alabama orthopaedic surgeons

PATIENT INFORMATION

Patient Name ______________________ Date of Birth: ______________

Address ____

City ____________________ State ______________ Zip ____________

Home Phone ____________________ Cell Phone ____________________

Marital Status: Single Married Divorced Widowed Child Gender: Male Female

Social Security # __________________ Race ______________

Email ____

Employer ____________________ Work Phone ____________________

Emergency Contact ________________ Phone ______________ Relationship ____________

PHARMACY ______________ Location ______________ Phone ____________

PRIMARY INSURANCE	SECONDARY INSURANCE
COMPANY ______________	COMPANY ______________
CONTRACT# ______________	CONTRACT# ______________
GROUP# ______________	GROUP# ______________
INSURED'S NAME ______________	INSURED'S NAME ______________
INSURED DOB ______________	INSURED DOB ______________
RELATIONSHIP TO PATIENT ______________	RELATIONSHIP TO PATIENT ______________

INSURANCE REFERRALS AND FINANCIAL RESPONSIBLITY

I understand that if my insurance should require a referral to see the doctor today or at any time during my treatment, it is my responsibility to provide your office with the referral. If my insurance company denies payment due to not obtaining a referral from my primary care doctor, I agree to pay Alabama Orthopaedic Surgeons in full for any charges incurred during my visit.

I hereby authorize Alabama Orthopaedic Surgeons to furnish any information concerning my medical condition, treatment, and prognosis to my insurance carriers and other treatment physicians. I hereby assign Alabama Orthopaedic Surgeons all payments for medical and/or surgical services rendered to me or my dependents due or received by third-party providers. I agree to be responsible for any amount not covered by my insurance or other providers. I hereby waiver all rights of exemption under the U.S. and Alabama Constitutions and the laws of the State of Alabama.

I agree to pay all costs of collection including a reasonable attorney's fee (should this account be placed with an attorney for collection), and interest on the unpaid balance to be determined by our collection agency. I agree to pay up to 33% of the unpaid balance for collection costs, or alternatively the maximum lawful fee, at such time my account is placed with a collection agency. I further understand that in the event the account is referred to an attorney for collection, I agree to be liable for such additional reasonable court costs and attorney's fees as may be determined by a court.

I hereby assign to Alabama Orthopaedic Surgeons- Insurance or other third-party benefits available for health care services provided to me. I understand that Alabama Orthopaedic Surgeons has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Alabama Orthopaedic Surgeons I agree to forward to Alabama Orthopaedic Surgeons all health insurance and other third-party payments I receive for services rendered to me immediately upon receipt. I authorize treatment by Alabama Orthopaedic Surgeons.

SIGNATURE OF PATIENT/LEGAL GUARDIAN ______________________________ Date ______________

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Medical History

Date__________________________

Name:____ Date of Birth: ______________________

Primary Care Physician: ____________________________ Who Referred you?_____________________________

Marital Status: M S D W Number of Children __________ Occupation:_____________________________

Hand Dominance: Right Left Height:____________________ Weight:___________________________

Are you allergic to any medication? Yes No If yes, please list: ___________________________________

____

Are you allergic to? Latex Iodine Tape List any other allergies:____

PLEASE FILL IN EACH OF THE FOLLOWING SECTIONS – (USE BACK OF SHEET IF NEEDED)

PRESCRIBED MEDICATIONS	Milligrams	CURRENT MEDICAL CONDITIONS (ex. Diabetes, High Blood Pressure)	SURGICAL HISTORY (Include year)
1		1.	1.
2.		2.	2.
3.		3.	3.
4.		4.	4.
5.		5.	5.

Hospital Admissions (non surgical):____

Do you use Tobacco products? Yes No If so how much per day_____________________________

Do you drink alcohol? Yes No If so, how much per week____________________________________

Are you currently pregnant, or any possibilities you may be so? Yes No

Do you have any Mechanical/Magnetic/Electrical Implants? Yes No Please List:______________________

GENERAL MEDICAL HISTORY – PLEASE CHECK ALL CONDITIONS THAT APPLY

Vision/Eye Problems____	Weight Loss____	**Cardiac Pacemaker____**	**Cardiac Defibrillator___**
Migraines____	Blood in Stool____	Shortness of Breath____	Arthritis____
Epilepsy____	Thyroid Disease____	Wheezing____	AIDS____
Dizziness____	Blood in Urine____	Pneumonia____	Cancer____
Blood Clots____	Skin Rash____	Stroke____	Depression____
Tuberculosis____	Hearing Loss____	High Blood Pressure____	Anxiety____
Heart Attack____	Irregular Heartbeat____	Swelling Feet/ Ankles____	Gout____
Diabetes____	Kidney Stones____	Vomiting of Blood____	Numbness____

Family History: Please circle any that apply: High Blood Pressure Heart Disease Cancer Diabetes

Anesthetic Complications Other____

Today's Visit: Length of Symptoms____________ Have you had similar symptoms before?___________

Where is your Pain? ____

Have you seen another doctor for this problem? Yes No If yes, Who?__________________________

Did you have an accident or injury? Yes No If yes, date of injury:____________________________

Where did the accident occur? __________________________________(ex: home, work, car accident, etc.)

Physician Signature:______________________________________ Date____________________________

52 Medical Park Suite 220 Birmingham, AL 35235 Office: 205-838-4747 Fax: 205-838-2712

Donald Slappey Jr. M.D. * F. Spain Hodges M.D. * Jason Cobb M.D.
Timothy Cool M.D. * Jerry Ambrosia M.D

Patient Name : ____________________________ **Date :** ___________________

DOB : ________________

Narcotic Pain Medication Policy

Narcotic pain medications have the ability to become addictive. This policy was developed concerning narcotic pain medications because we are concerned about patient's health.

ATTENTION: Due to DEA ruling effective October 6, 2014, ALL drugs containing hydrocodone will require a **WRITTEN** prescription. NO PHONING IN OR FAXING WILL BE PERMITTED.

Your provider is under no obligation to provide any medications to you and he reserves the right to discontinue these medications at any time.

Please discuss your need for narcotic pain medications with your physician during **YOUR OFFICE VISIT**. Failure to do so will result in a delay of up to 48 hours.

1. Narcotic pain medication is not ordered for seeking second opinions.

2. If narcotic pain medication is ordered by your physician during your office visit, pre-operative or post-operative patients, the dosage will be tapered under the physician's direction**. If the patient is in need of narcotic pain medication after 3 months of being treated by the physician we will refer the patient to Pain Management or Primary Care Physician.** Patient experiencing pain may be referred to **ONE** Pain Management Clinic at the physician's discretion. **Once you are referred to a Pain Management Clinic or back to your Primary Physician, our office will no longer prescribe pain medications**.

3. If narcotic pain medications are prescribed by our physicians, you agree that our office will SOLELY manage those narcotic pain medications; in other words, you agree NOT to take narcotic pain medications prescribed by other physicians.

4. You agree to take the narcotic pain medication only as prescribed and you will not alter the dose unless changed by your physician. **Medication will not be filled early for any reason.**

5. Narcotic pain medication should be kept in a safe place. NO medications that are lost or stolen will be replaced.

6. You agree NOT to drive a motor vehicle or operate heavy machinery while taking narcotic pain medication. Also, you agree NOT to use alcohol or recreational drugs while taking any narcotic pain medications.

7. Improper use of narcotic pain medications can lead to termination of physician-patient relationship.

8. Medication will only be renewed from **8:30 a.m. – 4:00 p.m. Monday – Thursday and 8:30 a.m.- 11:00 a.m. Friday.** No pain medications will be issued during evenings, after-hours, weekends, or holidays.

9. 48 hours must be allowed for narcotic pain medications to be written as your prescribing physician is not always in the office. Please plan to pick up your prescription at our office personally or by someone listed on your HIPPA form.

Patient Signature: ____________________________ Date: _________________________

RELEASE OF MEDICAL INFORMATION

Name____ Date of Birth_________________

I, hereby authorize Alabama Orthopaedic Surgeons, to furnish all information concerning my medical conditions, treatment, prognosis, test results, and appointment dates and times to the following individuals:

Name___________________________Phone_____________________Relationship____________

Name___________________________Phone_____________________Relationship____________

Name___________________________Phone_____________________Relationship____________

*I do not want my medical information released to anyone________________ (initial if applies)

Signature of Patient/Legal Guardian ____

Date______________________________

OFFICE CHARGES FOR RELEASE OF MEDICAL INFORMATION

FORMS: $25.00 fee (per form) and a 7-10 business day completion time.

X-RAYS: $10.00 fee per CD.

CHART NOTES OR OTHER RECORDS: $15.00 fee

NON-CANCELLATION OF SCHEDULED APPOINTMENTS $25.00 fee

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PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For instance, results of laboratory tests and procedures kept in your medical record will be available to all health professionals who may provide treatment to you or who may be consulted by staff members relating to your care.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information regarding dates of service, the services provided, and the medical conditions being treated.

Health Care Operations. Your health information may be used as necessary to support the day-to-day activities andmanagement of Alabama Orthopaedic Surgeons. Budgeting and financial reporting are examples of such usage.

Law Enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

Public Health Reporting. Your health information may be disclosed to public health agencies as required by law. For instance, we are required to report certain communicable diseases to the state's public health department.

Research. We may access your health information for research purposes; this may include Institutional Review, Board-approved and regulated clinical studies as well as retrospective reviews of patient outcomes.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you wish to change a previous authorization, you may to do so by submitting to our office a written revocation of that previous authorization. Please be aware that your decision to revoke the previous authorization will not affect or undo any prior use or disclosure of information associated with the initial authorization.

Additional uses of information: Appointment reminders. Our staff will use your health information to remindyou of pending appointments.

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition or on other health-related goods and services that you find to be of interest.

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of the above described Notice of Privacy Practice form, and I understand the rights of privacy as afforded me therein. Furthermore, I understand that reserves the right to modify the privacy practices outlined in the notice.

______________________________	______________________________
Name of Patient (Print)	**Date of Birth**
______________________________	______________________________
Signature of Patient	**Date**
______________________________	______________________________
Signature of Legal Guardian	**Relationship**