PATIENT INFORMATION

Name _____, _____
(Last) (First) (Middle)
Mailing Address _____

City _____ State _____ Zip_____-_____

Sex: Male/Female (Please circle one) Employed: Yes/No (Please circle one)
Employers Name & Address _____

Occupation _____

Date of Birth _____ Social Security # _____

Telephone Numbers: Resident _____ Work _____ Cell _____

Marital Status: Single Married Separated Divorced Widow/Widower
(Please circle one)

BILLING INFORMATION

Person responsible for paying bill: Patient Parent Spouse Other_____
Name (if different from above) _____

Address (if different from above) _____

Residence Telephone _____ Work Telephone _____

Responsible Party Date of Birth: _____ Responsible Party Social Security #_____

Employers Name & Address _____

Occupation _____

INSURANCE INFORMATION

PRIMARY INSURANCE:

_____
Insurance Co. Name Address, City, State, Zip Code, Phone Number

_____ _____ _____ _____
Subscriber ID Number Group Number Policyholder's Name Social Security #

Patients relationship to insured (please circle one) Self Spouse Child Other

Date of Birth of Subscriber _____

SECONDARY INSURANCE:

_____
Insurance Co. Name Address, City, State, Zip Code, Phone Number

_____ _____ _____ _____
Subscriber ID Number Group Number Policyholder's Name Social Security #

Patients relationship to insured (please circle one) Self Spouse Child Other

Date of Birth of Subscriber _____

Person to contact in case of emergency
Name: _____

Address: _____

Phone Number: _____ Relationship _____

Was this an accident? Yes/No If so indicate: Auto ____ Workers Comp _____ Other _____

Referring Physician: _____

Email address: _____

PLEASE COMPLETE ALL INFORMATION ON BOTH SIDES OF THIS FORM

Financial Policy

We strongly feel all patients deserve the very best medical care that we can provide. Everyone benefits when financial arrangements are agreed upon. We have prepared this material to acquaint you with our policy.

Our professional services are rendered to you, not the insurance company. Payment for treatment is your responsibility.

Financial Agreements (PLEASE INITIAL)

_____ I have no insurance coverage. I understand that I am responsible for payment of services rendered to myself or dependents at the time of service.

_____ I understand if I fail to pay amounts owed, the clinic has the right to secure an outside collection agency and/or attorney to collect the unpaid debt and to report the unpaid debt to a credit-reporting agency. I further understand that I will be responsible for any additional charges or fees necessitated by securing the collection agency or attorney, including reasonable attorney's fees.

Insurance Authorization and Assignment

_____ I hereby authorize the release of any information necessary to process insurance claims and request payment of benefits to be made for services rendered to my dependents or myself.

_____ I understand I am responsible at the time of service for paying any required copayment.

_____ All charges are your responsibility whether your insurance company pays or not. If your insurance carrier does not remit payment for services rendered, you will be responsible for the balance.

Medicare/Medigap

For Medicare Patients Only

_____ I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Finance Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment.

Medigap Authorization Statement

_____ I authorize any holder of medical or the information about me to be released to process this Medigap claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to myself or to the party who accepts assignment.

There will be a $25.00 charge on all returned checks.

I have read and understand the payment policy of this office and agree to abide by the said policy.

_____ _____

Patient/Parent/Guardian Date

Please present both your insurance card and your driver's license so we may make a copy for our records.

Southampton Orthopaedic & Sports Medicine Center

Manish A. Patel, MD, FAAOS

Board Certified – American Board of Orthopaedic Surgeons
Assistant Professor of Clinical Orthopaedic Surgery EVMS
Arthroscopic Surgery – Sports Medicine – Joint Replacement

Phone: 757-562-7301 www.SouthamptonOrtho.com **Fax: 757-562-7305**

New Patient Complaint / Injury

First Name:_____ Last Name:_____ Today's Date:_____

Date of Birth: _____ Age: ____ Height:_____ Weight: _____ Sex: M or F

Please **Circle All** affected extremity: **Left** **Right** **Both**

Shoulder	Arm	Elbow	Forearm	Wrist	Hand	Finger
Hip	Thigh	Knee	Leg	Ankle	Foot	Toes

Is Your pain (Circle): Sharp Dull Throbbing Stabbing Burning Numbness **NONE**

How and When did this injury / problem begin? (**Be specific**)

Is your Pain? (Circle One) **Better** **Worse** **Same** compared to your initial pain.

What has helped? | What makes it worse?

Please rate your pain level Using 0 (None) to 10 (Severe) [**0 1 2 3 4 5 6 7 8 9 10**]

Review of Systems:

Musculoskeletal: **Circle** any that apply to you or **Circle NONE**

Fractures	Joint Swelling	Joint Infections	Locking
Stiffness	Night Time Pain	Instability	**NONE**

Constitutional: **Circle** any that apply to you or **Circle NONE**

Weight Gain	Weight Loss	Fever	Chills	Fatigue
Weakness	Night Sweats	Insomnia	**NONE**	

Is this a Work Related Injury? (Answer Must be Circled)	**YES**	**NO**
Was this related to a Motor Vehicle Accident?	**YES**	**NO**
Is there a LAWSUIT involved? (Answer Must be Circled)	**YES**	**NO**

Have you been treated previously for this problem? **YES** **NO**

Physician: _____ Hospital:_____ City:_____

Circle **ALL** previous testing for the **CURRENT** problem:

X-ray	Cat Scan	MRI	Physical Therapy	DVT Study
Injections	Surgery	EMG	Bone Scan	**NONE**

(PLEASE SIGN) Patient or Guardian Signature _____

Doctor / Provider Signature: _____

First Name: _____ Last Name: _____ Today's Date: _____

Who is your Family Doctor? _____

Please list the consulting Doctor? _____

Do you have any of the following medical conditions? (**Circle** all that apply or **NONE**)

High Blood Pressure	Kidney Disease	Hepatitis
Lung Disease	Asthma	Bleeding Disorder
Sickle Cell	Osteoporosis	Diabetes
Poor Healing	Reflux / Ulcers	Heart Disease / Problems
High Cholesterol	Thyroid Problems	HIV / AIDS
Rheumatoid Arthritis	Osteoarthritis	Gout
Cancer	**NONE**	Other: _____

Does anyone in your immediate family have any of the following medical conditions?

High Blood Pressure	Kidney Disease	Hepatitis
Lung Disease	Asthma	Bleeding Disorder
Sickle Cell	Osteoporosis	Diabetes
Poor Healing	Reflux / Ulcers	Heart Disease / Problems
High Cholesterol	Thyroid Problems	HIV / AIDS
Rheumatoid Arthritis	Osteoarthritis	Gout
Cancer	**NONE**	Other: _____

Please indicate which family member:_____

Please List **ALL** supplements / medications, dosages, and frequencies that you take or **NONE**:

_____

_____

Do you take any blood thinners? NO or YES (List if yes) _____

Please list **ALL** allergies: **NONE** or YES (if yes, list medication and type of reaction):

_____

Please list any and all previous surgeries or **NONE**. (Include date and surgeon):

_____

Do you drink Alcohol? ___No ___ YES(What / How Much / When)_____

Do you smoke?(Check one): ___ YES ___ Never ___ Quit more than 6 months ago

What Pharmacy do you use? _____ Which Location? _____

(PLEASE SIGN) Patient or Guardian Signature:_____

Doctor / Provider Signature: _____

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PERMISSION TO RELEASE HEALTH INFORMATION

Your health information is confidential. We are not permitted to disclose health information to anyone except you. If there is/are someone you would like to permit us to release your health information to, please indicate below.

Name Relationship

_____

_____

_____

_____

I authorize Southampton Orthopaedic & Sports Medicine Center to release my health information to the above listed individual(s). I understand that I have the right to revoke this authorization at any time.

_____

Patient Signature

Initial if okay to leave general/medical phones messages at home_____ work _____

210 Fairview Drive
Suite A.
Franklin, VA 23851

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DEEMED CONSENT

I understand that, in accordance with Section 32.1-45.1 of the Code of Virginia, 1905, as amended, if a Southampton Orthopaedic and Sports Medicine Center healthcare provider is exposed to my blood or other bodily fluids in a manner which may transmit disease, I may be tested for infection with Human Immunodeficiency Virus (HIV), the virus which causes Acquired Immune Deficiency Syndrome (AIDS) or Hepatitis B or C viruses. I further understand that the results of any such test will be shared with me and the exposed healthcare provider; that the Virginia Department of Health will be notified; and that the appropriate counseling shall be provided if the results are positive.

DISABILITY FORM INFORMATION

Southampton Orthopaedic and Sports Medicine Center staff will complete all disability and/or FMLA forms that you require, within two weeks of the date requested. We are unable to complete forms while you wait. We require all requests for completing and copying disability forms, medical records, or x-rays to be pre-paid.

PRESCRIPTION REFILL POLICY

To request a prescription refill, please call our office Monday through Friday from 8am – 430pm. Please allow 48 hours for us to process your prescription refill request. Prescriptions for narcotics cannot be faxed to the pharmacy and must be picked up from the office. Please remember to call us in advance so that we can assist you in a timely manner. Please do not attempt to contact us after hours with prescription refills/requests.

CANCELLATION POLICY

Please give a 24 hour notice when cancelling your appointment.

NO SHOW POLICY

Two (2) no shows will result in a $50.00 fee. Three (3) no shows will result in dismissal from practice.

DELINQUENT ACCOUNTS

All delinquent accounts must be paid in full prior to being seen by Dr. Patel.

FINANCIAL RESPONSIBILITY

Your insurance is your responsibility. We file claims as a courtesy to you. Therefore, if your insurance company denies your claim, you will be responsible for the bill or contacting the insurance company regarding any denials/discrepancies. If your insurance requires a copay, this must be paid prior to seeing Dr. Patel. Your appointment will be rescheduled if you do not have this copay.

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POLICY FOR FORMS COMPLETION AND COPYING OF NOTES AND X-RAYS

Disability and FMLA Forms: We will be happy to complete any disability or FMLA form you require. Please allow at least 2 weeks for the completion of these forms. A $15.00 pre-paid charge will apply.

Medical Record Copies: We will be happy to provide copies of your medical records at your request. These records will be released to you or your authorized agent. A Medical Records Release Form is required before this information can be released. Please allow 1 week for these records to be released. The following pre-paid charges will apply:

Base charge (chart retrieval, Copying, postage, and labor)	$15.00
Each Page	$ .50

X-Ray Film Copies: We will be happy to provide copies of any x-rays taken. Please allow 1 week for the release of these x-rays. The following prepaid charges will apply:

Charge per CD	$5.00

I have read and understand the above stated policy of Southampton Orthopaedic and Sports Medicine Center.

_____ _____

Signature of Patient Date

210 Fairview Drive
Suite A
Franklin, VA 23851

Electronic Prescribing Notice

What is electronic prescribing? Why does your provider E-Prescribe?
E-Prescriptions, or Electronic Prescriptions, are computer-generated prescriptions created by your provider and sent directly to your pharmacy. Your provider participates in E-prescribing because he/she cares about your health and wellbeing and E-prescribing has multiple safety benefits.

How does E-Prescribing work?
Instead of writing out your prescription on a piece of paper, your provider enters it directly into the computer. Your prescription travels from your provider's computer to the pharmacy's computer. E-prescriptions are sent electronically through a private, secure, and closed network, so your prescription information is not sent over the open Internet or as e-mail. Your e-prescription arrives at the pharmacist's computer faster and may help to save you time. The e-prescription can be sent to the pharmacy you choose. If you do not want your prescription sent electronically, or your pharmacy does not accept e-prescriptions, your provider can print your prescriptions for you.

Privacy
The privacy of your personal health information contained in all your prescriptions, whether written or electronic, is protected by a federal law and state laws. The federal law is the Health Insurance Portability and Accountability Act (HIPAA). HIPAA requires that your personal health information be shared for treatment, payment, and healthcare operations. E-prescriptions meet this requirement.

Southampton Orthopaedic & Sports Medicine Center

Patient Consent for E-Prescribing (Electronic Prescribing)

I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

Parent, Patient's Signature or Authorized Representative	Date	Time
Relationship to Patient	Interpreter, if utilized	
Witness' Signature		