THOMASVILLE ORTHOPEDIC CENTER PC
100 MIMOSA DRIVE, SUITE 1R, THOMASVILLE, GA 31792-6678
229-226-9141 (Phone) 229-228-0637 (Fax)

PATIENT PRIVACY

Thomasville Orthopedic Center, PC is committed to securing the privacy of your health information. Accordingly, we have posted our practice's *Notice of Privacy Practices* in the reception area. You are not required to read this notice. However, we would like your acknowledgement that you have been notified that the practice has such a *Notice of Privacy Practices*.

If you want a person(s) to have access to your medical records, schedule or change appointments on your behalf, or make any changes to your account, please list their names and their relationship to you below:

_______________________________________ ____________________________________
Authorized Person Relationship

_______________________________________ ____________________________________
Authorized Person Relationship

Patient's name (printed): ____Date of birth: _____________________
Signature of patient (or representative): _____________________________ Date: ___________________________
Relationship, if other than patient:_________________________________

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E-PRESCRIBING CONSENT FORM

E-prescribing is a safe and effective way for your physician to send accurate, error-free prescriptions directly to the pharmacy of your choice. This is now becoming a standard of care for all patients and is an important element in improving the quality of patient care.

The benefits of this program include:
Formulary and benefit transactions – gives the prescriber information about which drugs are covered by the drug benefit plan.
Medication history transactions – provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
Fill status notification – allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up or partially filled.

By signing this consent form you are agreeing that Thomasville Orthopedic Center, PC may request and use your prescription history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Signature of patient (or representative): _______________________________ Date:____________________________

THOMASVILLE ORTHOPEDIC CENTER PC
PATIENT REGISTRATION

Last Name: ________________________________ **First Name**: ________________________________ **MI**: ________

Mailing Address: ________________________________ **City**: ______________________ **State:** ______ **Zip**: ________

Physical Address: ________________________________ **City**: ______________________**State**: _______**Zip**:_________

County: _________________________________

Patient's SSN: ______________________**Date of Birth**: _____/______/_____**Age**: __________ **Sex**: M F

Cell Phone: (_____) ______-________ **Work Phone**: (_____) ______-_________**Home Phone**: (_____) ______-_________

Marital Status: Married Divorced Widowed Single Other

Race: White African American Asian Hispanic Other

Employment: Employed Retired Student Disabled Unemployed

Employer: ____

Employer's address: ____Employer's Telephone#: (______) ______-_______

Emergency Contact: ____________________________**Relationship**: _______________Phone: (_____)-______-_______

Referring Doctor: ____

PCP (Family Doctor):____

IF PATIENT IS A MINOR:

Insured Parent's Name: ____________________________Date of birth: ____/_____/______ SSN: _____________________

Parent's Employer: __________________________Address: ____________________ Phone #: (______) ______-________

IF PATIENT IS MARRIED:

Spouse's Name: __________________________________ Date of birth: ____/_____/______ SSN: ____________________

Employer: ____ Work Phone: (_____)_____-___________

MEDICAL RELEASE

I hereby authorize consent for medical treatment and release of information regarding diagnosis and treatment to my insurance company to obtain pre-certification and submission of claim(s). I further allow the release of any medical records to any doctor Thomasville Orthopedic Center PC may refer me to while under their care. I allow fax transmittal of medical records if necessary.

Signature of patient (or representative): ______________________________________ **Date:** ___________________

THOMASVILLE ORTHOPEDIC CENTER PC
FINANCIAL POLICY

The Physicians and Staff of Thomasville Orthopedic Center PC are concerned about your physical health and well-being. We are dedicated to providing each and every patient with the highest quality medical care available. In order to assist with your care and treatment, we feel that you should understand our financial policy.

Patient Insurance
Thomasville Orthopedic Center will bill all health insurance plans with whom we have a contract and will collect any required co-payments before services are rendered (at check-in). In the event your health insurance plan determines a service "not covered", you will be responsible for the charges. In that event, we will bill you and payment is due upon receipt of statement. If you have coverage with an insurance company in which we do not participate, we will bill your insurance company for all services provided. Any balance due is your responsibility and will be due upon receipt of statement.

Self-Pay
For patients with no insurance, it is the policy of Thomasville Orthopedic Center, PC to collect at the time of check-in for **EACH** office visit as shown below. Your payment will be applied to your charges for that day. You will be offered a 50% discount on the total charges that exceed the amount paid if you pay the balance in full at time of service. If you are unable to pay the balance in full, you will be billed for the entire balance. At each subsequent visit, you will be required to pay upfront plus any balance due on your account. Any overpayment will be refunded (after all charges have been billed). **For Dr. Murphy-$1000.00, Dr. Hancock-$500, Dr. Walter-$500 & Dr. Messerschmidt-$500.**

FOR YOUR CONVENIENCE, PAYMENT CAN BE MADE BY CASH, CHECK, MASTERCARD OR VISA (DEBIT OR CREDIT CARD).

PLEASE NOTE: if your account is referred to an outside collection agency due to non-payment, your account will be charged for all collection costs incurred by Thomasville Orthopedic Center, PC.

Minor Patients
For all services rendered to minor patients, the adult accompanying the patient is responsible for payment and must be present at the time services are rendered.

Missed Appointments
In order to provide the best possible service to all our patients, we ask that you please call to cancel at least one day prior to your visit. For missed MRI appointments, a $25 "no show" fee will be billed to your account.

Surgery Cancellation/Reschedule
A fee of $250.00 will be charged for all surgeries which, absent a compelling reason, are not cancelled or rescheduled 72 hours prior to the pre-operative appointment date.

I have read and understand the financial policy of Thomasville Orthopedic Center PC and I agree to be bound by its terms. I also authorize my insurance benefits to be paid directly to Thomasville Orthopedic Center PC.

Signature of patient (or representative): ______________________________________ Date: ___________________

Thomasville Orthopedic Center PC

Patient's Name: ______________________________________ Date of birth: _____________ Date: ________________

Occupation: ____Height: ______ Weight: ______ Age: ______

Family Physician: _________________________________ Address: ____

Referring Physician: ________________________________Address: ____

Primary insurance:______________________________Secondary insurance:___________________________________

MEDICAL HISTORY/ACCIDENT DETAIL FORM

What part of the body will be treated? ___________________________________ Left or Right

Was this an injury? Yes or No If yes, date of Injury: ___/____/____ Did it happen on the job? Yes or No

How, where, and when did it happen? ____

If this is a workers' comp claim, please list employer: _____________________________Telephone #______________

****IF YOUR EMPLOYER HAS NOT APPROVED THIS VISIT, PLEASE LET THE RECEPTIONIST KNOW****

Have you received treatment for this injury? Yes or No If yes, where? _______________________________________

Were you x-rayed for this problem? Yes or No If yes, where? ____

Do you have any medication allergies? Yes or No
If yes, please list medication and its effect

____
____
____
____
____
____
____
____

Are you currently on medication? Yes or No
If yes, please list:

____
____
____
____
____
____
____
____

Name of Pharmacy: _________________________________
Pharmacy Location: _________________________________

Have you had previous surgeries? Yes or No
If yes, please list:

____
____
____
____
____
____

Do you have any metal in your body? Yes or No If yes, please explain: _______________________________________
Please list any serious illnesses: ____
____

Thomasville Orthopedic Center PC
Medical History/Accident Detail Form – Page 2 of 2

Patient's Name: ________________________________ ___________________Date: ______________________

PAST MEDICAL HISTORY	
Have you had High Blood Pressure? Yes or No	Have you had Pneumonia? Yes or no
Do you have Diabetes? Yes or No	Have you had a stroke? Yes or No
Have you had Ulcers? Yes or No	Do you have Seizures? Yes or No
Have you had Heart Problems? Yes or No	Do you have asthma? Yes or No

Do you have problems with?		If "Yes', please describe below:
Headaches or Neck Problems	Yes or No	_______________________________________
Eye, Ear, Nose, or Throat	Yes or No	_______________________________________
Heart Problems	Yes or No	_______________________________________
Stomach or Intestinal	Yes or No	_______________________________________
Kidney or Liver	Yes or No	_______________________________________
Phlebitis or Leg Swelling	Yes or No	_______________________________________
Skin Infections	Yes or No	_______________________________________
AIDS or HIV infection	Yes or No	_______________________________________

FAMILY HISTORY

Please circle if any member of your immediate family has trouble with:

Cancer	Diabetes	Kidney Problems	High Blood Pressure
Heart Disease	Stroke	Arthritis	

SOCIAL HISTORY

Do you live alone? Yes or No	Do you smoke cigarettes? Yes or No If yes, how much: ______________________
Are you working? Yes or No	Do you drink alcohol? Yes or No If yes, how much: _________________________
	Do you use drugs? Yes or No If yes, how much: ____________________________

Signature of patient (or representative): _______________________________________ Date: ___________________

Thomasville Orthopedic Center PC

Patient's Name: ____ **Date:** ___________________

Check the correct statement:

☐ Injured at work
☐ Other type of accident
☐ I do not recall an injury

Please use the figure below to show where on your body there is any kind of discomfort or unusual feeling.

Mark 000000's on area where you have numbness or tingling

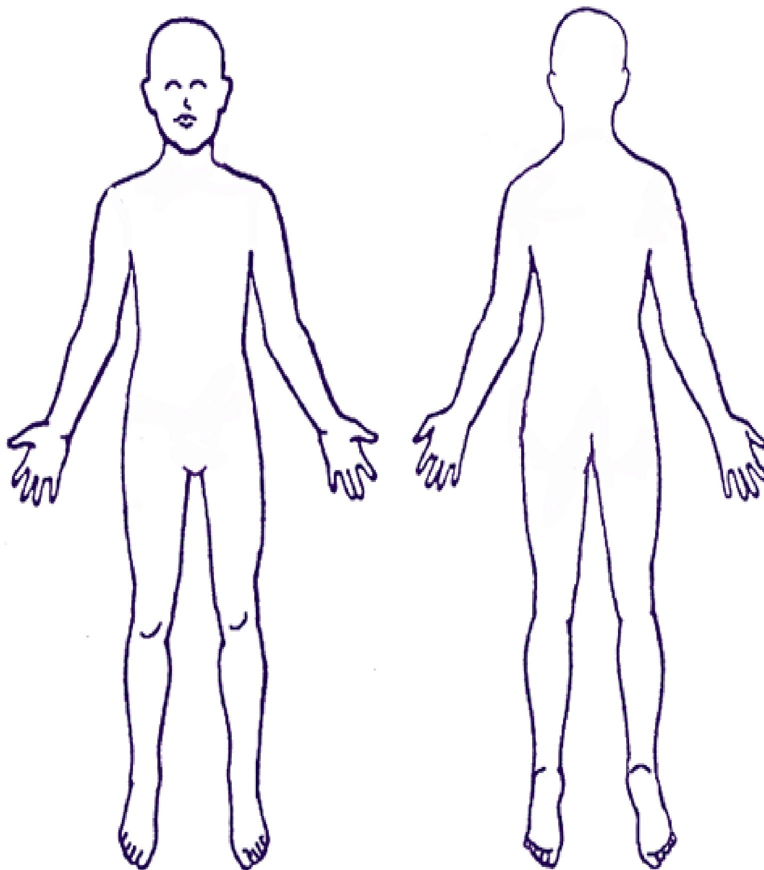
Mark XXXXX's where you have pain

I was injured by the following:

☐ Lifting
☐ Bending
☐ Falling
☐ Twisting
☐ Auto Accident
☐ Other (please specify)

If you have had to stop work because of your pain, complete the following:

____________________ last date of full duty
____________________ last date of light duty



My arm pain is:

☐ No arm pain
☐ Worse than my neck pain
☐ The same as my neck pain
☐ Not as bad as my neck pain

My leg (or hip/buttock) pain is:

☐ No leg pain
☐ Worse than my back pain
☐ The same as my back pain
☐ Not as bad as my back pain

CIRCLE THE NUMBER THAT BEST DESCRIBES THE INTENSITY OF YOUR PAIN

0	1	2	3	4	5	6	7	8	9	10
No Pain					Distressing Pain				Unbearable Pain	

CIRCLE THE WORD THAT BEST DESCRIBES HOW YOUR PAIN FEELS

Aching   Burning   Throbbing   Sharp   Dull