Welcome to Southeastern Orthopaedics

Patient Name: ____________________________________ Date of Birth: _______________________
Mailing Address: ____
City: ____ State: _________ Zip code: ___________
Age: ________ SSN: _________________________ Sex: Male Female Race: ________
Email: ____________________________________Home #:________________ Cell #: ________________
Employer: ____________________________ Employer Phone: _____________________
How did you hear about our practice? ____
Emergency Contact Name and Number: ____

Parent or Guardian Information: (if the patient is under 18 years old)
Name: _________________________________Relationship: _________________________
Mailing Address: ____
City: ___________________________ State: ________ Zip code: _____________
Phone: (_____)_________________Email: ______________________________________
Date of Birth: ___________________ Age: ________ SSN: _______________________
Insurance Information:
Primary: ____________________________ Secondary: ______________________________
Plan ID: _____________________________ Plan ID: ________________________________

I authorize the release of all information relating to all claims and benefits submitted on behalf of myself or dependents. I authorize my insurance company to pay and hereby assign all benefits, if any to Southeastern Orthopaedics, otherwise payable to me. I authorize James Barber, MD or Joel Hernandez, PA-C to medically treat myself or my dependents including any labs or tests he feels necessary.

Signature:___________________________________ Date: ___________________________

HIPAA PRIVACY:

This is the authorization for use and disclosure of personal health information. Southeastern Orthopaedics or its business associates may use or disclose your personal health information, including medical records and charges, for the purpose (s) of patient referrals, payment of medical bills for your insurance company, and overall related to patient care. You may request a detailed description of your rights and permitted uses and disclosures under HIPAA. Copies of the most current Privacy Notice will be available upon request or on our website myseortho.com and posted in our main lobby. Please list below the person (s) we may share or communicate your personal medical information. I understand that the authorized persons (s) I listed above may re-disclose my health information and is no longer protected by federal privacy regulations. You have the right to revoke this authorization by submitting a signed written request to our office, your revocation request will be effective upon receipt. Any specific violations may be reported in writing to: Southeastern Orthopaedics, Attn: Privacy Officer. The authorization will remain in effect until two years from the date signed. By signing this consent form, you give SEO permission to use and disclose protected health information about you for treatment, payment, and healthcare operations. A copy of this Notice of Privacy Practices is available to you prior to signing this consent form. **Name and Relationship:_________________________**
Name and Relationship:_________________________

I acknowledge and agree:
Patient or Guardian Signature:________________________Date:_____________

Patient Name: _____________________________

Minor Consent for treatment:

Please list any persons and relationship to child below that you give permission to bring your child to their follow up appointments. Name: __________________________ Relationship: ___________________

Guardian Signature:__________________________Date:_____________

Southeastern Orthopaedics Financial Policy

- **Payment Policy:** All copays and previous balances will be collected at the front desk during the check-in process. You will receive 3 statements from our office for the account patient balances. All balances are due within 60 days unless a preapproved payment plan is in place. All balances due after 90 days will be charged interest and reviewed for collection activity from an outside collection agency. A fee of $40.00 will be added for any return checks. We gladly accept cash, VISA or Mastercard, and checks for your convenience.
- **We do offer automatic payment check or credit card drafts for your convenience**. Please ask our staff for more information.

Please initial which one(s) apply to you:

- **_______Commercial Insurance:** Copays and balances are due at the time of services. SEO will submit your claim to your carrier as a courtesy if all current and accurate information is provided. Payments on existing balances are also due the day of your appointment. If payment is not received from your insurance company within 30 days, the balance becomes your responsibility.
- **_______Self-pay:** A predetermined prepayment is required at the time of service for each visit. This prepayment may not cover the entire charges for each visit depending on your treatment. The remaining balance is due on your next visit. A payment is expected every 30 days or at the time of your next visit. Remaining balances are due within 60 days of date of service. Any balances due after 90 days will be charged interest and reviewed for collections activity from an outside agency.
- **_______Workman's comp:** All work-comp accounts must be approved by an insurance company and employer before your visit. If we have verified the claim with your work-comp carrier no payment necessary. If your work-comp claim is denied the charges becomes your responsibility and self-pay policy applies on any balance.
- **_______Medicare:** If you are currently enrolled in Medicare part B or any Medicare CMO, a copay, deductible and coinsurance may apply. Medicare will not cover your entire bill. All balances must be paid in full within 60 days from date of service.
- **_______Medicaid:** We are currently participating with Medicaid, Peachstate, Wellcare, and Caresource. If for any reason the claim is denied the balance will be your responsibility and must be paid in full within 60 days of the date of service.

- **Disability and leave of absence forms will be completed every Wednesday for a fee of $15.00. Please bring forms in early to allow adequate processing time. Unfortunately, we cannot accept forms via fax or return completed forms via fax. You MUST pick them up completed forms from our office.**
- **Please sign in agreement to the terms above:**

Signature:___________________________________ Date:___________________________

Patient Health Information Date: _________________

Name:______________________________ Age: ______________Weight:_____________lbs

Reason for today's visit: ____

Allergies:____
____
____

Recent Hospitalization, surgeries or major illness: (include dates):

____
____
____
____

Medication List: (including over the counter, shots and dosage):

____
____
____
____

Social History: (check all that apply)

A. Marital Status: Married ____Single ___ Divorced ___Widowed ______
B. Social: Smoke _______ Drugs _______ Exercise ______Other ________________

Have you ever had or do have? (Circle all that apply)

HIV-AIDS Hepatitis Cancer Diabetes Heart Disease Thyroids Nonhealing Sores High Blood Pressure Bursitis Leukemia Emphysema Kidney Disease Recurrent Infections Polio Phlebitis Anemia Migraines Paralysis Stomach Ulcers Stomach pain Neuritis Asthma Meningitis Joint pain Muscle spasms Night sweats Head Injury Mental condition Alcoholism Stroke Sciatica Breast Lumps Prostate problems Pneumonia

1) Women Only – Are you pregnant? Yes or No

2) Referring/ Primary Physician or Facility?_________________________________

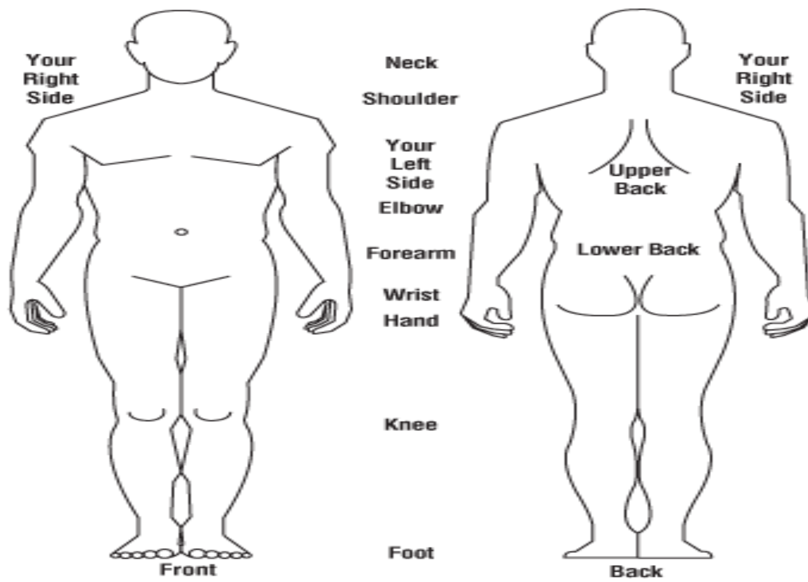
3) Did the accident happen at work? Yes or No

4) What pharmacy do you use?_____________________________________

Patient Name: ____

Please circle: Have you had: x-rays, MRI, CT, EMGs ? Where? ______________________________

Where do you hurt? Circle the area(s) that hurts on the demonstration below:



Rating scale: 0 = No pain 10 = extremely intense pain

1) How is the pain now? _____________
2) How is the pain at its worst? ___________
3) How is the pain at its best? ___________

- Present symptoms: I would describe my pain as:
  - Dull Ache Stiffness Sharp/Stabbing
  - Shooting Soreness Spasms
  - Numb Burning Tingling
- My pain is worse with:
  - Lifting Bending Standing
  - Walking Sitting Pulling
  - Climbing Stretching Pushing
- My pain occurs:
  - Intermittently Weekly Daily
  - Monthly Consistently
- My pain is better with:
  - Bed rest Medication Heat
  - Ice Motion None/other

Signature:_______________________________ Date:_ _____________________________