*Board-Certified, Sports Trained Orthopedic Surgeon * Specializing in General Orthopedics and Sports Medicine*

Basic Patient Demographics

Last Name: ________________________________ First Name: ____
Middle Name: ______________________________ Birthdate: _____________________ Sex: ___________________
Preferred Language: ________________ Race: ___________________________________ Marital Status: ________
Social Security Number: _________________ Ethnicity: Non-Hispanic / Hispanic

Home #: __________________________ Work #: _______________________ Cell #: ________________________
Email Address: ____
(By giving your email address and cell number, you consent to email and text communications from our office.)

Address: Street: ____
City: ______________________ State: ______________________ Zip Code: ___________________
County: ____

Person/Parent Responsible for the account (other than the patient)

Relationship: __________________________________
Last Name: ___________________________________ First Name: ______________________________
DOB: ____________ SS#: _______________________ Contact Info Same as Patient: Yes / No Address:
_________________________________ City: ________________ State: __________ Zip: ___________
Home #: __________________________ Work #: _______________________ Cell #: ______________________
Email: ____

Additional Providers

Referring Provider: ____
Primary Care Provider: ____

Insurance Information

PLEASE COMPLETE AND SUPPLY A COPY OF YOUR CARD(S)

Primary Insurance: ___________________________________ Policy#: ______________________________
Name of Insured: _____________________________________ Relationship to Patient: _________________
Birthdate: _________________ SSN: _____________________ Driver's Lic #: _________________________
Is this a Medicare Plan? Yes / No Is this a Marketplace Plan? Yes / No
Are you under Hospice Care? Yes / No
Are you currently a resident in a Nursing Home? Yes / No, If Yes, Where? ___________________________________

Secondary Insurance: ___________________________________ Policy#: ______________________________
Name of Insured: _____________________________________ Relationship to Patient: _________________
Birthdate: _________________ SSN: _____________________ Driver's Lic #: _________________________

Worker's Compensation Information

[ ] **NO,** I am NOT here due to a work-related injury.
[ ] **YES** , I am here for a work injury and have reported this to my employer. My employer has sent the appropriate authorization for treatment. If you choose this option, your medical insurance will NOT be filed.
My Employer Is ___________________________________ Phone: _____________________________

X ____ DATE: ______________________________
(SIGNATURE OF PATIENT (18 YEARS OR OLDER)/LEGAL GUARDIAN)

3301 First Street East, Suite A • Vidalia, Georgia 30474
(912) 537-4411 • Fax (912) 538-8485

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Patient Name: ____ Birthdate: __________________________

PATIENT HIPAA FORM

I hereby authorize Spivey Orthopedic Clinic to share my personal health information with:

[ ]NO ONE other than myself and those required by law.

[ ]My Spouse: ____

[ ]My Parent(s): ____

[ ]My Children: ____

[ ]My Friend: ____

[ ]Other: ____

X ____ DATE: ___________________________________
(SIGNATURE OF PATIENT (18 YEARS OR OLDER)/LEGAL GUARDIAN)

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Patient Name: ____ Birthdate: __________________________

ACKNOWLEDGEMENT OF LEGAL AGE OR GUARDIANSHIP

Signing below acknowledges that you are of legal age (18 years or older) or the legal guardian. If you are not 18 or older, or the legal guardian, do not sign this consent and see the front staff immediately

X ____ DATE: ____________________________________
(SIGNATURE OF PATIENT (18 YEARS OR OLDER)/LEGAL GUARDIAN)

____
(PRINTED NAME)

*Board-Certified, Sports Trained Orthopedic Surgeon * Specializing in General Orthopedics and Sports Medicine*

Patient Name: ____ Birthdate: _____________________________

SURESCRIPT CONSENT

I authorize Mark Spivey Orthopedic Clinic, LLC to import my medication history from the SureScript Directory.

X ____ DATE: ______________________________________
(SIGNATURE OF PATIENT (18 YEARS OR OLDER)/LEGAL GUARDIAN)

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Patient Name: ____ Birthdate: ____________________________

NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment, and healthcare operations. Treatment means providing, coordinating, or managing healthcare and related services by one or more healthcare providers. An example of this would include a physical examination. Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment. Healthcare operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review. We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer: The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we agree to a restriction, we must abide by it unless you agree in writing to remove it. The right to reasonable request to receive confidential communications of protected health information from us by alternative means or at alternative locations. The right to inspect and copy your protected health information. The right to amend your protected health information. The right to receive an accounting of disclosures of protected health information. The right to obtain a paper copy of this notice from us upon request. We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of January 2004 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office. You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Right

X ____ DATE: ____________________________________
(SIGNATURE OF PATIENT (18 YEARS OR OLDER)/LEGAL GUARDIAN)

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Patient Name: ____ Birthdate: __________________________

FINANCIAL CONSENTS AND OFFICE POLICIES

MEDICATION REFILLS

I understand and agree that refills for all medications will only be filled during regular business hours when my complete medical records are available. Normal business hours are Monday thru Thursday, 8 am - 5 pm, and Friday, 8 am – 3 pm. Refill requests should be called in before 3:00 pm, Monday thru Thursday, and before noon on Fridays.

PAYMENT POLICY

The doctor(s) and staff of Mark Spivey Orthopedic Clinic are committed to providing our patients with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. To achieve this, we need your assistance and understanding of our payment policy. All services are provided on a fee-for-service basis unless you are associated with a managed care plan. In the case of a managed care plan, you will be required to pay your co-pay only. Payments for office visits, insurance co-pays, and deductibles are expected when the service is rendered. We accept cash, personal checks, and/or credit cards.

AUTO ACCIDENTS / OTHER ACCIDENTS

When your injuries are the result of an accident and an attorney will be handling your case in court or another party's insurance company is presumed responsible for your charges, the patient is still responsible for payment of the bill. Mark Spivey Orthopedic Clinic cannot be expected to wait for the conclusion of long-term court cases or the settlement of a disputed insurance claim before being paid.

WORKER'S COMPENSATION

Patients who are injured on the job should report the injury directly to their employer. The employer will be responsible for directing the employee to a doctor who is listed on the PANEL OF PHYSICIANS. Before we will be able to see you as a patient, we will require you to fax or bring in a letter verifying that your employer will be responsible for the charges. If a patient comes in for a visit without this information, we will have to reschedule the appointment. This information is necessary to avoid the patient being responsible for the bill.

MEDICAID

Please bring a copy of your Medicaid card to each visit; otherwise, we will have to bill you directly. You will be responsible for all services not covered by Medicaid. This will include certain supplies and any office visits made after your twelve (12) authorized visits.

INSURANCE

Your Insurance coverage is a contract between you and your insurance company. As a courtesy, we will file your office and surgery charges and all Medicare services with your insurance carrier. You may be requested to pre-pay your unmet deductible and co-insurance before any surgery performed or following emergency services You will continue to receive a monthly statement even though your insurance is pending. Spivey Orthopedic Clinic cannot accept the sole responsibility for collecting your claim or negotiating a settlement on a disputed claim since we are not a party to your insurance contract. If you have a question regarding your account or the filing of your insurance, call Spivey Orthopedic Clinic and ask for the Insurance Department. We will be happy to assist you. If you need to set up an extended payment arrangement, contact our Insurance Department. If payment has yet to be received after 90 days from the date the services are rendered, necessary collections procedures will begin. If your insurance sends payment for services to you instead of our office, you acknowledge that payment and remittance are due to the office or the full balance becomes the guarantor's responsibility.

CONSENT FOR TREATMENT

I, the undersigned, do voluntarily consent to receive treatment, medications, and /or procedures as prescribed by the group, Mark Spivey Orthopedic Clinic, LLC, and its designated assistants for the prescribed course of diagnosis and treatment of my illness/injury. I also understand that a parent or legal guardian must be present for the treatment of minors (under the age of 18).

AUTHORIZATION FOR SERVICES

The signature below serves as authorization for services rendered by Mark Spivey Orthopedic Clinic for the above-named patient, and release of information for payment of services, treatments, and/or operational purposes; and assigns benefits otherwise payable to the policyholder to be made payable directly to Mark Spivey Orthopedic Clinic, LLC. I understand I am financially responsible for any balances not covered by the insurance carrier-a copy of the signature is as valid as the original.

AUTHORIZATION FOR THE RELEASE OF INFORMATION

The signature below serves as authorization for Mark Spivey Orthopedic Clinic to release or receive medical information for patient referral. A copy of this signature is as valid as the original.

X ____ DATE: ____________________________________

(SIGNATURE OF PATIENT (18 YEARS OR OLDER)/LEGAL GUARDIAN)

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Patient Name: ____ Birthdate: _____________________________

NO-SHOW POLICY AND FEES

Our office has a strict no-show policy. You are sent reminders via the numbers/emails supplied on your demographic paperwork. This notice informs you that if you can't keep your appointment and choose not to contact the office to cancel it, you will be charged a fee. For office visits, a fee of $50.00 is due prior to your next appointment. For surgery, where notice is not given within 7 days of surgery, a fee of $250.00 will be charged.

X ____ DATE: ______________________________________
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Patient Name: ____ Birthdate: ____________________________

PAST MEDICAL HISTORY (Not Orthopedic Related)

o Anxiety	o Asthma	o Atrial Fibrillation
o Bipolar Disorder	o Chronic Anemia	o Chronic Obstructive Lung
o DiseaseChronic Pain	o Coronary Arteriosclerosis	o Deep Venous Thrombosis
o Depression	o Diabetic On Insulin	o Disease Caused by 2019-nCoV
o End-Stage Renal Disease	o Epilepsy	o Hypertension
o Gastroesophageal Reflux	o Hyperparathyroidism	o Hx of Radiation Therapy
o HIV	o Hypercholesterolemia	o Hyperthyroidism
o Hypothyroidism	o Inflammatory Disease of the Liver	o Ischemic Heart Disease
o Leukemia	o Malignant Lymphoma	o Morbid Obesity
o Obstructive Sleep Apnea	o Fibromyalgia Syndrome	o Pulmonary Embolism
o Type 2 Diabetes Mellitus	o Malignant Tumor of: oBreast oColon oLung oProstate	

Other:____

____

PAST SURGERIES (Not Orthopedic Related)

o Bypass of Stomach	o Coronary Artery Bypass	o Kidney Transplant
o Colostomy	o Colectomy	o Pancreatectomy
o Liver Excision	o Coronary Angioplasty	o Heart Valve Replacement
o Heart Transplant	o Liver Transplant	o Low Anterior Rectum Resection
o Mechanical Heart Valve Replacement		o Mastectomy: o Left o Right o Bilateral

Other:____

____

MUSCULOSKELETAL DISEASE (Orthopedic Related)

o Ankylosing Spondylitis	o Bursitis	o Chronic Low Back Pain
o Rheumatoid Arthritis	o Compression Fracture	o Osteoarthritis
o Osteoporosis	o Idiopathic Scoliosis	o Malignant Neoplasm of Bone
o Gout	o Prolapsed Cervical Disc	o Prolapsed Lumbar Disc
o Psoriasis w/ Arthropathy	o Rickets	o Sarcoma of Bone
o Sciatica	o Cervical Spinal Stenosis	o Lumbar Spinal Stenosis
o Vitamin D Deficiency	o Osteopenia	o Vertebral Epidural Steroid Injection

o Adhesive Capsulitis of Shoulder	o Right	o Left
o Carpal Tunnel Syndrome	o Right	o Left
o Shoulder Impingement	o Right	o Left

Fracture of: List Body Part and Side:: ____

Other:

____

____

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MUSCULOSKELETAL SURGICAL HISTORY (Orthopedic Related)

oRight o Left oBilateral: ______________________________

oRight o Left oBilateral: ______________________________

oRight o Left oBilateral: ______________________________

oRight o Left oBilateral: ______________________________

MUSCULOSKELETAL FAMILY HISTORY

o Diabetes o Hypertension o Multiple Hereditary Exostosis
o Osteoarthritis o Osteoporosis o Scoliosis
Other:

____

CURRENT MEDICATIONS / SURESCRIPT CONSENT

I consent for Spivey Orthopedic Clinic to import my medication list from Surescript.

__________**(Initial/Date)**

If you do not consent to the above statement, list your Medication Name(s) and Dosage Below:

____

____

ALLERGIES

List all allergies below.

____

____

SOCIAL HISTORY

What is your smoking status? o Never o Former o Heavy o Light
Do you consume alcohol? oNone o Less than 1/day o1-2 per day o3+ per day
Do you use recreational drugs? o Yes oNo

FAMILY HISTORY

o Diabetes o Heart Disease o Hypertension o Bleeding Problems
o Epilepsy o Connective Tissue o Muscular Dystrophy o Stroke
o Cancer o Osteoporosis o Rheumatoid Arthritis
Other:

____

X ______________________________ DATE: ______________________________
(SIGNATURE OF PATIENT/LEGAL GUARDIAN)

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