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

PATIENT NAME: _____

APPOINTMENT DATE: _____ TIME: _____

- BILL BARNES, MD; ORTHOPAEDIC/SPORTS
- KEVIN STEVENSON, MD; SPINE/NEUROSURGERY
- MEF GALLE, MD; OCCUPATIONAL MEDICINE
- PAMELA ONDERKO, DPM; PODIATRY
- ASHLEY PEPPERS, NP; ORTHO
- LAUREN PRICE, NP; SPINE

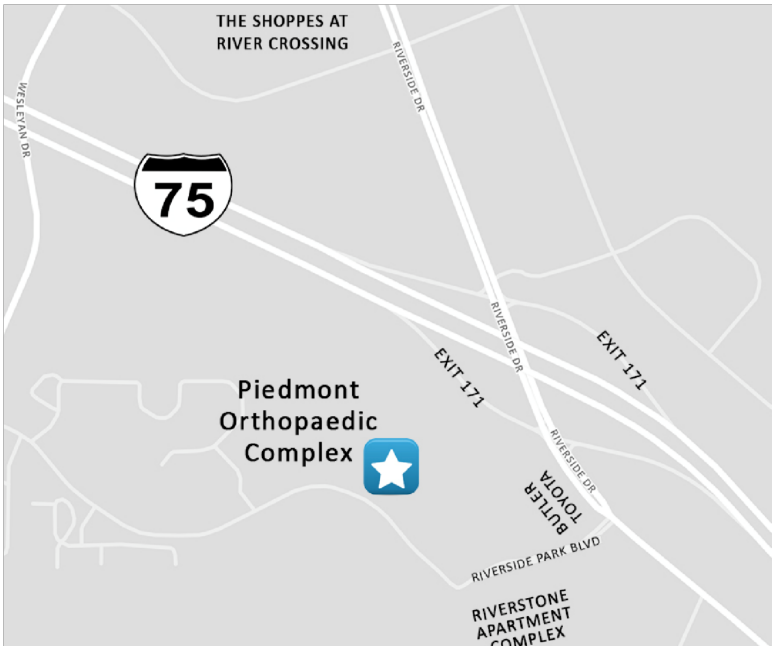
Piedmont ORTHOPAEDIC Complex
Orthopadics. Spine. Foot & Ankle.
4660 Riverside Park Blvd., Macon, GA
(478) 474-2114
Fax: (478) 474-8001

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 more than 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 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: **[INITIAL HERE TO INDICATE YOU HAVE READ THIS PORTION_____]**
  1. Completed New Patient Paperwork
  2. Photo ID, Copies of current insurance coverage, Method of payment for services/co-payment
  3. X-Rays and/or MRI reports (including disks) that pertain to the condition/injury
  4. Bottles of current medications labeled with the prescribing physician
- Piedmont employs experienced nurse practitioners and physician assistants who work closely with our surgeons. Depending on your visit, you may see an NP or PA instead of the surgeon to expedite treatment.
- If you cannot make it to your appointment, please call to reschedule with 24 hours notice.
- Directions: Take Interstate 75 to Exit 171, 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: _____

Piedmont ORTHOPAEDIC Complex
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

Medication Policy:

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:

- If you need a refill of your *current* 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 *will not* 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.

Authorization to Release Information:

By signing below, I hereby authorize Piedmont Orthopaedics and Sports Medicine Complex to release information to insurance carriers concerning my illness and treatment.

Authorization to pay:

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.

Acceptance of Financial Responsibility:

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. *Insurance is filed as a courtesy to you, but you are ultimately responsible for your balances.* My signature below indicates I have read and understand all of the financial responsibilities that may arise during my course of treatment at Piedmont.

Notice of Privacy Practices:

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 Notice of Privacy Practices and Notice of Individual Rights.

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: _____

What Would You Like to Be Seen About? ☐ Chronic Problem ☐ Specific Injury (complete below)

Type of Injury: ☐ Work ☐ Athletic ☐ 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.

Constitutional
- ☐ Weight loss
- ☐ Weight gain
- ☐ Poor appetite
- ☐ Fatigue
- ☐ Insomnia
- ☐ Night sweats

Eyes
- ☐ Blurry vision
- ☐ Eye pain
- ☐ Discharge
- ☐ Redness
- ☐ Decreased vision
- ☐ Dry eyes
- ☐ Double vision

ENT
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Ear pain
- ☐ Hearing loss
- ☐ Discharge
- ☐ Nose bleeds
- ☐ Tinnitus
- ☐ Sinusitis

Cardiovascular
- ☐ Heart murmur
- ☐ Poor circulation
- ☐ Foot/leg swelling

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Alcohol/drug dependence

Endocrine
- ☐ Goiter
- ☐ Heat/cold intolerance
- ☐ Increased thirst
- ☐ Increased sweating

Hemo/Lymphatic
- ☐ Low blood count
- ☐ Prolonged bleeding
- ☐ Blood clots
- ☐ Transfusions

Respiratory
- ☐ Chronic cough
- ☐ Coughing blood
- ☐ History of TB

Gastrointestinal
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation

Genitourinary
- ☐ Urinary frequency
- ☐ Blood in urine
- ☐ Incontinence
- ☐ Urinary retention
- ☐ Frequent urinary tract infections

Skin
- ☐ Rash
- ☐ Hives
- ☐ Hair loss
- ☐ Skin loss
- ☐ Ulcers/open wounds
- ☐ Itching
- ☐ Nail changes

Musculoskeletal
- ☐ Joint pain
- ☐ Muscle aches/weakness
- ☐ Bone pain
- ☐ Joint swelling
- ☐ Back/neck pain

Neurological
- ☐ Seizures
- ☐ Tremors
- ☐ Migraines
- ☐ Numbness
- ☐ Dizziness/vertigo
- ☐ Loss of balance

Allergic/Immunologic
- ☐ Allergic reactions
- ☐ Hay fever
- ☐ Frequent infections
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Positive TB Test

Patient Medical Information Form

Patient's Legal Name: _____ DOB: _____

Current Providers

Current Pharmacy Name, Location and Phone Number: _____

_____

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#: _____

Health History

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

_____

_____

_____

_____

_____

List any other information 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	☐	☐	☐	☐
Diabetes Type II	☐	☐	☐	☐
Chest Pain/Heart Palpitations	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Heart Attack	☐	☐	☐	☐
Pacemaker (Implant Date: _____)	☐	☐	☐	☐
Kidney Stones	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐
Dialysis	☐	☐	☐	☐
Peripheral Vascular	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Hyperthyroid	☐	☐	☐	☐
Hypothyroid	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐
Asthma/COPD	☐	☐	☐	☐
Stroke/CVA/TIA	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
AIDS/HIV	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐
Cancer (location(s): _____)	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐
Blood Clots	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐
Congestive Heart	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐
Sleep Apnea (Do you use a CPAP? ☐ Yes ☐ No)	☐	☐	☐	☐

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