Birmingham Orthopedics and Sports Specialist

4600 Highway 280, Suite 210
Birmingham, AL 35242
Phone – 205-971-8000
Fax – 205-971-8020

PATIENT INFORMATION

Patient Name: Last_____ First_____ Middle_____
Address: _____City_____ State_____ Zip Code_____

Home: _____ Work: _____ Cell: _____

Email: _____ Marital Status: _____Birthdate: _____/_____/_____

Social Security #: _____Race/Ethnicity: _____

Employer: _____ Employer Ph: _____

Spouse's Name (if married): _____ Spouse's Employer: _____

Emergency Contact: _____ Phone: _____

Relatives/friends who are patients here?_____ Who referred you to us: _____

REASON FOR VISIT:

Body Part: _____ Left _____ Right _____
Date of Injury/Accident Occurred _____
How did injury occur? _____

Have you had x-rays? _____ When/Where? _____

Pharmacy Name & Phone # _____

INSURANCE INFORMATION

Insurance Company (Primary): _____

Policy Holder's Name: _____ Birthdate _____/_____/_____

Contract Number: _____ Group Number: _____
Insurance Company (Secondary): _____
Policy Holder's Name: _____ Birthdate _____/_____/_____

Contract Number: _____ Group Number: _____

Name of Person Responsible for Bills _____

Is this a WORKMAN COMPENSATION CASE? Yes ____ No ____ If yes, please provide the following:
Date of Injury: _____ Employer: _____
Work Comp Carrier: _____ Address: _____

List the Coach, Trainer, or Doctor and Complete Address that referred you.
Doctor/Coach/Trainer: _____

Are you participating in a research study? _____

Name: _____

Primary Care Doctor: _____

Ht _____ Wt _____ Date of Birth _____ Today's Date _____

Drug Allergies: _____

Present Medications	Medical Problems	Previous Surgeries
1. _____	1. _____	
2. _____	2. _____	1. _____
3. _____	3. _____	2. _____
4. _____	4. _____	3. _____
5. _____	5. _____	4. _____
6. _____	6. _____	5. _____
		6. _____

Do you use tobacco products? _____ NO _____ YES _____ #Packs/Day

Do you drink Alcohol:? _____ NO _____ YES _____ #Drinks/Week

Are you pregnant? _____ NO _____ YES

Latex Allergy? _____ NO _____ YES

Marital Status: Single Married Divorced Separated Widowed

Number of Children: _____ Occupation: _____

Family History:

High Blood Pressure	_____Y ____N	Cancer	_____Y _____N
Heart Disease	_____Y _____N	Diabetes	_____Y _____N
Anesthetic Complications	_____Y _____N	Other	_____

Have you ever had or experienced or are you currently experiencing:

_____ Y _____ N	Vision/Eye Problems	_____ Y _____ N	Skin Rash
_____ Y _____ N	Migraine Headaches	_____ Y _____ N	Hearing Loss
_____ Y _____ N	Epilepsy	_____ Y _____ N	Irregular Heart Beat
_____ Y _____ N	Dizziness	_____ Y _____ N	Shortness of Breath
_____ Y _____ N	Blood Clots in Legs	_____ Y _____ N	Wheezing
_____ Y _____ N	Tuberculosis	_____ Y _____ N	Pneumonia
_____ Y _____ N	Heart Attack	_____ Y _____ N	High Blood Pressure
_____ Y _____ N	Blood in Stool	_____ Y _____ N	Stroke
_____ Y _____ N	Vomiting of Blood	_____ Y _____ N	Swelling of Feet or Ankle
_____ Y _____ N	Kidney Stones	_____ Y _____ N	Blood in Urine
_____ Y _____ N	Numbness	_____ Y _____ N	Cancer
_____ Y _____ N	Anxiety	_____ Y _____ N	Depression
_____ Y _____ N	Bleeding Disorder	_____ Y _____ N	Aids
_____ Y _____ N	Arthritis	_____ Y _____ N	Diabetic

Comments or Additional History:

_____

_____

_____

Reviewed by: _____ Date: _____

Birmingham Orthopedics and Sports Specialist

Authorization for Medical Treatment: The undersigned will be informed of the treatment procedures considered necessary for the patient and that the treatment/procedures will be directed by a physician and performed by employees of Birmingham Orthopedics and Sports Specialist. The undersigned understands that no guarantee for assurance has been made as to the results that may be obtained from treatment. Authorization is hereby granted for treatment.

Information Privacy: Birmingham Orthopedics and Sports Specialist will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change in detail with time and we will always post the current notice at our facilities, on our website and have copies available for distribution. The undersigned acknowledges receipt of this information.

Release of Information: Birmingham Orthopedics and Sports Specialist is hereby authorized to disclose all or part of my information regarding medical condition, treatment and prognosis to insurance carriers, other treating physicians, trainers, rehabilitation nurses, orthopedic technicians and/or coaches. I also authorize Birmingham Orthopedics Sports & Spine to utilize medical information obtained during the course of my treatment in medical research and education programs, provided my name and likeness are not revealed and my privacy is completely protected.

Assignment of Insurance Benefits: In the event the undersigned is entitled to benefits of any kind whatsoever arising out of any policy of insurance insuring the patient or any other party liable to the patient, said benefits are hereby assigned to Birmingham Orthopedics and Sports Specialist for application on the patient's bill. The undersigned and/or patient agree to be responsible for charges not covered by the assignment, including deductible and co-payments prescribed by law.

Financial Agreement: The undersigned agrees that in consideration for the services to be rendered to the patient, he/she individually agrees to be totally responsible for all charges for services, including any non-covered charges. The undersigned agrees to assign payment for the unpaid charges from services provided by a specialist and by physicians for whom Birmingham Orthopedics and Sports Specialist is authorized to bill. Should the account be referred to an attorney for collection, the undersigned agrees to pay all coasts of collections, including reasonable attorney fees of one third of the balance. All delinquent balances shall bear interest at the legal rate.

Medicare Authorization: I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services (CMS) or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible in part for my treatment. (Section 11288 of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information). Regulations pertaining to Medicare assignment of benefits also apply.

Miscellaneous Provisions: I understand that under no circumstances will be liable for property of patients.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND UNDERSTANDS THE FOREGOING, IS THE PATIENT OR ONE AUTHORIZED BY THE PATIENT TO EXECUTE THE ABOVE, AND ACCEPTS THE TERMS THEREOF.

_____	_____
Undersigned (Patient's Signature)	Signature – if signed by Undersigned's Authorized Agent
_____	_____
Witness	Relationship to Undersigned
_____	_____
Witness – Need Only if Signatures are Made By Mark (X)	Month Day Year Time(AM/PM)

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. I, _____ authorize all medical service sources and health care providers to use and/or disclose the protected health information (PHI) described below to my Personal Representative(s) named as follows:

_____

2. This authorization for release of PHI covers the period of healthcare (check one)

a. ☐ from (date)_____ to (date) _____. OR

b. ☐ all past, present, and future periods.

3. I hereby authorize the release of PHI as follows (check one):

a. ☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse). OR

b. ☐ I authorize the release of my complete health record with the exception of the following information:

- ☐ Mental health records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization to release information to my Personal Representative will automatically expire two (2) years following the termination of my enrollment with the Health Plan.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____

Signature of Member or Personal Representative Date

_____

Printed name of patient or personal representative and relationship to Member

GRANDVIEW MEDICAL CENTER

Anesthesia Preoperative Screening Form

Fax: (205) 971-4444

Patient Name: _____ Date of Birth: _____

Surgery Date: _____ Height: _____ Weight: _____

Allergies: _____

1.	Do you become short of breath or develop chest pain when climbing a flight of stairs?	NO	YES
2.	Do you have high blood pressure that requires 2 or more medications to control it?	NO	YES
3.	Have you ever had heart disease, pacemaker/defibrillator, heart surgery, angioplasty, a stent placed, abnormal EKG or a heart attack? Cardiologist: _____	NO	YES
4.	Have you ever had blood clots, stroke, carotid artery blockage, or TIA ("mini-strokes")?	NO	YES
5.	Are currently taking blood thinners such as Coumadin (warfarin), Plavix (Clopidogrel), Effient (prasugrel), etc.?	NO	YES
6.	Do you have a history of excessive bleeding following medical or dental procedures, or have you had to see a doctor due to problems with bleeding or clotting?	NO	YES
7.	Do you have asthma, chronic bronchitis, emphysema? Pulmonologist: _____	NO	YES
8.	In the last two years have you been on steroids like prednisone for a condition such as lupus, severe rheumatoid arthritis, chronic lung conditions, or hypopituitary condition?	NO	YES
9.	Are you more than 100 lbs over weight?	NO	YES
10.	Do you have diabetes?	NO	YES
11.	Do you have kidney problems and regularly see a nephrologist (kidney specialist) or receive Dialysis? Kidney Specialist: _____	NO	YES
12.	Do you have a history of cirrhosis or chronic liver disease?	NO	YES
13.	Are you currently being treated for cancer, excluding basal cell? Oncologist: _____	NO	YES
14.	Have you or anyone in your family ever had significant complications with anesthesia other than nausea or vomiting?	NO	YES

You will receive a call from an anesthesia nurse once your surgery has been scheduled at Grandview Medical Center. This call will take about 30 minutes to complete and is very important to ensure you have a safe anesthesia experience. ***Please have your complete medication list with drug names and dosages available at the time of your call.***

Best Day(s) for a 30 min Phone Call *(circle all that apply)*: M Tu W Th F	Best Time for a 30 min Phone Call:	Best phone number to reach you:

Cancellation Policy/No Show Policy

We strive to promote the best quality healthcare for our patients. One of the ways we meet your healthcare needs is to provide appointments with our physicians in a timely manner, many times within the same day. In order to provide these appointments, we have the following No Show/Cancellation policy.

1. *Cancellation/ No Show Policy for Doctor Appointment*

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an
Appointment, you may be preventing another patient from receiving much needed treatment.
Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment schedule.

If an appointment is not cancelled at least 24 hours in advance you may be subject to fees which are not covered by your insurance company. More than 3 no shows within a six month period will result in dismissal from the practice. Violators will receive a letter after the second no show as a reminder of the policy.

2. *Scheduled Appointments*

We understand that delays can happen however we must try to keep the other patients and our physicians on time.
If a patient is 15 minutes past their scheduled time, it may be necessary to reschedule your appointment.

3.*Cancellation/ No Show Policy for Surgery/Procedure*

Due to the large block of time needed for surgery and/or procedures, last minute cancellations can cause problems and added expenses for the office.

If your are scheduled for a surgery/procedure is not cancelled at least 10 days in advance you may be subject to fees which are not covered by your insurance company.

4. Account balances

We will require that patients with self-pay balances do pay their account balances to zero (0) prior to receiving further services by our practice.
Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns.
Patients with balances over $100 must make payment arrangements prior to future appointments being made.

_____ _____ _____/_____/_____

Print Name Patient Signature Patient/Guardian Date