Foothills Orthopaedics & Sports Medicine Center
3150 Hwy 153 | Piedmont, SC 29673
Phone 864-295-1231 | Fax 864-295-0095
Daniel E. Lee, MD | Janice Lee, FNP-C | Anne-Claire Edwards, MD | John P. Evans, MD

Patient Intake Paperwork

Name: _____ Today's Date: _____

DOB: _____ SSN: _____-_____-_____

Email: _____

Mobile Phone: _____ Home Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Race: _____ Ethnicity: ☐ Hispanic ☐Non-Hispanic

Preferred Language: ☐ English ☐ Other: _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Significant Other

Primary Care/Family Doctor: _____

Other Current Physicians: _____

Past Medical History

Major events, hospitalizations, surgeries, etc: _____

_____

_____

Drug Allergies, Food/Environmental Allergies:_____

Ongoing Medical Problems

Have you ever been diagnosed with:

☐ Acid Reflux	☐ Addiction	☐ Anxiety	☐ Atrial Fibrillation
☐ Bloody Urine	☐ Bloody Stool	☐ Bone Disease	☐ Bradycardia
☐ CAD	☐ Chronic back pain	☐ Clotting Disorder	☐ COPD
☐ _____ Cancer (please specify)	☐ Depression	☐ Eating Disorder	☐ Gout

☐ Heart Disease	☐ High Cholesterol	☐ HIV/AIDS	☐ Hypertension
☐ Lupus	☐ Migraines	☐ MS	☐ Muscle Pain
☐ Obesity	☐ Osteoarthritis	☐ Osteoporosis	☐ Paget's Disease
☐ Pain Management	☐ Palpitations	☐ Parkinson's	☐ PAD
☐ Renal Disease	☐ Seizures	☐ Stomach Ulcers	☐ Stroke
☐ Swollen Feet	☐ Hyperthyroidism	☐ Visual Problems	☐ Diabetes
☐ Hypothyroidism	☐ Joint Pain	☐ Kidney Disease	☐ Liver Disease

Have you broken a bone? ☐ Yes ☐ No If yes, what bone? _____ Age: _____

Were you treated? ☐ Yes ☐ No If yes, where? _____

Have you ever had chemotherapy or radiation therapy? ☐ Yes ☐ No

Do you have a chronic pain doctor? ☐ Yes ☐ No If yes, who? _____

Family Medical History

Have any of your grandparents, parents, siblings, or children been diagnosed with the following:

Cancer ☐ Yes ☐ No. Which type? _____ Which family member(s)? _____

Diabetes ☐ Yes ☐ No. Which family member(s)? _____

Heart Disease ☐ Yes ☐ No. Which family member(s)? _____

Hypertension ☐ Yes ☐ No. Which family member(s)? _____

High Cholesterol ☐ Yes ☐ No. Which family member(s)? _____

Arthritis ☐ Yes ☐ No. Which family member(s)? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks do you have per week? _____

Do you smoke or use chewing tobacco or snuff? ☐ Yes ☐ No

If yes, how many packs do you use per day? _____

Have you had your flu shot for this year? ☐ Yes ☐ No

Medications List:

☐ Please check this box if you are not currently on any medications.

☐ Please check this box if you did not bring your medication bottles or list and will need to call the office after your appointment to provide this information.

☐ If you have a written or typed list of your medications, please attach a copy to this paperwork instead of writing them out below (we can make a photocopy if needed).

Otherwise please fill in the following information regarding your medications:

Name: Dosage (mg): # of Pills: When taken: Prescribed by:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____

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HIPAA Privacy Authorization Form

Authorization for use or disclosure of Protected Health Information required by the Health Insurance Portability and Accountability Act - 45 CFR Parts 160 and 164

Please list any individuals (including family members and spouses) that we may discuss/release your protected health information to (including upcoming appointments, treatment, billing, surgical procedures, condition, and prognosis).

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Phone #: _____ Phone #: _____

☐ Please check this box if you **do not** want any information regarding your treatment at our office to be shared with anyone (including family members and spouses).

Messaging and Appointment Reminders per the Telephone Consumer Protection Act (TCPA)

Let us know if we can send messages about your protected health information (including reminders for upcoming appointments) by:

Phone call/voicemail? ☐ Yes ☐ No

Email? ☐ Yes ☐ No

Text? ☐ Yes ☐ No

This authorization will be in effect for all past, present, and future dates (up to 9 months after the patient's death) unless a preferred expiration date is specified here: _____.

If you would like to make any changes to this authorization, please notify our office so that a new HIPAA form can be completed and added to your file.

Patient Name (please print): _____

Patient Signature: _____ Date: _____

Staff Signature: _____ Date: _____

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Financial Policy

Please review our financial policy guidelines in their entirety and let us know if you have any questions.

- **Payments:** Payment in full is expected at the time of service. This includes co-pays. We can accept payments by cash, check, Visa, Discover, or Mastercard.

- **Returned Checks:** There will be a $35.00 non-sufficient charge for all returned checks.

- **Insurance:** We are in-network with most insurance plans. If you are insured by a plan we are not in-network with or you do not have insurance at this time, payment is expected in full at each visit. If you are insured by a plan that we are in-network with, it is your responsibility as the patient to make sure that we have all of your up-to-date insurance information in order to process any claims. **Knowing your insurance benefits is your responsibility.** Please be sure to contact your insurance company prior to your visit with any questions you may have regarding your coverage.

- **Co-pays:** All copayments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect copayments from the patient can be considered fraud. Please keep in mind that when you arrive for your appointment our receptionist will ask to collect your co-pay.

- **Non-Covered Services:** Please be aware that some of the services you may receive may not be covered or not considered to be medically necessary by some insurance companies. If this occurs, the patient will be responsible for the balance that is not covered.

- **Proof of Insurance:** All patients must complete our Patient Intake Paperwork before being seen by our providers. We must obtain a copy of your driver's license and current valid insurance card. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.

- **Claim Submission:** We will submit your claims and assist you in any way we can within reason to help you get your claims paid. Your insurance company may need you to supply certain information to them before payment can be made. It is your responsibility to comply with their requests. **Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays towards your claim. Your insurance benefits are determined by a contract between you and your insurance company.**

- **Coverage Changes:** If your insurance changes, please notify our office before your next visit so that we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you.

- **Disability and FMLA Paperwork:** A fee of **$25.00** must be paid before any disability or FMLA forms will be completed by our providers. Our office will call to notify you once these forms have been completed and to ask if you would prefer to pick them up or have them faxed or emailed to your employer.

- **Prescription Refills:** It is the patient's responsibility to provide the name of the pharmacy as well as the telephone number or address so that the prescription can be called in. **Please be aware that all prescriptions that are called in may take at least 48 hours to be filled if they require further authorization from our providers.**

- **Records:** Patients must complete and sign a **Records Release Form** to authorize the transfer of any records of treatment performed at our office to another provider's office. Note that all x-ray reports are recorded in your visit note, but if you require a copy of your x-rays films on a disc, there is a $5.00 charge (please notify our office in advance so we can prepare the disc prior to your arrival).

- **Missed Appointments:** It is your responsibility to remember your appointments, however, we understand that there may be times when you might have to miss an appointment due to prior obligations or emergencies. Missed appointments are not only a cost to us, but also mean that we were unable to provide services to other patients who could have been seen in the time that was set aside for you. Please notify us as soon as possible if you need to cancel or reschedule an appointment. **Patients who have not shown to 3 appointments in a row may be declined a return visit.**

- **Being late to an appointment:** If you arrive more than 15 minutes late for your appointment, you will have to reschedule.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual customary charges of our area. We thank you for your understanding. Please let us know if you have any questions or concerns.

☐ I have read and understand the Financial Policy and agree to abide by these guidelines.

Patient Name (please print): _____

Patient Signature: _____ Date: _____

Staff Signature: _____ Date: _____

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Controlled Substance Policy

If your provider at Foothills Orthopaedics & Sports Medicine Center determines that it is **medically necessary** to have your pain managed with narcotic pain medications, all patients must adhere to the following guidelines:

1. These medications may cause physical dependence and addiction. The use of these medications in ways other than prescribed may result in adverse effects of an unforeseen nature. They are also highly regulated by the Drug Enforcement Agency (DEA). It is mandatory that you adhere to the prescribed treatment plan in order for your provider to prescribe these medications safely.
2. Take your medications only as directed. For any changes in dose or frequency, you must see your provider at Foothills Orthopaedics.
3. Only take controlled substances that are prescribed by your provider at Foothills Orthopaedics.
4. If any other provider you are seeing prescribes you other controlled substances, you must inform your provider at Foothills Orthopaedics immediately.
5. Your provider will not prescribe narcotic medications to you for an extended length of time. You will not receive over ninety (90) tablets of narcotic medication per month, and you will only receive three (3) refills of these medications with your prescription per your provider's discretion.
6. Narcotic prescriptions can no longer be called into the pharmacy. These prescriptions must be picked up in person from our office during business hours. The individual picking up the prescriptions must present photo identification and sign for the prescriptions.
7. You will not receive replacements for lost or stolen medications. It is your responsibility to make sure your amount dispensed from the pharmacy is correct.
8. You must abstain from alcohol or any other mood-altering substances not prescribed by a physician while on the controlled substance. These medications can interact with alcohol in negative and extremely hazardous ways.
9. You must agree to provide random urine and/or blood drug screens at any time as requested by your provider at Foothills Orthopaedics.
10. You must agree to accept referral for addiction evaluation if and when your provider feels it is appropriate.
11. Failure to adhere to any part of this agreement will result in discontinuation of treatment at Foothills Orthopaedics & Sports Medicine Center

☐ I have read and understand the Controlled Substance Policy and agree to abide by these guidelines.

Patient Name (please print): _____

Patient Signature: _____ Date: _____

Staff Signature: _____ Date: _____