



OrthoNC

PATIENT REGISTRATION FORM

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Social Security #: _____ Sex: ☐ M ☐ F

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Consent to call? ☐ Yes ☐ No Consent to text? ☐ Yes ☐ No

Marital Status: ☐ M ☐ S ☐ D ☐ Sep ☐ W Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Race: _____ Language: _____

How did you hear about us?

☐ My doctor referred me: If so, who is your doctor? _____

☐ Athletic team referral: If so, what school/team? _____

☐ Hospital ☐ Friend/Family Member ☐ Advertising ☐ Internet Search ☐ I was a former patient

☐ Insurance Company ☐ Other: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Employer: _____ Occupation: _____

Primary Care Physician: _____ Office: _____

First Name Last Name

Was this injury a result of a motor vehicle accident? ☐ Yes ☐ No Were you injured on the job? ☐ Yes ☐ No

GUARANTOR INFORMATION (IF PATIENT IS A MINOR)

Name: _____ DOB: _____ Patient's relationship to guarantor: _____

INSURANCE INFORMATION

Primary Insurance: _____ Secondary Insurance: _____

Policy holder's name: _____ DOB: _____ Relationship to patient: _____

CONSENT

I hereby consent to the necessary treatment for the care of the above named person for whom I am legally responsible. To promote better patient care, I give Orthopaedic Specialists of NC permission to retrieve my medication history.

Signature: _____ Date: _____



HIPAA Consent Form

Patient Name: _____ Date of Birth: _____

The patient or legal guardian has the right to review Orthopaedic Specialists of North Carolina’s (OrthoNC) Notice of Privacy Practices and gives permission to the facility to disclose the Protected Health Information (PHI), to the parties below. If no parties are listed, it will be understood that OrthoNC does not have authorization to release information to anyone other than the patient or legal guardian who signs the form.

Name	Relationship	Type of Info to disclose
		Medical Financial Other
		Medical Financial Other
		Medical Financial Other
		Medical Financial Other

By signing below, consent is given to OrthoNC to release medical records to referring providers, primary care physicians, or other providers required for treatment of the patient. Please keep in mind that if the person or entity receiving PHI is not a health care provider or health plan covered by federal privacy regulations, the PHI may be disclosed to other individuals or institutions and no longer protected by these regulations. The patient or legal guardian may inspect or copy the PHI information to be used or disclosed under this authorization. You may revoke or update this authorization in writing at any time by completing a new form or sending written notification to Orthopaedic Specialists of North Carolina. Your revocation or update will not apply to action taken by the requesting person/entity prior to the date any updates or revocations were made.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment.

Signature of Patient or Personal Representative

Date

Email Consent:
Standard email correspondence is not a secure means of communication. There is a risk that any PHI contained in standard email may be intercepted by or misdirected to unauthorized 3rd parties. By signing below, the patient or legal guardian acknowledges these potential risks and gives OrthoNC authorization to correspond via email as needed or as initiated by the patient. **As an alternative, patients may use or request access to our Patient Portal where messages may be sent and received in a secure environment.**

Signature of Patient or Personal Representative

Date



OrthoNC Financial Policies

Thank you for choosing Orthopaedic Specialists of North Carolina. We are committed to providing outstanding patient care to you and your family members. Before we provide medical services, we require that you review our financial policies and agree in writing to accept them.

Payment Required at Time of Service

Payment in full is required at the time of service. Any patient with a collections balance will be required to pay it in full prior to checking in for any scheduled appointment. All patients with balances 30 days or older will be required to pay in full and/or set up a payment plan prior to checking in for any scheduled appointment. This policy also applies to applicable estimated coinsurance/deductible and copayments under your health insurance policy, provided we are in-network with your plan. Additionally we require a credit card on file for high deductible plans, payment plans, and self pay patients. We accept cash, Discover, VISA, MasterCard, and Care Credit. We do not accept personal checks.

Policy for Handling Insurance

Our office participates with many health insurance plans. These are listed on our Website, www.orthonc.com. Because each plan is different, we may not have all the details of your insurance benefits. Some of your questions are best answered by a representative of your insurance company. If we are a network provider for your insurance plan, we will submit the claim on your behalf, provided the accurate information has been received in our office within 30 days of the date of service. When you come for your visit, please bring with you a current insurance ID card. If we don't have current insurance information, we automatically consider you a self-pay patient. After we have accurate information on your insurance eligibility and coverage, we will file a claim with your insurance company. If we are a participating provider with your insurance plan, both copayments and estimated co-insurance/deductibles are due at the time of service. If we are not a participating provider, you are responsible for paying the out-of-network rates at the time of service and filing the claim to your insurance. In some cases, we may provide you with an estimate for your service. Estimates may differ from the final amount owed once insurance processes your claim. You are responsible for any balance due created by the adjudication of the final claim.

Motor Vehicle Accident Policy

Please be informed that we do not bill third party automobile policies/insurances. There is no guarantee that these services will be paid by your health insurance. This is to notify you that if there is any delay in payment, or no payment received then you will be financially responsible for these services. Due to the nature of these claims, there could be a delay in receiving statements for these services.

Self Pay Policy

We offer a self pay rate for patients without insurance, utilizing our HealthME dashboard for these transactions. Payments for services will be made at the time of service via this platform. In the event you receive services that were rendered on the date of your visit and you did not pay at the time of service, you will be responsible for any balance owed, prior to being seen in follow up.

Delinquent Accounts

Patients with an **outstanding balance more than thirty (30) days old** must make arrangements for payment or pay in full prior to being seen for any scheduled appointments. If payment arrangements are not made and the account is more than ninety (90) days delinquent, the account may be turned over to a collections agency. Once the collections agency has your account, you are required to pay the agency directly. Your balance can be paid directly on our patient portal, over the phone, or in the office. If you wish to set up a payment plan please call our billing department at 919-562-9410 prior to your scheduled appointment. **If you have a collections account you will be required to pay your balance in full prior to being seen.**

Forms

We charge a **\$15 fee** for the completion of each form you ask us to complete on your behalf. Please allow 7-10 days for your form to be completed.

If the Patient is a Minor

An adult parent or guardian accompanying the minor is responsible for the payment of the patient's account regardless of who holds the insurance policy. Unaccompanied minors can be denied non-emergency treatment until a parent or guardian is present or until such time as we receive written permission for the treatment and payment of the account. Unaccompanied minors must provide all co-pays and other payments on the day of service.

Refunds

If an overpayment is made on your account, we will process refunds once a month. If your treatment is ongoing, at your request, we will apply the overpayment to any future balances.

Missed Appointments

If you need to cancel an office visit, please notify our office no less than 24 hours ahead of time so we can reschedule your appointment. If you are unexpectedly delayed, please call us so we can make arrangements for you to come at a later time or on a different day.

Surgeries and Procedures

All surgeries and in office procedures, including MRIs are required to pay prior to service or risk being rescheduled. A minimum of 72 hours' notice is required to cancel surgery without incurring a \$250 fee.

In signing below, you are permitting your insurance payer to remit payment directly to Orthopaedic Specialists of NC.

I UNDERSTAND AND AGREE TO THESE POLICIES.

Signature of Patient or Guardian

Date



PATIENT MEDICAL HISTORY

Name: _____ Date of Birth: _____
Referring Doctor: _____ Primary Care Physician: _____
Describe your complaints: _____

Medication Allergies/Sensitivities

Please list all allergies or sensitivities to medication and the reaction you have

Allergy	Reaction
_____	_____
_____	_____
_____	_____

Current Medications:

_____	_____
_____	_____
_____	_____

Social History

Please answer or circle all that apply

Are you currently employed? ☐ Yes ☐ No

Work Status: ☐ Full-Time ☐ Part-Time

Work related injury? ☐ Yes ☐ No

Auto related injury? ☐ Yes ☐ No

If injured, is litigation ongoing? ☐ Yes ☐ No

Case Manager: _____

Attorney: _____

Able to Care for Self:

☐ Yes ☐ No

Do you have difficulty walking or climbing stairs?

☐ Yes ☐ No

Do you have difficulty dressing or bathing?

☐ Yes ☐ No

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Sep ☐ Widow Home Status: ☐ Alone ☐ With others

Smoking Status: ☐ Never Smoker ☐ Current everyday smoker ☐ Smoker-current status unknown

☐ Former Smoker ☐ Current some day smoker ☐ Unknown if ever smoked

Smoking-How much? ☐ None ☐ 1PPW ☐ 2PPW ☐ ¼ PPD ☐ ½ PPD ☐ 1PPD ☐ 2PPD ☐ 3+PPD

Chewing Tobacco: ☐ None ☐ 1/day ☐ 2-4/day ☐ 5+/day

Tobacco- years of use: _____

Alcohol Intake: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Alcohol-years of use: _____

Illicit Drugs: _____ Years of illicit drug use: _____

Exercise Level: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Sports Activities: (Please list all) _____

School you attend: (if applicable) _____



Past Surgical History

Please check all that apply and provide date if known

- | | |
|---|-------|
| ☐ No Significant Past Surgical History | |
| ☐ Ankle/Foot Surgery | _____ |
| ☐ Appendectomy | _____ |
| ☐ Arthroscopy Ank/kn/sh/elbow | _____ |
| ☐ Back Fusion/Discectomy | _____ |
| ☐ Caesarean Section | _____ |
| ☐ Cardiac Stents | _____ |
| ☐ Fracture Surgery | _____ |
| ☐ Gallbladder Surgery | _____ |
| ☐ Gastrointestinal Surgery | _____ |
| ☐ Hernia Repair | _____ |
| ☐ Hysterectomy | _____ |
| ☐ Neck Surgery | _____ |
| ☐ Oophorectomy | _____ |
| ☐ Open Heart/CABG | _____ |
| ☐ Pacemaker/Defibrillator | _____ |
| ☐ Plastic Surgery | _____ |
| ☐ Thyroid Surgery | _____ |
| ☐ Tonsillectomy/Adenoidectomy | _____ |

Other: _____

Past Medical History

Please check all that apply

- | | | |
|---|--|--|
| ☐ AIDS/HIV | ☐ Heart Disease/Problems | ☐ Pacemaker |
| ☐ Anxiety/Depression | ☐ Hepatitis | ☐ Peripheral Vascular Disease |
| ☐ Arthritis | ☐ Hernia | ☐ Pulmonary Embolism |
| ☐ Asthma | ☐ High Cholesterol | ☐ Rheumatoid Arthritis |
| ☐ Bleeding Disorder | ☐ History or Infection/MRSA | ☐ Seizures/Epilepsy |
| ☐ Blood Clot | ☐ Hypertension | ☐ Stroke |
| ☐ Cancer | ☐ Kidney Disease | ☐ Thyroid Problems |
| ☐ Concussion | ☐ Liver Disease | ☐ Tuberculosis |
| ☐ COPD | ☐ Migraines | ☐ Ulcers |
| ☐ Diabetes | ☐ Orthotics | |
| ☐ Gout | ☐ Osteoporosis | |
| ☐ Heart Attack (MI) | | |