

John R. Dorris, MD
David W. Bacastow, MD
Yancey Shuman, PA-C
Natalie Moseley, PA-C



Date: _____ New Patient () Returning Patient ()

Patient Name: _____ Patient Gender: () Male () Female

Patient Address: _____

City: _____ State: _____ Zip: _____ Email _____

Telephone: _____ Cell Phone _____ Work Phone: _____

Social Security No.: _____ Date of Birth: _____ Age: _____

Spouse/Parent Name: _____

Patient Employer & Address: _____

Occupation: _____

Referring Doctor Name: _____ Telephone: _____

Address: _____

Primary Care Doctor: _____ Telephone: _____

Address: _____

Medical History

Height: _____ **Weight:** _____

Body Part to be examined/complaint: _____

() Right () Left () Both Dominant hand: () Right () Left

Date of injury of first date of symptoms: _____

Is this injury result of: () Work Injury () Sports Injury () Auto Accident () Other

If work injury, please state in your own words what happened: _____

Have you had an MRI of this problem area () Yes () No If yes, at which facility? _____

Have you had any type of therapy? () Yes () No If yes, please describe _____

Have you had any injections? () Yes () No If yes, please describe _____

Do you smoke: () Yes () No How much? _____

Do you drink: () Yes () No How much per day? _____

Do you take illicit/street drugs: () Yes () No / Have you ever taken illicit/street drugs: () Yes () No

Are you pregnant: () Yes () No If yes, How far along? _____

Do you have osteoporosis: () Yes () No

Do you exercise: () Yes () No How often? _____

Are you current on your immunizations: () Yes () No Date of last tetanus: _____

Date of last DEXA (bone density test): _____

Have you ever had an operation: () Yes () No

Type

Date

Location

Physician

Have you ever had problems with anesthesia: () Yes () No Explain: _____

Are you currently having of have you ever had problems with your:

	Circle		Describe 'Yes' Response
Lungs, Breathing	No	Yes	_____
Digestion/Heartburn	No	Yes	_____
Bowel/Bladder/ Prostate	No	Yes	_____
Diabetes	No	Yes	_____
Headache	No	Yes	_____
Heart Problems	No	Yes	_____
High Blood Pressure	No	Yes	_____
Bleeding Problems/Clots	No	Yes	_____
Balance Problems	No	Yes	_____
Blackouts/Fainting	No	Yes	_____
Numbness/Tingling	No	Yes	_____
Psychological Problems	No	Yes	_____
HIV/AIDS	No	Yes	_____
Cancer	No	Yes	_____
Epilepsy	No	Yes	_____
Depression	No	Yes	_____
Other	No	Yes	_____

Allergies _____

Payment Information

Guarantor information same as patient? () Yes () No

Guarantor Name: _____ Guarantor Gender: () Male () Female

Guarantor Address: _____

Guarantor Telephone: _____ Guarantor Work Telephone: _____

Guarantor Social Security No: _____ Guarantor Date of Birth: _____

Guarantor Employer and Address: _____

Primary Insurance Company: _____

Address: _____ Phone Number: _____

Policy #: _____ Group #: _____ Group Name: _____

Secondary Insurance Company: _____

Address: _____ Phone Number: _____

Policy #: _____ Group #: _____ Group Name: _____

If Student, Name of School: _____

Address: _____

Student Parent's Day Time Phone Number: _____

Next of kin not living with Patient and Phone Number: _____

I AUTHORIZE ATHENS BONE & JOINT, P.C. TO RELEASE MY INSURANCE COMPANY, EMPLOYER AND/OR REFERRING PHYSICIAN ANY INFORMATION REQUIRED IN THE COURSE OF MY EXAMINATION AND TREATMENT. I ALSO AUTHORIZE ANY PHYSICIAN, HOSPITAL, OR CLINIC TO PROVIDE DETAILS OF MY HISTORY TO ATHENS BONE & JOINT, P.C.

I HEREBY GIVE CONSENT TO THE PHYSICIAN OF ATHENS BONE & JOINT, P.C. FOR MEDICAL TREATMENT.

I HEREBY ASSIGN PAYMENT DIRECTLY TO ATHENS BONE & JOINT, P.C. FOR MEDICAL BENEFITS PAYABLE FOR THESE SERVICES. I UNDERSTAND I AM RESPONSIBLE FOR PAYMENT OF ALL SERVICES, INCLUDING PHYSICIAN ASSISTANT AND/OR SUPPLY FEES, RENDERED REGARDLESS OF INSURANCE COVERAGE. IF A PATIENT IS A MINOR, I AM RESPONSIBLE FOR PAYMENT OF SERVICES. I UNDERSTAND ATHENS BONE & JOINT, P.C. WILL CHARGE A BILLING FEE SHOULD THE ACCOUNT BE TURNED OVER TO COLLECTIONS. THE BILLING FEE WILL BE 33% OF THE TOTAL BALANCE. BY SIGNING BELOW, I HAVE READ AND UNDERSTAND THE ABOVE.

Patient Signature/Responsible Party: _____ Date: _____

THE PERSON WITH MINOR PATIENT IS RESPONSIBLE FOR BILL. BY SIGNING BELOW, I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT

Signature: _____ Date: _____

Social Security No: _____

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Natalie Moseley, PA-C



Patient Name: _____

Address: _____ City _____ Zip _____

I have agreed to let certain individuals participate in discussions and decisions related to my medical care. Therefore, I hereby give permission for Athens Bone and Joint, P.C. and Dr. Dorris and his staff to disclose my personal medical information to the following individual (s):

Name: _____ Relationship to Patient: _____ Phone _____

Name: _____ Relationship to Patient: _____ Phone _____

Name: _____ Relationship to Patient: _____ Phone _____

Conditions for Disclosure (*Check the item(s) that apply:*

- The practice may disclose my personal health information to the individual(s) Above **only** in my presence.
- The practice may disclose my medical information to the individual(s) above in Discussions in my presence when I am physically present, including disclosures by telephone, answering machine, facsimile, e-mail or regular mail.
- Other Conditions of Disclosure: _____

I understand that this consent may be revoked by me at any time by written notice to the practice.

Patient Signature: _____

Date of Signature: _____

Witnessed by: _____

Title/Position _____

Print Name of Witness: _____

Date: _____

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FINANCIAL POLICY

At Athens Bone and Joint, PC, we are committed to meeting your healthcare needs. Our goal is to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this in a cost effective manner, we ask that you adhere to the following guidelines:

1. Payment is due at the time of service.
2. We will file your insurance for you if we are a participating provider of your plan. We will make every attempt to verify your coverage at the time of service. Since insurance plans cannot guarantee eligibility or benefits, we cannot do so either. You will be responsible for any and all services in excess of your insurance limits, as well as all non-covered services.
3. All co-payments are due at the time of service.
4. If we are not participating providers of your plan, and you do not have out-of-network benefits, payment in full is expected today. Please understand that if we do not participate in your plan, any associated surgery, testing or therapy may not be covered as well.
5. Claims for patients with insurance plans that have out-of-network benefits will be filed. Any outstanding claims not paid by insurance within sixty (60) days will be due by the patient.
6. Patients covered under Workman's Compensation may be responsible for payment if the claim is controverted.
7. **All copayments, unmet deductibles and any amounts deemed by your insurance policy that are the responsibility of the patient are due and payable prior to surgery.**

I have read and understand the Financial Policy.

Signature

Date

NOTICE OF PRIVACY PRACTICES

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

I have been given the opportunity to review/obtain a copy of Athens Bone and Joint, PC's Notice of Privacy Practices.

Signature

Date