THOMASVILLE ORTHOPEDIC CENTER PC
100 MIMOSA DRIVE, SUITE 1R
THOMASVILLE, GA 31792
229-226-9141
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
_____	_____
Authorized Person	Relationship

_____	_____
Patient's Signature	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

Home Phone: (_____) _____-_____ **Work Phone**: (_____) _____-_____**Cell 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 Physician: _____

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.

Patient or Guardian Signature: _____ 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. Nusbickel-$200, Dr. Hancock-$500 & Dr. Walter-$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.

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.

Patient or Guardian Signature:_____ _____

Patient's Signature **Date**

Thomasville Orthopedic Center PC
Medical History/Accident Detail Form – Page 1 of 2

Patient's Name: _____ Date of birth:_____ Date: _____

Occupation:_____Height: _____ Weight: _____ Age: _____

Family Physician: _____ Address: _____

Referring Physician:_____Address:_____

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 contact name:_____Telephone #_____

Name of Insurance we are filing:_____

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: _____

Patient or Guardian Signature:_____ Date:_____

Thomasville Orthopedic Center PC

Patient's Name: _____ Date: _____

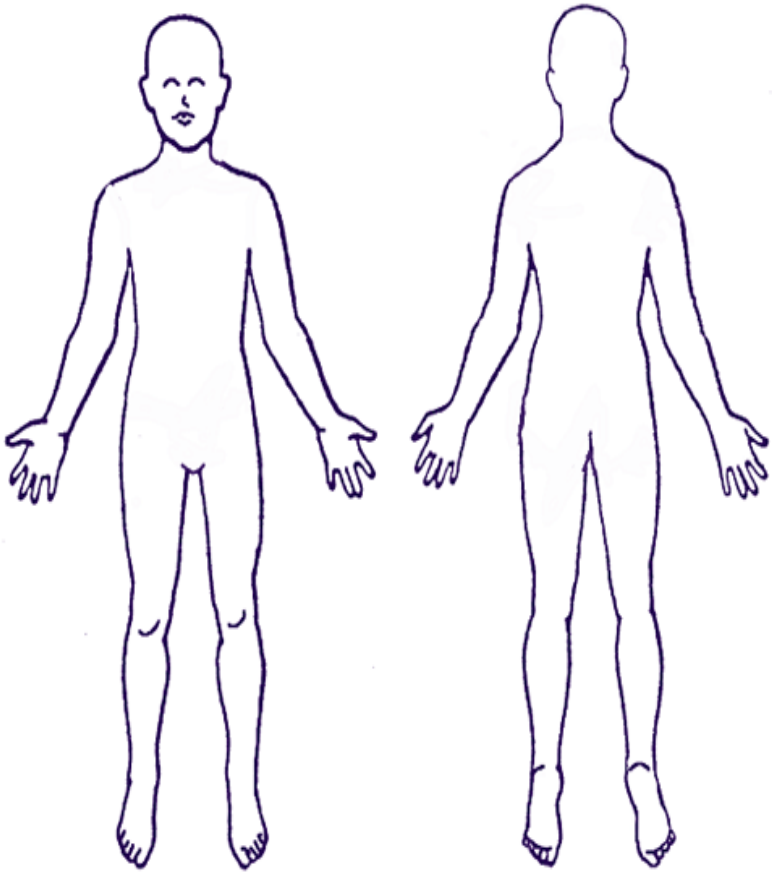
Check the correct statement:

- ☐ 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

THOMASVILLE ORTHOPEDIC CENTER, PC

E-PRESCRIBING CONSENT FORM

Thomasville Orthopedic Center, PC has implemented E-Prescribing in each of our offices.

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.

Patient name (printed):_____Date of birth:_____

Signature of patient (or representative):_____

Date:_____ Relationship, if other than patient:_____