

Patient Name _____ Date _____
 Street _____ City _____ State _____ Zip _____
 Phone Numbers: Home(_____) _____ Work(_____) _____ Cell (_____) _____
 Email: _____@_____ Other Contact: _____
 SS# _____ Sex _____ Date Of Birth _____ Age _____ Marital Status _____
 Date Of Injury _____ Was The Injury Work Related? _____ Auto Accident? _____
 Significant Medical Problems (Diabetes, Cancer, Heart/Lung Disease) _____
 _____ Last Menstrual Period _____ Drug Allergies _____
 Employer _____ Address _____
 Name Of Spouse _____ Spouse Work Phone(_____) _____
 Relative Or Friend _____ Phone(_____) _____
 Primary Care Provider (PCP) _____ Referred By _____

INSURANCE INFORMATION

#1 Primary Insurance:

Insurance Company _____ Phone _____
 ID# _____ Group # _____
 Insured's Name _____ Insured's DOB _____
 Relationship To Patient _____ Insured's SS# _____

#2 Secondary Insurance:

Insurance Company _____ Phone _____
 ID# _____ Group # _____
 Insured's Name _____ Insured's DOB _____
 Relationship To Patient _____ Insured's SS# _____

AUTHORIZATION

I authorize North Dekalb Orthopedics, PC to secure medical information from other providers and to release medical information to insurers (including Medicare if appropriate) and other physicians. I authorize these to be faxed. I also authorize North Dekalb Orthopedics, PC to release medical and insurance information to outside agents used to assist in diagnosis and treatment. I understand these may be faxed.

I further authorize the physicians treating me to perform basic office procedures such as manipulations, casting, taking X-rays and performing injections as they are discussed by me. I authorize the use of my verbal consent in leu of a written consent for these procedures, which have been explained to me.

I also authorize benefits to be paid directly to North Dekalb Orthopedics, PC on my behalf. I understand I am financially responsible for any balance not covered by my insurance. A copy of this signature is as valid as the original.

I also understand that it is my responsibility to make sure that my referral is accurate, and denial of payment because of my not obtaining this will result in my being personally responsible for the charges incurred.

I also understand that it is my responsibility to make sure that insurance information provided is accurate and up to date. If it is not, I will assume responsibility for charges that are denied because of not filing to the right place in a timely fashion.

Patient Signature _____ Date _____



Paul F. Richin, MD
Robert S. Bachner, MD
Damien A. Doute', MD
Mark W. Feeman, DO

Patient Name: _____ SS#: _____

Address: _____

Insured's Name: _____ SS#: _____

INJURY INFORMATION

Briefly **describe your injury**. If this is not a specific injury, please tell us **how long you have been experiencing pain**.

Where did the injury occur? _____

Was this **Work Related**? Yes No

Auto Accident? Yes No

When did the injury occur? **Date:** _____ **Time:** _____

I authorize North Dekalb Orthopedics, PC to release accident information to insurers if necessary to determine benefits payable. This information may be faxed if necessary. A copy of this signature is as valid as the original.

Signature: _____ **Date:** _____



Paul F. Richin, MD
 Robert S. Bachner, MD
 Damien A. Doute', MD
 Mark W. Feeman, DO

COMPLETE MEDICAL HISTORY

Name: _____ Date: _____

Date of Birth: _____ Age: _____

Occupation (If student, name of school): _____

Referring Physician: _____

Please describe your main problem : _____

How long has this been present? _____

Is this the first time you have had such a problem? _____

Other problems you wish to discuss? _____

Do you consider your **general health** to be (Check one): Excellent Good Fair Poor

Are you: Right handed Left handed

Do you consider yourself **disabled**? Yes No

List, in order by date, **previous surgeries** you have had and doctors. Include tonsils and appendectomy.

| DATE: | SURGERY: | REASON: | DOCTOR: |
|-------|----------|---------|---------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Have you had any **hospitalizations** for non-surgical conditions? If so, when? _____

Do you, or have you ever had, any of the following? Check all that apply.

- | | | |
|---|---|---|
| <input type="checkbox"/> Arthritis, bursitis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Strokes |
| <input type="checkbox"/> Bled excessively after surgery/ injury | <input type="checkbox"/> Hayfever | <input type="checkbox"/> T.I.A. |
| <input type="checkbox"/> Cancer (please list below) | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Gall bladder trouble |
| <input type="checkbox"/> Diabetes (Sugar) | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Epilepsy or seizures | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Hepatitis or yellow jaundice |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Leukemia | <input type="checkbox"/> Pulmonary Embolism | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Kidney stone |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Ulcer (Peptic or gastric) |
| <input type="checkbox"/> Scarlet fever | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Treatment for psychiatric/depression | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Deformity of any body part |
| <input type="checkbox"/> Tumor, Growth, or cyst | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Loss of any part of arm or leg |
- Childhood Diseases:**
- | | | | |
|--------------------------------------|----------------------------------|--------------------------------|----------------------------------|
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Measles | <input type="checkbox"/> Mumps | <input type="checkbox"/> Rubella |
|--------------------------------------|----------------------------------|--------------------------------|----------------------------------|

List any **other illnesses** you have had and **date** them. _____

List **accidents** of any kind that you have had and **date** them. _____

Do you **exercise** on a regular basis? Yes No If yes, How often? _____
 How much **tobacco** do you smoke or use? _____
 How much **alcohol** do you consume? _____

What **medications** are you taking (including over the counter)? Please give **dosages** (how much, how often).

Do you have history of **drug abuse**? Yes No
 Have you ever been on **Prednisone**? Yes No **Coumadin**? Yes No
 Please list any **drug allergies** and how they affect you. _____

Are you on a special **diet**? If so, what kind? Also, list any **food sensitivities**. _____

| | Living/Age | Deceased | Age and Cause of death |
|-----------------|------------|----------|------------------------|
| Father | | | |
| Mother | | | |
| Brothers | | | |
| | | | |
| | | | |
| Sisters | | | |
| | | | |
| | | | |

Has anyone in your family ever had any of the following? If yes, explain and give their present age.

Yes No

- Heart Disease
- High blood pressure
- Diabetes (Sugar)
- Kidney disease

Yes No

- Cancer If yes, what type? _____
- Bone or Muscle disease
- Died under anesthesia

In the **past six months**, have you had any of the following:

Yes No

- Weight Gain/Loss
- Frequent headaches
- Head injury
- Growth/lumps on head
- Loss of memory
- Ear, nose, throat trouble
- Ringing in ears
- Decreased hearing
- Eye trouble
- Stopped up nose (not colds)
- Nose bleeds
- Frequent colds
- Frequent sore throats
- Difficulty/pain swallowing
- Severe tooth/gum trouble

Yes No

- Shortness of breath
- Chest pain
- Had an abnormal EKG
- Chronic cough
- Coughed up blood
- Pain on breathing
- Indigestion
- Jaundice
- Numbness
- Foot trouble
- Pain on urination
- Sugar/Albumin in urine
- Bloody/cloudy urine
- Frequent urination
- Recurrent back pain

Yes No

- Difficulty with bowels/bladder
- Change in bowel habits
- Frequent diarrhea
- Bloody bowel movements
- Black stools
- Vomited up blood
- Recurrent nausea/vomiting
- Stomach/liver/intestinal trouble
- Problems eating apples/cabbage
- Fatty food intolerance
- Intolerance of spicy food
- Black-outs/Unconsciousness
- Depression/excessive worry
- Painful/Red/Swollen joints
- Weakness/Pain in muscles/joints

OFFICE USE ONLY

| | | | | |
|---------------------|---------------------------|--------------------|---------------------------|--------------------|
| Height: _____ | Reviewed By: _____ | Date: _____ | Reviewed By: _____ | Date: _____ |
| Weight: _____ | _____ | _____ | _____ | _____ |
| Respirations: _____ | _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ | _____ |



Paul F. Richin, MD
Robert S. Bachner, MD
Damien A. Doute', MD
Mark W. Feeman, DO

EFFECTIVE DATE OF THIS NOTICE: 8/15/2006

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your **Individually Identifiable Health Information (IIHI)**. In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your **IIHI**. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your **IIHI**
- Your privacy rights in your **IIHI**
- Our obligations concerning the use and disclosure of your **IIHI**

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.



Paul F. Richin, MD
Robert S. Bachner, MD
Damien A. Doute', MD
Mark W. Feeman, DO

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Privacy Official
505 Irvin Court
Suite 220
Decatur, GA 30030
404-294-4111

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your **IIHI**.

- 1. Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.
- 2. Payment.** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.
- 3. Health Care Operations.** Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.
- 4. Appointment Reminders.** Our practice may use and disclose your IIHI to contact you and remind you of an appointment.
- 5. Treatment Options.** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.
- 6. Health-Related Benefits and Services.** Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

7. Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

8. Disclosures Required By Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when an Institutional Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

8. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your IIHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI

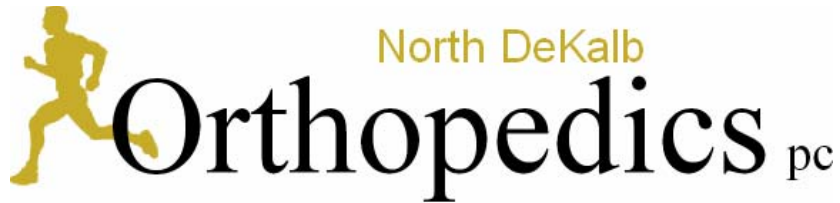
You have the following rights regarding the IIHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Privacy Official 404-294-4111** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to **Privacy Official 404-294-4111**. Your request must describe in a clear and concise fashion:

- (a) the information you wish restricted;
- (b) whether you are requesting to limit our practice's use, disclosure or both; and
- (c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **Privacy Official 404-294-4111** in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.



Paul F. Richin, MD
Robert S. Bachner, MD
Damien A. Doute', MD
Mark W. Feeman, DO

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to **Privacy Official 404-294-4111**. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

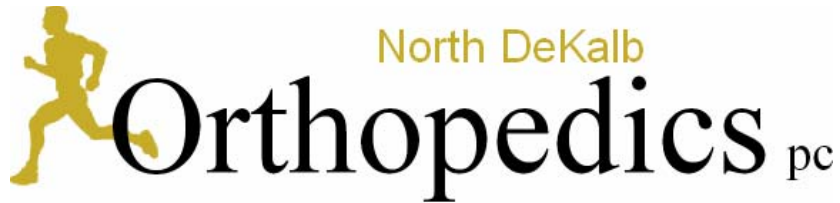
5. Accounting of Disclosures. All of our patients have the right to request an “accounting of disclosures.” An “accounting of disclosures” is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment, non-payment or non-operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to **Privacy Official 404-294-4111**. All requests for an “accounting of disclosures” must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **Privacy Official 404-294-4111**.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **Privacy Official 404-294-4111**. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact **Privacy Official 404-294-4111**



Paul F. Richin, MD
Robert S. Bachner, MD
Damien A. Doute', MD
Mark W. Feeman, DO

Please Sign and Bring THIS PAGE To The Office With You.

**RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM.**

I, _____, have read the Notice of Privacy Practices of
NORTH DEKALB ORTHOPEDICS, P.C.'S as provided me on their webpage and/or in the office.

Signature of Patient

Date



Paul F. Richin, MD
Robert S. Bachner, MD
Damien A. Doute', MD
Mark W. Feeman, DO

OUR FINANCIAL POLICY

To provide the best possible care to ALL our patients, we must work hard to keep our financial house in order. To achieve this goal, we would like to clarify the financial policy that governs our practice.

1. We share your concerns about the increasing costs of quality health care. Asking for payment at the time of service helps us to lower our expenses and keep down our costs. In order to keep patient accounts current, we require a copy of insurance information.
2. Our service are provided to patients, not insurance companies. Financial responsibility is yours. Regardless of insurance coverage. Health insurance is a contract between you and your insurance carrier to reimburse you for your covered medical services.
3. We do participate in several HMO's and PPO's. Patients affiliated with these companies may still be responsible for a co-payment and/or deductible at the time of their office visit.
4. Insurance coverage is determined by your contract with the company in which you are enrolled. Recipients of medical care are expected to pay for those services whether covered by insurance or not.
5. For certain services (i.e., procedures, hospitalizations) we will assist you by filing a claim on your behalf to your insurance company. Bills not paid by insurance remains the responsibility of the patient.

If you have any questions, our staff will be glad to assist you in finding the answers.

I understand the financial policy stated above and understand, as a patient I have certain obligations for my care.

Patient/Guardian Signature

Date



Paul F. Richin, MD
Robert S. Bachner, MD
Damien A. Doute', MD
Mark W. Feeman, DO

Nobody Likes To Wait...

We know that your time is important. That is why we do whatever we can to try to keep things running smoothly.

BUT, certain things can happen that can cause some minor or major delays. These include:

- 1) Your doctor may have to deal with an **emergency** (either in the office or at the hospital)
- 2) Your doctor may be **delayed in surgery** at the hospital. We try to work around this whenever possible, but we cannot always be sure how long a delay may be.
- 3) **Some orthopaedic problems may be more complicated** than expected. In these cases, the doctor must spend extra time to complete an exam, discuss an impending surgery, or deal with a fracture. For these occasions we ask you to put yourself in the shoes of the person who is being treated, and we know that you would expect the appropriate amount of "quality time" needed to take care of the orthopaedic problem to the best and fullest degree possible.
- 4) **Referrals and authorizations** sometimes need to be confirmed with your insurance company before services can be performed (or additional services performed). For this we need your patience - We are all just trying to work within a system that makes things difficult for us all...

What you can do?

- 1) **Be on time**, and up to 15 minutes early in order to go over paperwork and confirm that we have the most current information regarding your address and insurance information.
- 2) **Bring any outside X-Rays and MRI's** with you, plus a complete list of your **medications**
- 3) Make sure that you have an **updated Medical History** in our chart... These can be obtained off of our website and filled out in advance. If there are any changes in medicines or other medical problems, please let us know so that we can update your existing history in our chart.
- 4) **Please be understanding if an emergency occurs.**

Thank you for your understanding and patience. We strive to give all of our patients the time they need, but sometimes we can get somewhat behind schedule.

North DeKalb Orthopedics, PC.



Paul F. Richin, MD
Robert S. Bachner, MD
Damien A. Doute', MD
Mark W. Feeman, DO

Disability Forms:

While disabled from working, many of our patients ask our office to assist them in completion of special forms which cover credit cards, car payments, mortgage payments, and short or long term disability income.

- 1) You must allow for 1 week for completion of these forms.
- 2) The patient portion of the form must be completed and signed prior to us filling out the rest of the form.
- 3) If you can attach on a separate piece of paper the specific dates and answers to questions asked of us, this will help us in more accurately and efficiently completing your forms... Please work with us.
- 4) All forms must be accompanied by payment in cash of the amount requested.

Medications:

All calls made between the hours of 9AM and Noon, and 1:30 thru 3PM when the office is open will be handled on the same day.

We will try to address later calls on the same day, but after 3PM, we cannot promise that calls will be addressed until the next business day.

No refills will be called in over the weekend or at nighttime by the On Call Physician.

No refills will be done if we feel that you haven't seen your physician in a reasonable timespan, or if we are concerned about non-compliance with a prescribed treatment plan or abuse of medications.

I HAVE READ AND UNDERSTAND THE ABOVE DISABILITY FORMS AND MEDICATIONS POLICIES.

_____ date: _____
Signature (patient, parent, guardian)