another patient at that time. In case of inclement weather, we put patient safety first and realize that a 24-hour notice may not be possible, and the fee is waived.

CHILDCARE POLICY:

We feel that it is best that young children not accompany you because they will not be permitted in the physical therapy gym while you are receiving therapy. This will allow you to be able to concentrate on your therapy without distractions. In certain situations where children do accompany you, we suggest that you bring toys, books and homework to keep them busy in the waiting room while you are being treated. Thank you for your cooperation!

WORKERS COMPENSATION CLAIMS:

If you claim Workers' Comp benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for the services rendered to you.

AUTHORIZATION TO TREAT:

I authorize Southeastern Orthopaedic Specialists to render physical therapy to myself/child or person to whom I am legal guardian.

I have read, understand and accept the above terms/conditions of Southeastern Orthopaedic Specialists Sports Medicine Center.

Signature of patient or responsible party

Date

FINANCIAL AND INSURANCE POLICY:

It is the patient's responsibility to provide a current insurance card before beginning therapy. If a patient's **insurance changes** while during treatment, it is their responsibility to provide us with the new insurance information prior to further treatment. Insurance co-pays/and or deductibles are **DUE AT THE TIME OF SERVICE** and will be collected at check in. **A $20.00 service fee will be charged if the co-pay is not paid at the time of service.** The payment collected at the time of service is an estimate based on the information available at the time of service. **Any remaining balance after the patient's insurance process is the responsibility of the patient.** We are contracted with most major insurance carriers. Many insurance companies require authorization for visits. As a courtesy, we will pre-authorize and bill the insurance company for the remainder of the physical therapy services performed at each visit. Payments made by the insurance company will be credited to the patient's account. We are often asked what insurance companies will cover and because policies vary so widely both in amount and number of visits allowed, we have no way of knowing the answer to these questions. There may be services provided that the insurance carrier will not cover. It is the **patient's responsibility** to be aware of the provisions of their individual insurance policy - as this is a contract between the patient and their insurance company. **You agree to pay any portion not covered by the insurance carrier and you are ultimately responsible for the timely payment of your account.** For your convenience, we accept cash, personal checks, Master Card, Discover, American Express, Visa, and Care Credit. **A $25.00 service fee will be charged to your account for returned checks and payment will be due immediately.**

DIVORCE:

In the case of divorce or separation, the parent authorizing treatment for the child/children will be responsible for the charges. If the divorce decree requires the other parent to pay all or part of the treatment cost, it is the authorizing parent's responsbility to collect from the other parent.

I have read, understand and accept the above terms/conditions of Southeastern Orthopaedic Specialists Sports Medicine Center.

Signature of patient or responsible party

Date