

MGC Orthopaedic Surgery - Pelham Office Policies

Please arrive at least 30 minutes prior to your first visit, allowing adequate time for the check-in process. Our goal is for our physicians to see you as close to your appointment time as possible. **If you are more than 15 minutes late, we will reschedule your appointment.**

If the first new appointment to our office is "No-Showed", no additional appointments will be scheduled.

For follow-up care visits, 3 No Shows or cancellations less than 48 hours before appointment time, within a 12 month period, could result in discharge from our practice:

- 1st occurrence will result in a reminder letter being sent
- 2nd occurrence will result in a fee
- 3rd occurrence will result in a discharge from the practice

It is your responsibility to know your insurance benefits and requirements. If you have any questions concerning coverage of a certain test, visit type or procedure, please contact your insurance company prior to your visit. It is your responsibility to keep our office informed of any changes in your phone number, address, insurance information, and other pertinent information.

Patients under the age of 18 must be accompanied by a responsible adult or have written permission, for treatment, from a parent or guardian.

Bring either an up-to-date medication list *or* the medication bottles with you to each appointment. Remember to include medications prescribed by other physicians and any over the counter medications and supplements you are taking.

The best time to get a prescription refill is at your appointment. If you are requesting a new prescription please inform your physician during your scheduled appointment. New or refill requests made after your visit may result in a \$10.00 fee. If you need to call in for a refill, please allow 24 hours for the physician to review your request and call the medication in. All refill requests must go through our refill request line. Please check with your pharmacy first to see if the prescription has been called in. Narcotic pain medications **will not** be called in.

We do not prescribe narcotics for chronic use. We do not call in narcotics after hours. If you require use of narcotics, our physicians will refer you to a pain management specialist. Narcotics that are prescribed through our office will require a signed Medication Use Agreement.

Samples are only available if we have them in stock; there is no guarantee that we will have the drug you may need. We do not stock pain medications!

There will be a \$34.00 charge for completion of any forms, (i.e. disability forms, FMLA papers). Please allow 7 to 10 business days for completion of forms.

Village Orthopaedics has a no tolerance policy for rude, unkind or discourteous behavior toward the physician or office staff. In return, our staff is expected to extend kindness and respect to all patients.

Due to Emergency Call Coverage, we occasionally have to schedule patients on an emergency basis. We apologize for any delay you may experience at your appointment time.

If you need to request medical records, please be aware it may take 5 to 7 business days but we will make every effort to fulfill all request as quickly as possible. We are contacted with an outside vendor, Healthport, and upon the completion of records you may receive an additional bill.

Patient Signature _____ Date: _____

Patient Registration Form

Please print or write legibly



PATIENT INFORMATION

Name: _____ Date of Birth: _____ Sex: M F

Mailing Address: _____ Marital Status: S M LS D W

City: _____ State _____ Zip _____ Social Security#: _____

Street Address (if different from mailing) _____ Email address: _____

City: _____ State _____ Zip _____ Primary Language _____

Race: [] White/Caucasian [] Black/African American [] Native Hawaiian [] AM Indian/Alaska Nat [] Asian/E Indian [] Unavailable/Unknown

Ethnicity: [] Hispanic/Latino [] Not Hispanic/Latino [] Declined

Phone: Home: _____ Cell: _____ Work: _____ Preferred Phone: home cell work

Employer/School: _____ Student: FT _____ PT _____ Primary Care Physician: _____

[If a minor] Childs Fathers Name _____ Childs Mothers Name _____

[If the patient is a minor child] and the parents are legally separated or divorced please complete the following:

Which parent has legal custody of the minor child? _____

Which parent is financially responsible for the minor child's medical expenses after insurance? _____

Please provide a copy of the legal documentation stating the parent responsible for medical expenses to be included in the patient's medical record.

[] check if same as patient

GUARANTOR INFORMATION (person financially responsible for any patient balances)

Name: _____ Date of Birth: _____ Sex: M F

Mailing Address: _____ Social Security#: _____

City: _____ State _____ Zip _____ Relationship to Patient: _____

Phone: Home: _____ Cell: _____ Work: _____ Preferred Phone: home cell work

Employer/School: _____ email address: _____

INSURANCE INFORMATION (please provide copies of all medical insurance cards)

Name of Primary Insurance: _____ Certificate Number _____

Group Number _____ Co Pay Amount _____ Effective Date _____

SUBSCRIBER INFORMATION (Person who carries the insurance)

[] Check here if same as the patient

Name: _____ DOB _____

Mailing Address: _____ Social Security#: _____

City: _____ State _____ Zip _____ Relationship to Patient: _____

Phone: Home: _____ Cell: _____ Work: _____ Preferred Phone: home cell work

Employer/School: _____



INSURANCE INFORMATION

(please provide copies of all medical insurance cards)

Name of **Secondary** Insurance: _____ Certificate Number _____

Group Number _____ Co Pay Amount _____ Effective Date _____

SUBSCRIBER INFORMATION (Person who carries the insurance)

Check here if same as the patient

Name: _____
DOB _____

Mailing Address: _____ Social Security#: _____

City: _____ State _____ Zip _____ Relationship to Patient: _____

Phone: Home: _____ Cell: _____ Work: _____ Preferred Phone: home cell work

Employer/School: _____



Financial Policy

This information is to provide clarification for patients of Medical Group of the Carolinas regarding matters of insurance, co-pay, deductibles and co-insurance amounts due at the time of service. Physician Group Practices have an obligation to various Healthcare plans to apply any deductible and/or collect any co-payment prior to provision of services.

Co-Pays

You will be required to pay your co-payment upon arrival for your appointment

Deductibles and Co-Insurance

You will be asked at check in or check out for any deductible or co-insurance that may be applicable to your office visit

Previous Balances

You will be expected to provide payment for previous balances or balances sent to collections prior to your office visit. If you are unable to pay your balance in full, you may be asked to set up a payment plan. You may set up this plan with our office or contact Physicians Billing Service at 1-877-596-2455. Physicians billing service is Medical Group of the Carolinas billing service and will be glad to assist you with your questions about any billing inquiry

PLEASE SIGN THE ACKNOWLEDGMENT BELOW

I acknowledge that the above information is true and accurate demographic and insurance information for the patient listed on this registration form. I also acknowledge that by signing this form, I authorize payment of medical benefits to the undersigned physician or supplier for services described. I have also read the above Medical Group of the Carolinas financial policy and agree to the terms of the policy.

Patient Signature _____ Parent or Guardian Signature: _____



Patient Name _____ DOB: _____

PLEASE INDICATE YOUR PREFERRED METHOD OF CONTACT & HIPAA RELEASE OF INFORMATION

How would you like to be contacted regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for your healthcare provided at the Medical Group of the Carolinas.

Any Method of Contact

Restricted Contact Preferences

Home Telephone May we leave a message on your answering machine? Yes No

Cell Phone Work Phone Mail

HIPAA DELEGATES

OPTION 1: THESE ELECTIONS WILL BE IN EFFECT FOR ALL SRPG LOCATIONS

I authorize the person (s) listed below to receive all health information about appointments, treatment and/or other information pertinent to my healthcare and/or payment for my healthcare provided at the Medical Group of the Carolinas. These individuals will be designated as my emergency contacts.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

HIPAA DELEGATES

OPTION 2: THESE ELECTIONS WILL BE IN EFFECT FOR ALL SRPG LOCATIONS

I do not authorize any information to be disclosed to any other parties except to me as the patient/guardian except in the event of an emergency. Please note the following are emergency only contacts

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Minor Patient Release

MINOR PATIENT RELEASE OPTION 3: THESE ELECTIONS WILL BE IN EFFECT FOR ALL SRPG LOCATIONS

I authorize the following individual (s) to consent to medical treatment in my absence

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

PLEASE SIGN AND DATE BELOW

PATIENT/GUARDIAN SIGNATURE: _____ **DATE** _____

MGC Orthopedic Surgery - Pelham

Today's Date _____ Patient Name: _____ Date of Birth: _____ Age: _____

Height: _____ Weight: _____ Referring Physician: _____ Date of Injury(s) _____

Sport/Activity you are trying to return to: _____ Hand Dominance: Right Left Both

Please circle your current pain level: 0 1 2 3 4 5 6 7 8 9 10
Mild Moderate Severe

<p style="text-align: center;"><u>Past Medical History</u> NONE <input type="checkbox"/></p> <p>Have you had any medical problems?</p> <p>High Blood Pressure Yes / No Heart Disease Yes / No Stroke Yes / No Emphysema Yes / No Diabetes Yes / No Kidney Disease Yes / No Thyroid Disease Yes / No Hepatitis Yes / No Immune Disease Yes / No Chemical Dependency Yes / No Arthritis Yes / No Blood Clots Yes / No Other: _____</p>	<p style="text-align: center;"><u>Current Medications</u></p> <p>Please list all CURRENT medications: (If you have a list please give it to the Receptionist) NONE <input type="checkbox"/></p> <p>_____ _____ _____ _____ _____ _____</p>	<p style="text-align: center;"><u>Social History</u></p> <p style="text-align: center;"><u>Do You use:</u></p> <p>Tobacco Yes / No Alcohol Yes / No Drugs Yes / No Exercise Yes / No</p> <p>Circle one: (Exercise) Daily Weekly Monthly Never Occupation: _____</p> <p>Unemployed: _____ Worker's Compensation: Claim (this injury)? Yes / No On Disability? Yes / No</p>
<p style="text-align: center;"><u>Past Surgical History</u></p> <p>Please list any surgeries you have had: (If you have a list please give it to Receptionist) NONE <input type="checkbox"/></p> <p>_____ _____ _____ _____ _____</p>	<p style="text-align: center;"><u>DRUG Allergies</u></p> <p>List all DRUGS to which you are allergic to: Please <input checked="" type="checkbox"/> box if you have <input type="checkbox"/> NO DRUG allergies <input type="checkbox"/> Allergic to Latex</p> <p>_____ _____ _____ _____</p>	<p style="text-align: center;"><u>Family History</u></p> <p><u>Anyone in your family with:</u></p> <p>Heart Disease: Yes / No Stroke: Yes / No Cancer: Yes / No Rheumatoid Arthritis: Yes / No Muscle Skeletal Disease: Yes / No Other: _____</p> <p><u>Do you have:</u> Anyone to assist you at home: Yes/No Steps into your home: Yes / No</p>

***Review of Systems** Do you have any of these symptoms? Please circle **Yes** or **No** for each condition

<p style="text-align: center;"><u>Constitutional</u></p> <p>Fever Yes / No Weight Loss/Gain Yes / No</p> <p style="text-align: center;"><u>Heart</u></p> <p>Chest Pain Yes / No Irregular Heart Beat Yes / No Poor Circulation Yes / No</p> <p style="text-align: center;"><u>Genitourinary</u></p> <p>Bloody Urine Yes / No Pain in Urinating Yes / No Unable to Urinate Yes / No</p> <p style="text-align: center;"><u>Neurological</u></p> <p>Paralysis Yes / No Frequent Headaches Yes / No</p> <p style="text-align: center;"><u>Blood</u></p> <p>Bleeding Problems Yes / No Blood Transfusion Yes / No</p> <p><u>GYN</u> Date of last menstrual cycle: _____ Pregnant Yes / No</p>	<p style="text-align: center;"><u>Eyes</u></p> <p>Decreased Vision Yes / No Cataracts Yes / No</p> <p style="text-align: center;"><u>Lungs</u></p> <p>Shortness of Breath Yes / No Wheezing Yes / No Persistent Cough Yes / No</p> <p style="text-align: center;"><u>Musculoskeletal</u></p> <p>Joint Swelling Yes / No Muscle Aches Yes / No Joint Pain Yes / No Gout Yes / No</p> <p style="text-align: center;"><u>Psychiatric</u></p> <p>Depression Yes / No Bipolar Yes / No</p> <p style="text-align: center;"><u>Allergies</u></p> <p>Allergies to Food Yes / No Seasonal Yes / No</p>	<p style="text-align: center;"><u>Ear, Nose and Throat</u></p> <p>Loss of Hearing Yes / No Sinus Problems Yes / No</p> <p style="text-align: center;"><u>Gastrointestinal</u></p> <p>Stomach Pain Yes / No Diarrhea Yes / No Persistent Vomiting Yes / No</p> <p style="text-align: center;"><u>Skin</u></p> <p>Rash Yes / No Dryness of Skin Yes / No</p> <p style="text-align: center;"><u>Endocrine</u></p> <p>Thyroid Disease Yes / No Diabetes Yes / No</p> <p><u>Other:</u> _____</p> <p>Are you being treated for these conditions? Yes / No</p>
--	--	---

<p style="text-align: center;"><u>Current Orthopedic Problem:</u></p> <p>Foot Elbow Ankle Forearm Leg Wrist Knee Hand/Fingers Hip Shoulder Back Neck</p> <p style="text-align: center;"><u>Right or Left</u></p>	<p><u>Injury:</u> <input checked="" type="checkbox"/> all those that apply</p> <p>None/ Gradual: <input type="checkbox"/> Fall: <input type="checkbox"/> Twisting: <input type="checkbox"/> Car Accident: <input type="checkbox"/> Altercation: <input type="checkbox"/> Pulling: <input type="checkbox"/> Lifting: <input type="checkbox"/> Other: _____</p>	<p><u>Symptoms:</u> <input checked="" type="checkbox"/> those that apply</p> <p>Pain: <input type="checkbox"/> Popping: <input type="checkbox"/> Looseness: <input type="checkbox"/> Catching/Locking <input type="checkbox"/> Weakness: <input type="checkbox"/> Stiffness: <input type="checkbox"/> Numbness: <input type="checkbox"/> Other: _____</p>	<p style="text-align: center;"><u>Physician:</u></p>
--	---	---	---



**GENERAL CONSENT TO TREAT/
PATIENT AUTHORIZATION/ACKNOWLEDGEMENT OF BENEFITS RELEASE**

The following are the conditions for services provided by the Medical Group of the Carolinas which is affiliated with Spartanburg Regional Health Services District, Inc. (District) for the patient whose name appears at the bottom of this page.

CONSENT FOR MEDICAL TREATMENT

I/we voluntarily consent to medical treatment and diagnostic procedures provided by Medical Group of the Carolinas and its associated physicians, clinicians and other personnel. I/we consent to the testing for infectious diseases, such as, but not limited to syphilis, AIDS, hepatitis and testing for drugs if deemed advisable by my physician. I/we am/are aware that the practice of medicine and surgery is not an exact science and I/we acknowledge that no guarantees have been made as to the result of treatments or examinations.

AUTHORIZATION FOR RELEASE OF INFORMATION

The practice and physicians are authorized to release any medical information required in the processing of applications or submission of information for financial coverage, discharge planning and further medical treatment. To include information referring to psychiatric care, sexual assault or tests for infectious diseases including AIDS/HIV for services provided during this visit. I/we also agree to the release of medical or other information about me to government federal or state regulatory agencies as required by law.

ASSIGNMENT OF INSURANCE BENEFITS

I/we guarantee payment of all charges made for or on account of the patient and I/we assign our rights in any insurance benefits or other funding to the physician and the Medical Group of the Carolinas. I/we understand that I/we am/are responsible for any charges not covered by insurance or other forms of benefits. I/we understand the Medical Group of the Carolinas can obtain my/our credit report for review in collection of this debt. In the event that this account is placed with a collection agency or attorney for collection or collected following the SC Setoff Debt Collection Act, I/we shall pay all collections fees and costs, including reasonable attorney's fees. For Medicare beneficiaries: I/we have provided all necessary information for proper assignment of Medicare benefits.

WORKER'S COMPENSATION PATIENT RECORDS RELEASE AND AUTHORIZATION FORM

I understand that South Carolina and North Carolina Worker's Compensation law provides that written information which pertains directly to a workers' compensation claim must be provided by a healthcare facility/physician to the insurance carrier, the employer, the employee, their attorneys, or the applicable State Workers' Compensation Commission pursuant to the SC Code Ann § 42-15-95 and NC ST § 97-27. **I authorize Medical Group of the Carolinas to provide copies of my medical records or to speak to duly authorized representatives of any of the above regarding my medical records, medical treatment, or condition.**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I/we have received a copy of the Notice of Privacy Practices. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. The Notice of Privacy Practices may be accessed at www.srhs.com.

Date and Time

Signature of Patient/(Relationship to Patient)
(Parent, Guardian or Legally Authorized Representative)

Hospital Witness

Signature of Guarantor (Relationship to Patient)