



EXPERIENCE & INTEGRITY

NEW PATIENT REGISTRATION FORM

Patient (Legal) Name: _____ Nickname: _____

SSN (>Age 18): _____ Date of Birth: _____ Sex: Male Female

Mailing Address: _____ Home Address: _____
Street/PO Box Street
City State Zip Code City State Zip Code

The Federal government now requires that we collect the following information:
Race: White Black/African American Hispanic/Latino Asian Multi-racial Other: _____
Ethnicity: Hispanic Non-Hispanic

Marital Status: Single Married Widowed Divorced Student Status: Full-Time Part-Time N/A

Daytime Phone: _____ Home Phone: _____

Cell Phone: _____ Email: _____

Emergency Contact: _____ Phone #: _____

(1) Primary Insurance

Insurance Name: _____ Effective Date: _____

Policy Holder Name: _____ Date of Birth: _____

Policy Holder Relationship to Patient: Self Spouse Parent Policy Holder Sex: Male Female

Policy ID #: _____ Group #: _____

(2) Secondary Insurance

Insurance Name: _____ Effective Date: _____

Policy Holder Name: _____ Date of Birth: _____

Policy Holder Relationship to Patient: Self Spouse Parent Policy Holder Sex: Male Female

Policy ID #: _____ Group #: _____

For Minor Children Only: "Responsible Party" is the parent who completes this form

Responsible Party Name: _____ Home Phone: _____

SSN: _____ Date of Birth: _____ Cell Phone: _____

Mother's Name: _____ Daytime Phone: _____

Father's Name: _____ Daytime Phone: _____

ASSIGNMENT OF BENEFITS:

I verify that the information provided above is complete and correct. I request that payment of authorized insurance or Medicare benefits be made on my behalf to Cape Fear Orthopaedic Clinic, P.A. for any medical services or supplies furnished to me by that organization. I understand that I am financially responsible to the organization for any charges not covered by my health care benefits.

Patient/Legal Guardian Signature: _____ Date: _____

(Office Use Only) Person#: _____



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FINANCIAL POLICY

We would like to thank you for choosing Cape Fear Orthopedics as your medical provider. Because we are committed to providing you with the best possible care and service, we would like to make you aware of our financial policy. We require that you read and sign this document prior to receiving medical treatment.

Co-payments, Deductibles, and Fees: Your insurance carrier requires that we collect your co-pay at the time of service. Deductibles and fees for services not covered by your insurance are also due at the time service is rendered. We accept cash, checks, VISA, MasterCard, and American Express. A \$25.00 fee will be assessed to your account if a check is returned for non-sufficient funds.

Insurance: You must present a current insurance card at each visit. If you or your children do not present a current insurance card, you will be responsible for payment in full at the time of service. Your medical insurance is a contract between you and your insurance company. We will assist in filing your insurance claim, but you are primarily responsible for any charges incurred while you are a patient. If your insurance carrier is not one that we participate with, you are responsible for payment in full at the time of service. You have a responsibility to provide timely information to our office so a claim can be properly submitted. If your insurance company has not paid a claim on your behalf within 60 days, because of information that you have not provided, the balance will be transferred to your account and you will be responsible for payment. If the claim is paid at a later date, you will be reimbursed by Cape Fear Orthopedics.

Minors and Dependents: Our practice will bill the insurance for both parents (if applicable). The parent that accompanies the child to his or her first appointment will be considered financially responsible for payment, regardless of the subscriber (parent) listed on the child's insurance card. We do not get involved in child custody issues.

Auto Insurance/Third Party Liability: We DO NOT accept auto insurance or other third party liability insurance. If you are being seen for an injury due to an automobile accident or third party liability, you will be responsible for paying in full at the time of service.

Missed Appointments: We may charge a \$25.00 "no show" fee if you fail to keep a scheduled appointment or fail to cancel an appointment with at least 24 hours notice. This fee is not covered by your insurance plan and is your responsibility. Repeatedly missing, rescheduling, or cancelling appointments may be grounds for dismissal from the practice.

Prompt Payment: Just as we make every effort to accommodate you when you are in need of medical care, we expect that you will make every effort to pay your bill promptly. If you do not have medical insurance, have a financial hardship, or if you are unable to pay your bill in its entirety please contact our billing office prior to your appointment to discuss payment options. If you have a past due balance on your account, you may be required to reschedule your appointment. Chronic non-payment will be grounds for dismissal from the practice. We reserve the right to turn any account over to a collection agency if the account is not paid within 30 days.

Patient Financial Responsibility:

I acknowledge full financial responsibility for services rendered by Cape Fear Orthopedics. I understand that I am financially responsible for prompt payment of any portion of the charges not covered by insurance, including deductibles and co-pays. I understand payment of co-pays and any prior balance I may owe is due at the time of service unless a payment agreement is on file. I hereby request that payment of insurance or Medicare benefits be made on my behalf to Cape Fear Orthopedics for any medical services or supplies furnished to me by that organization.

Patient Name: _____ Date of Birth: _____

Patient/Legal Guardian Signature: _____

(Office Use Only) Person#: _____

PRESCRIPTION REFILL AND PAIN MEDICATION POLICY

Prescription Refills:

1. Only one pharmacy may be used for filling prescriptions. You should notify us if you change pharmacies.
2. Because most physicians are only in clinic 2-3 days per week, prescription refills may take 3-5 business days to process. Please do not wait until you run out of medication to request a refill.
3. Take your medication exactly as instructed by your provider. Never change the dosage or frequency of your medication without instructions from your physician. Refill requests will **not** be approved if you "run out early".
4. You may request a refill during our normal business hours. Requests for refills will **not** be accepted after hours.
5. You are responsible for keeping your prescriptions and medications safely in your care. Lost or stolen medications or prescriptions will **not** be replaced until it is time for your next refill. Exceptions may be made if you have a police report, but only at the discretion of your doctor.
6. You may be required to see your physician for a follow-up visit prior to obtaining a medication refill.

Pain Medications:

If you have a medical condition requiring pain control, your medical provider may recommend that you take a narcotic (pain-killer) drug. These drugs should lower or take away your pain. There are some important things you should know about narcotic (pain-killer) drugs before you agree to take them:

- Pain-killer drugs may have major side effects and risks. Medication should be taken only as directed.
- Narcotic use is under the control of many regulatory agencies. Doctors must follow local, state, and federal laws when prescribing these drugs.

Risks and common problems include:

1. **Addiction** – You could become mentally and physically dependant on them. Your doctors may order extra blood, urine, or hair testing and may refer you to an addiction specialist if there is a worry about addiction.
2. **Side effects** – Include a feeling of sickness to your stomach, trouble having a bowel movement, sweating, and itchiness of the skin. You may also feel sleepy.
3. **Pregnancy** – Do **not** get pregnant while you are taking pain-killers. These drugs could result in harm to your baby or loss of the pregnancy (miscarriage).
4. **Alcohol or illegal drugs** – Do **not** use alcohol or illegal drugs while taking pain-killers. This mixture could cause death.
5. **Heavy or dangerous machinery** – Do **not** use heavy or dangerous machinery, handle guns, or use other weapons while taking pain-killers.
6. **Driving** – Driving while on a pain-killer drug is **not** recommended. Pain-killers can change your driving skills.

By signing below you agree that you have read this document and understand the clinic's policy regarding prescriptions and the rules for taking narcotic (pain-killer) drugs:

1. It is against the law to make any changes to a prescription after it is written. If you change a prescription, it will be reported to the police and no more drugs will be given to you.
2. Getting pain-killer drugs from more than one doctor at a time is not allowed. This is against the law and may be considered a felony. You have a duty to let other doctors know if you are taking narcotic (pain-killer) drugs.
3. From time-to-time, our staff may talk to the pharmacist or access the NC Controlled Substance Reporting System to check your full prescription profile.
4. Prescriptions should only be picked up by you. If you are unable to pick up your prescriptions, we will only release your prescription to authorized persons as listed on your HIPAA Consent Form. Our office does require that you show a photo ID when picking up prescriptions.

Patient Name: _____ Date of Birth: _____

Pharmacy Name and Location: _____

Patient/Legal Guardian Signature: _____ Date: _____

(Office Use Only) Person#: _____

Cape Fear Orthopedics - November 2011



EXPERIENCE & INTEGRITY

HIPAA CONSENT & ACKNOWLEDGMENT

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice also contains a patient rights section describing your patient rights under the law. You have a right to review this Notice before signing this Consent. The terms of the Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction but if we do, we shall honor the agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for:

1. Treatment (including direct and indirect treatment by other health care providers involved in your medical care);
2. Payment from your insurance company or other third party payers;
3. The day-to-day health care operations of our Practice.

You have the right to revoke this Consent, in writing, at any time. However, any use or disclosure that occurred prior to the date you revoke this consent is not affected. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- protected health information may be disclosed or used for treatment, payment or health care operation.
- the Practice has a Notice of Privacy Practices and the patient has the opportunity to review this Notice.
- the Practice reserves the right to change the Notice of Privacy Practices.
- the patient may revoke this Consent in writing at any time.
- the Practice may condition receipt of treatment upon the execution of this Consent.

Please provide us the name(s) of family members or other persons, if any, to whom we may release information regarding your general medical condition, financial account, or who have permission to pick up information you have requested.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Name: _____ Date of Birth: _____

Signature of Patient Representative: _____
() Self () Parent () Legal Guardian () Representative under Health Care POA

Date: _____

(Office Use Only) Person#: _____

CONSENT TO TREATMENT

Patient Name: _____ Date of Birth: _____
(Please Print Clearly)

I am a new patient at Cape Fear Orthopedics. By signing this form, I consent to be treated by the providers of this practice.

My medical provider needs more medical facts about my health. I ask for and allow the medical providers and staff to give me the needed medical treatment and services recommended by my physician or physician assistant.

I understand that treatment and services may include, but is not limited to the following:

- routine exams
- casts/splints
- lab tests
- screening tests
- diagnostic tests
- injections
- x-rays

I understand that no promises have been made to me about the results of any treatment or services.

Patient/Legal Guardian Signature: _____

Date: _____ Time: _____ am/pm

Witness Signature: _____

Date: _____ Time: _____ am/pm

Cape Fear Orthopedics - PEDIATRIC MEDICAL HISTORY QUESTIONNAIRE

FOR OFFICE USE ONLY

X-rays	Y N	Date of Injury/Onset _____	Seen by provider # _____
MRI	Y N	Interviewers Initials _____	Date Interviewed _____
CT scan	Y N		
Medical Records	Y N		
Other Test	Y N		

Chart # _____ Patient (Legal) Name _____
 Date of birth _____ Gender: Male Female Age _____ Height _____ Weight _____
 Referring Physician _____ Primary Care Physician _____
 Reason for today's visit _____ When did the injury/problem occur? _____

HEALTH HISTORY OF PATIENT

Immunizations up-to-date----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Delay in development----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty walking----- <input type="checkbox"/> Yes <input type="checkbox"/> No
Seizures----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Mental illness----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Serious injuries----- <input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Bleeding disorders----- <input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart trouble----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Disease----- <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach trouble----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney/bladder trouble----- <input type="checkbox"/> Yes <input type="checkbox"/> No
Thyroid disease----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Other illness----- <input type="checkbox"/> Yes <input type="checkbox"/> No	

Explain all "yes" answers: _____

List ALL operations and approximate date: _____ Current medications and dosage: _____ List ALLERGIES to medications----- NONE

FAMILY HISTORY

Heart problems----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis----- <input type="checkbox"/> Yes <input type="checkbox"/> No
Seizures----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Mental illness----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney/Bladder trouble----- <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding disorders----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Other----- <input type="checkbox"/> Yes <input type="checkbox"/> No	

Explain all "yes" answers: _____

SOCIAL HISTORY

Number of people living in child's home _____ Grade in school _____
 How many are adults (number and relationship) _____ Smoke _____ packs per day
 How many are brothers (number and ages) _____ Alcohol use----- None Occasional
 How many are sisters (number and ages) _____ Illicit Drug use----- None Presently Past
 Other's (number and ages) _____

DEVELOPMENTAL HISTORY (if child is younger than 2 years of age)

Roll over back to front----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Sit with support----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Crawl----- <input type="checkbox"/> Yes <input type="checkbox"/> No
Pull to a stand----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Walk independently----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Run----- <input type="checkbox"/> Yes <input type="checkbox"/> No

DEVELOPMENTAL HISTORY (if child is 2 to 6 years of age)

Stairs, one leg at a time----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Stairs, alternating legs----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Jumps----- <input type="checkbox"/> Yes <input type="checkbox"/> No
Hops on one foot----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Skips----- <input type="checkbox"/> Yes <input type="checkbox"/> No	

REVIEW OF SYSTEMS (Present NOW or Past 2 months)

Chills or fever----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Unusual weight change----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures----- <input type="checkbox"/> Yes <input type="checkbox"/> No
Frequent headaches----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Exhaustion----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Depression----- <input type="checkbox"/> Yes <input type="checkbox"/> No
Change in vision----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Reading glasses----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of hearing----- <input type="checkbox"/> Yes <input type="checkbox"/> No
Ear pain----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent nosebleeds----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Hoarseness----- <input type="checkbox"/> Yes <input type="checkbox"/> No
Sore throat----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty swallowing----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of breath----- <input type="checkbox"/> Yes <input type="checkbox"/> No
Heart or chest pain----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Poor appetite----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Toothache/gum trouble----- <input type="checkbox"/> Yes <input type="checkbox"/> No
Nausea or vomiting----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach pain----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent constipation----- <input type="checkbox"/> Yes <input type="checkbox"/> No
Frequent loose bowel movements <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent urination (passing water) <input type="checkbox"/> Yes <input type="checkbox"/> No	Burning sensation during urination-- <input type="checkbox"/> Yes <input type="checkbox"/> No
Frequent rash----- <input type="checkbox"/> Yes <input type="checkbox"/> No	Hot or cold spells----- <input type="checkbox"/> Yes <input type="checkbox"/> No	

Form Completed by _____ Relationship _____ Date _____

Reviewed by _____ MD/PA-C Date _____



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AUTHORIZATION TO TREAT A MINOR CHILD IN ABSENCE OF A PARENT OR LEGAL GUARDIAN

Please check one of the following:

- the minor child under my legal care is 15-17 years of age and I give my consent for him/her to attend an unaccompanied appointment.
the minor child under my legal care is under 15 years of age and I give my consent for him/her to attend an appointment accompanied by an adult representative greater than 18 years of age as designated below.

I, _____, the parent or legal guardian of _____

(Name of Parent or Legal Guardian)

_____, hereby authorize

(Name of Minor Child)

_____ to accompany my above-named

(Name of Adult bringing child to the office)

child to office visits with Cape Fear Orthopedics and consent to the examination and/or treatment of my child during the office visits.

Medical Care of Current Condition:

The undersigned hereby authorizes Cape Fear Orthopedics as our agent to provide ongoing medical treatment, by any physician, physician assistant or physical therapist (including support staff) licensed through the State of North Carolina and employed by Cape Fear Orthopedics, for my minor child, when such treatment is deemed necessary by the physician in conjunction with the current injury/illness being treated by Cape Fear Orthopedics.

Emergent Care - If applicable

In addition, I hereby authorize Cape Fear Orthopedics as our agent to provide emergent care by any licensed physician, physician assistant or physical therapist (including support staff) for the above mentioned minor if I cannot be reached within a reasonable time, by reason of absence from the community or otherwise. Such consent may include, but is not limited to medical treatment, test, x-ray examination, injections or drugs and the performing of whatever procedures may be deemed necessary or advisable. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide the authority to consent thereto as our said agent and the above-named child's attending physician, in the exercise of his or her best judgment, may deem advisable.

- This authorization:
is effective only on ____/____/____.
is effective from ____/____/____ to ____/____/____.
is effective until revoked by me in writing.

Signature of Parent or Legal Guardian

Date

Signature of Witness

Date