

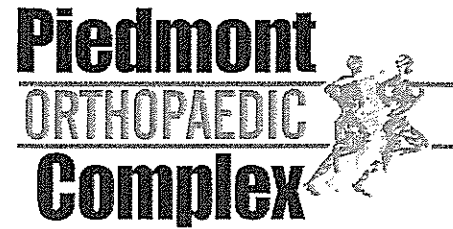
****FORMS MUST BE FILLED OUT AND COMPLETED PRIOR TO YOUR APPOINTMENT TIME****

PATIENT NAME:

APPOINTMENT DATE:

TIME:

- BILL BARNES, MD; ORTHOPAEDIC/SPORTS
- RYAN DECOONS, MD; ORTHOPAEDIC/SPORTS
- KEVIN STEVENSON, MD; SPINE/NEUROSURGERY
- PAMELA ONDERKO, DPM; FOOT AND ANKLE
- KEVIN MOORE, DPM; FOOT AND ANKLE
- PAUL PETERSON, PA-C; ORTHOPAEDIC CARE
- LAURENPRICE, NP-C; ORTHOPAEDIC & SPINE



Orthopaedics. Spine. Foot & Ankle.
4660 Riverside Park Blvd., Macon, GA
(478) 474-2114
Fax: (478) 474-8001

Welcome to Piedmont Orthopaedic Complex.

Our mission is to help increase your mobility and alleviate your joint pain in a comfortable and friendly environment. Piedmont Orthopaedic Complex has been meeting the orthopaedic needs of families in Middle Georgia for 30 years. Piedmont employs surgeons of varying backgrounds, including orthopaedics, spine, and foot and ankle, to provide comprehensive musculoskeletal care for each patient. Piedmont's campus also includes a 15,000 square foot rehabilitation center and an out-patient surgical center where a variety of orthopedic and spine procedures are performed.

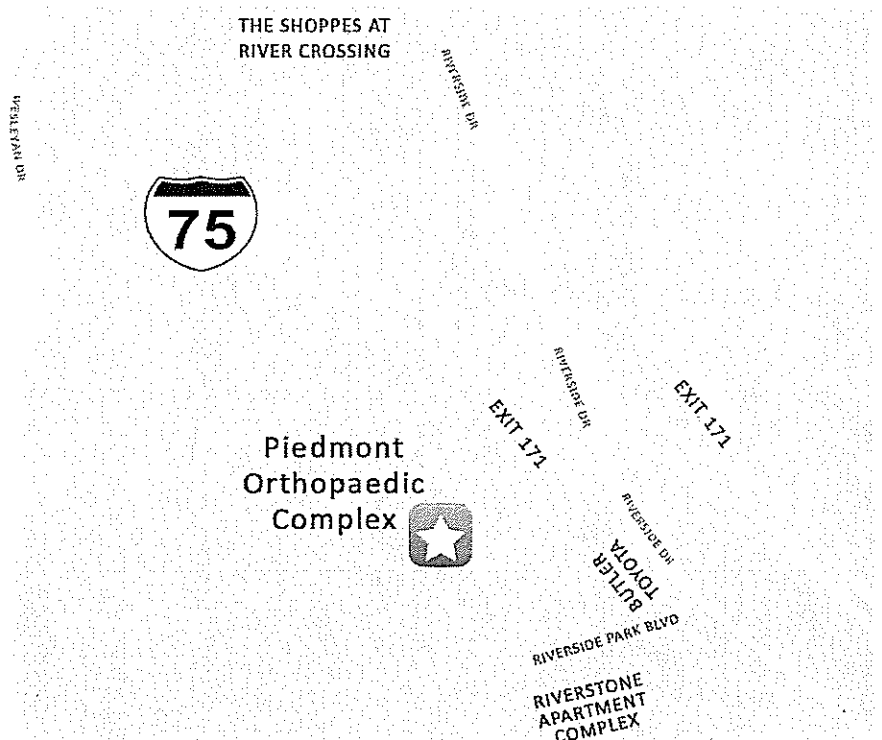
We look forward to serving you. Please visit our website to learn more about common musculoskeletal conditions and treatment options and to get to know our medical providers.

Your First Appointment: What to Know

- When you come for your first appointment, please bring:
 - Completed New Patient Paperwork
 - Photo ID, Copies of current insurance coverage, Method of payment for services/co-payment
 - X-Rays and/or MRI reports (including the disks) that pertain to the condition or injury
 - Bottles of current medications labeled with the prescribing physician

Please Initial:

- Piedmont employs experienced physician's assistants and nurse practitioners who work closely with our surgeons to provide timely care. Depending on what your visit is regarding, you may see a PA or NP instead of the surgeon in order to expedite your treatment.
- If you cannot make your appointment, please call to reschedule with 24 hours notice.
- **Driving Directions:** Take Interstate 75 to Exit 171, then go south on Riverside Drive. Take your first right onto Riverside Park Blvd. (between Butler Toyota and Butler Lexus). Follow the road behind Butler Toyota and Piedmont will be on the right.



Name: _____ Date: _____

Signature: _____



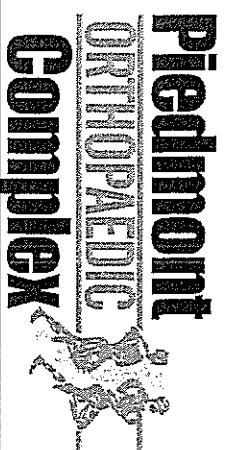
4660 Riverside Park Blvd
Macon, GA 31210

Financial Policy

Thank you for choosing Piedmont Orthopaedic Complex for all of your orthopedic, spine and podiatric needs. To keep you informed of our current office and financial policies, we ask that you read and sign our Financial Policy prior to treatment. You can print a copy at www.PiedmontOrthoComplex.com.

- In order to maximize your coverage and reduce insurance fraud, we require that you provide your medical insurance card(s) and your state-issued photo ID at the time of service. If you are unable to produce your medical insurance card(s) and we are not able to quickly and easily obtain proof of coverage, you may be asked to reschedule your appointment.
- Health insurance is always filed as a courtesy to you, but it is not considered a form of payment. Please remember that as the patient, you assume full financial responsibility for your care that is not covered by your insurance carrier.
- Please be prepared to pay your co-pay and balance at the time of service. If you are not able to pay at the time of service, you may be asked to reschedule your appointment.
- Any patient that has Medicare only will have to pay half of the deductible at their first visit of the year.
- Any patient with one insurance that has a deductible, 50% of that deductible can be collected at their first visit of the year.
- Balance and deductibles must be paid in full before surgery is scheduled. Any remaining balance after surgery has to be paid within six months.
- Patient accounts will be in default if payment is not received within 60 days of the first statement. If for some reason you cannot pay the amount billed to you in full, please call our office immediately. If there has been no response after the 3rd statement, and an attempt to contact you via a pre-collect letter or phone call has been made with no response, you may be turned over to collections and dismissed from the practice.
- Returned checks will not be re-run and will result in a \$30 fee being charged to your account.
- If you file bankruptcy, Piedmont has the right to dismiss you from the practice.
- Should your health insurance company require a referral or prior authorization from your primary care provider, it is your responsibility to obtain that referral.
- It is not Piedmont's responsibility to determine who is accountable for a child's medical bills. We consider the parent or guardian bringing the child in for treatment to be the responsible party, unless otherwise indicated. Proof of guardianship may be required.
- Patients that do not have health insurance coverage may ask our staff for additional information regarding our self-pay fee schedule.
- We do not accept attorney liens. We will only bill your health insurance.
- If your injury relates to a workers' compensation claim, we must have written authorization from your workers' compensation insurance carrier before scheduling. We will file and retrieve necessary authorizations for procedures. It is your responsibility to work with Piedmont's Workers' Compensation Coordinator if you have questions related to your claim.
- Forms requiring our office's signatures and/or completion will cost \$30 at the time the form is provided to Piedmont. Please allow 10 business days for forms to be completed.
- If you are a Medicaid recipient, please be advised that we are not Medicaid providers for physical therapy and DME services. We will file on your behalf, but you will be liable for any services not reimbursed by Medicaid.
- It is your responsibility to make sure the contact information kept on file for you at Piedmont is up to date so you can receive important billing correspondence.

Patient Policy and Financial Responsibility Agreement



<p>Medication Policy:</p> <p>In an effort to answer the overwhelming number of calls regarding medication refills, and to serve your needs more efficiently, we have established the following policies:</p> <ul style="list-style-type: none"> ✓ If you need a refill of your <u>current</u> medication, please have your pharmacy call our office before noon for a same day medication refill. All prescription calls placed after noon will be filled on the next business day. Medications will not be filled on nights, holidays, or weekends. Please check your supplies before these times. ✓ We do not refill prescriptions for patients who have not been seen by a provider in our practice within the previous six (6) months. ✓ We do not fill narcotics if you fail to keep your appointment or you have not been evaluated in the previous eight (8) weeks. ✓ You must agree to use only one pharmacy to fill any narcotic prescriptions. Failure to comply may result in grounds for immediate discharge from this practice. ✓ Lost or stolen medication <u>will not</u> be refilled or replaced under any circumstances. ✓ Medications will not be refilled until your account balance is current. ✓ Once your orthopaedic problem has been treated and you are discharged from this practice, you will no longer receive prescriptions from our clinic. 	<p>Authorization to Release Information:</p> <p>By signing below, I hereby authorize Piedmont Orthopaedics and Sports Medicine Complex to release information to insurance carriers concerning my illness and treatment.</p> <p>Authorization to pay:</p> <p>By signing below, I hereby assign Piedmont Orthopaedic and Sports Medicine Complex any outstanding payments due for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by my insurance company.</p> <p>Acceptance of Financial Responsibility:</p> <p>All professional services rendered are the responsibility of the patient regardless of insurance coverage and whether or not there is an accident with another person at fault. <i>Insurance is filed as a courtesy to you, but you are ultimately responsible for your balances.</i> My signature below indicates I have read and understand all of the financial responsibilities that may arise during my course of treatment at Piedmont.</p> <p>Notice of Privacy Practices:</p> <p>I acknowledge by signing below that I understand I can ask for and receive or retrieve from the company website a copy of Piedmont's <u>Notice of Privacy Practices and Notice of Individual Rights</u>.</p>
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I hereby agree that in addition to intending to follow the policies and procedures listed above, I have provided true and accurate information to the best of my ability. I also agree that if I have questions about any of these policies, I will address them before signing with a Piedmont staff member who will then note the question or concern on the back of this form.

Patient's Name (or Responsible Party): _____ Patient's DOB: _____

Patient's Signature (or Responsible Party): _____ Date: _____

Patient Medical Information Form

Patient's Legal Name: _____ DOB: _____

Injury Details:

Please tell us more about what brought you to our practice: Chronic Problem Specific Injury (complete below)

Date of Injury: _____ Body Part: _____

Type of Injury: Work Athletic Accident Home Other: _____

How did the injury occur? _____

Current Health Information:

Height (in feet/inches): _____ Weight (in pounds): _____

Marital Status: Single Married Divorced Widowed Life Partner

Living Situation: Alone With Family/Spouse Nursing Home Assisted Living

Employment: Employed (Occupation: _____) Unemployed Retired

Working Condition: Active/Rigorous Some Seated Mostly Seated Sedentary

Smoking History: Never smoked Ex-smoker Current Smoker (____ packs/day X ____ years)

Alcohol Consumption: Never Occasional Drinker Regular Drinker (____ drinks/day)

Do you have any allergies? None Latex

Foods: _____

Medications: _____

Other: _____

Are you on any medications? None Yes, I take the following: (list below, with dosage)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Patient Medical Information Form

Patient's Legal Name: _____

DOB: _____

Review of Symptoms:

Please place a checkmark next to any symptoms you are currently experiencing.

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Vomiting	<input type="checkbox"/>																																																																																																																																																																										
Diarrhea	<input type="checkbox"/>																																																																																																																																																																										
Constipation	<input type="checkbox"/>																																																																																																																																																																										
Genitourinary																																																																																																																																																																											
Urinary Frequency	<input type="checkbox"/>																																																																																																																																																																										
Blood in Urine	<input type="checkbox"/>																																																																																																																																																																										
Incontinence	<input type="checkbox"/>																																																																																																																																																																										
Urinary Retention	<input type="checkbox"/>																																																																																																																																																																										
Frequent Urinary Tract Infections (UTI)	<input type="checkbox"/>																																																																																																																																																																										
Skin																																																																																																																																																																											
Rash	<input type="checkbox"/>																																																																																																																																																																										
Hives	<input type="checkbox"/>																																																																																																																																																																										
Hair Loss	<input type="checkbox"/>																																																																																																																																																																										
Skin Loss	<input type="checkbox"/>																																																																																																																																																																										
Ulcers/Open Wounds	<input type="checkbox"/>																																																																																																																																																																										
Itching	<input type="checkbox"/>																																																																																																																																																																										
Nail Changes	<input type="checkbox"/>																																																																																																																																																																										
Musculoskeletal																																																																																																																																																																											
Joint Pain	<input type="checkbox"/>																																																																																																																																																																										
Muscle aches/weakness	<input type="checkbox"/>																																																																																																																																																																										
Bone Pain	<input type="checkbox"/>																																																																																																																																																																										
Joint Swelling	<input type="checkbox"/>																																																																																																																																																																										
Back/Neck Pain	<input type="checkbox"/>																																																																																																																																																																										
Neurological																																																																																																																																																																											
Seizures	<input type="checkbox"/>																																																																																																																																																																										
Tremors	<input type="checkbox"/>																																																																																																																																																																										
Migraines	<input type="checkbox"/>																																																																																																																																																																										
Numbness	<input type="checkbox"/>																																																																																																																																																																										
Dizziness/Vertigo	<input type="checkbox"/>																																																																																																																																																																										
Loss of Balance	<input type="checkbox"/>																																																																																																																																																																										
Allergic/Immunologic																																																																																																																																																																											
Allergic Reactions	<input type="checkbox"/>																																																																																																																																																																										
Hay Fever	<input type="checkbox"/>																																																																																																																																																																										
Frequent Infections	<input type="checkbox"/>																																																																																																																																																																										
Hepatitis	<input type="checkbox"/>																																																																																																																																																																										
HIV/AIDS	<input type="checkbox"/>																																																																																																																																																																										
Positive TB Test	<input type="checkbox"/>																																																																																																																																																																										

Patient Medical Information Form

Patient's Legal Name: _____ DOB: _____

Current Providers

Current Pharmacy Name & Location: _____ Pharmacy Phone #: _____

Are you currently being seen at a pain clinic? Yes No
If yes, are you under a medication contract at that facility? Yes No

Please list ALL current care providers, their specialty and contact information here:

Primary Care Doctor: _____ Ph#: _____

Ph#: _____

Ph#: _____

Ph#: _____

Ph#: _____

Health History:

Please tell us about any major surgeries or hospitalization stays you have had:

List any other information here our office will need to know about:

Patient Medical Information Form

Patient's Legal Name: _____ DOB: _____

Have you or any of your immediate family members (living or deceased) been diagnosed with any of the following?

Condition	Self	Mother	Father	Sibling
Diabetes Type I	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Type II	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain/Heart Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker (Implant Date: _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Peripheral Vascular	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyperthyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypothyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/COPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke/CVA/TIA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer: (location(s): _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congestive Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Apnea (Do you use a CPAP? <input type="checkbox"/> Yes <input type="checkbox"/> No)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I hereby confirm that all information provided is correct to the best of my knowledge. I also agree to inform a Piedmont staff member if any information changes regarding my current health status.

Patient's Signature

Date