

Patient Information

(Please Fill Out Completely)

Contact Information	Full Name: Last _____ First _____ Middle _____ (Maiden) _____			
	Address (Street or Box) _____		City _____	State _____ Zip _____
	Do you reside in a nursing home? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list the name, address and phone number below.			
	Name: _____		Address: _____	
	Home Phone _____		Phone number: _____	
	Cell Phone _____		Date of Birth _____	
	Work Phone _____		Social Security # _____	
	Email _____		Sex _____	
			Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced	
	Are You Employed? Please list Employer, Occupation, Position and Address: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Insurance	If Student, Indicate School _____			
	Please Provide Name & Daytime <input type="checkbox"/> Spouse			
	Number of one of the following: <input type="checkbox"/> Relative Other Than Parents		Daytime _____	
	<input type="checkbox"/> Friend Name _____		Phone # _____	
	If Patient is a Minor please provide Parent or Guardian's Name: _____			
	Social Security # _____		Date of Birth _____	
			Parent's Phone _____	
	Parent's Employer / Employer's Address _____		Work Phone _____	
			() _____	
			() _____	
Referral	Do you plan to file Worker's Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, who should we call to verify compensation? _____	
	Company Name: _____		Person to Verify: _____	
	Phone _____		() _____	
	Name of Primary Insurance Company: _____		Is this a Medicare Advantage Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	
			Effective Date of Policy _____	
	1.			
	Group Number / Name _____		Policy Number _____	
			Where is the insurance claim to be mailed? <input type="checkbox"/> Home <input type="checkbox"/> Employer Name: _____ <input type="checkbox"/> Insurance Company	
	Address _____		City _____ State _____ Zip _____	
	Name of Insured _____		Birthdate of Insured _____	
		Social Security # of Insured _____		
		Relationship to Insured _____		
Name of Secondary Insurance Company: _____		Effective Date of Policy _____		
Complaint	2.			
	Group Number / Name _____		Policy Number _____	
			Where is the insurance claim to be mailed? <input type="checkbox"/> Home <input type="checkbox"/> Employer Name: _____ <input type="checkbox"/> Insurance Company	
	Address _____		City _____ State _____ Zip _____	
	Name of Insured _____		Birthdate of Insured _____	
			Social Security # of Insured _____	
			Relationship to Insured _____	
	If Medicare is secondary why? <input type="checkbox"/> Working age spouse <input type="checkbox"/> Employed <input type="checkbox"/> Disabled <input type="checkbox"/> Other If other explain: _____			
	How were you referred to our office? <input type="checkbox"/> Another physician <input type="checkbox"/> Employer <input type="checkbox"/> Insurance Co. <input type="checkbox"/> Former patient <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Family member <input type="checkbox"/> Newspaper <input type="checkbox"/> Web site (name) <input type="checkbox"/> Other (please specify): _____ <input type="checkbox"/> A friend: (Please provide name) _____			
	Please give the full name, city and state of your Primary Care or Referring Physician below, if any:			
Name _____		Clinic _____		
		City _____		
		State/Zip _____		
		Phone _____		
Did you go to an Emergency room? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, hospital or Urgent Care name: _____		
		Date of treatment _____		
		Please provide name of attending physician: _____		
Is this the result of an injury? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please give date: _____		
		Type of injury? <input type="checkbox"/> Auto <input type="checkbox"/> Other <input type="checkbox"/> Work		
		Were X-Rays taken? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		If yes, did you bring the X-Rays? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		Are you seeking a second opinion? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Signature of Patient, Parent or Guardian: _____ Date: _____



Patient Medical History

Name: _____ Date of Birth: _____

Your Gender: 1 Female 2 Male

Doctors To Whom Reports Should Be Sent: _____

PRIOR HOSPITALIZATIONS & SURGERY

Hospital	Date	Reason	Physician
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

CURRENT MEDICATIONS

Name of Medicine	Dose or Strength	How Often?
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

ALLERGIES

None

Medication or Allergen	Type of Reaction
1. _____	_____
2. _____	_____

Medical History, Review of Systems, Family History

HAVE YOU OR YOUR FAMILY MEMBERS HAD ANY OF THE CONDITIONS LISTED BELOW?

(Please circle any number if "yes")

Self	Family		Self	Family	
1	2	Osteoarthritis/Degenerative Joint Disease	1	2	Migraine Headaches/Frequent Headaches
1	2	Inflammatory Arthritis (e.g., Rheumatoid, Lupus)	1	2	Depression/Anxiety
1	2	Gout	1	2	Attention Deficit Disorder
1	2	Multiple Fractures	1	2	Sleep Disorders
1	2	Problems with Anesthesia	1	2	Fibromyalgia/Myofascial Pain
1	2	Heart Attack/Heart Disease	1	2	Stroke
1	2	Chest Pain	1	2	Seizures/Epilepsy
1	2	Palpitations/Irregular Heartbeat	1	2	Fainting/Dizziness
1	2	Murmur/Mitral Valve Prolapse	1	2	Thyroid Troubles
1	2	High Blood Pressure	1	2	Stomach Problems/Ulcers
1	2	Chronic Cough/Pneumonia/Bronchitis	1	2	Hepatitis ("Yellow Jaundice")/Liver Disease
1	2	Asthma	1	2	Diverticulitis
1	2	Lung Disease/Emphysema/Shortness of Breath	1	2	Coughing Up Blood
			1	2	Black or Bloody Stools
1	2	Diabetes ("Sugar")	1	2	Weight Loss (Unexplained; not diet-related)
1	2	Urinary Tract Infections/Urinary Troubles	1	2	Unexplained Fever
1	2	Kidney Disease/Dialysis	1	2	Serious or Recurrent Infections (Describe):
1	2	Kidney Stones			_____
1	2	Circulation Problems/Vascular Disease			_____
1	2	Anemia/Bleeding/Clotting Disorders/Hemophilia	1	2	Cancer - If "yes", what type:
1	2	Blood Clot/Deep Vein Thrombosis			_____

1	2	Skin Disease. Give Type: _____	1	2	Other Medical Problems (Describe):

Do you use tobacco? 1 No 2 Yes Number of packs per day? _____ Number of years? _____

Do you drink alcoholic beverages? 1 Never 2 Occasionally 3 Daily

Do you live with anyone who can take care of you at home? 1 No 2 Yes

X _____
SIGNATURE OF PATIENT, PARENT OR GUARDIAN

X _____
DATE

X _____
DOCTOR'S INITIALS



New Problem Questionnaire

Last Name: _____ First Name: _____ Middle Initial: _____ Age: _____

Please circle the appropriate numbers.

1. **Where is your main problem?** _____
2. **What is your main problem?**

1 Pain	5 Unstable or Dislocating Joint
2 Numbness	6 Swelling
3 Weakness	7 Other (explain): _____
4 Stiffness	
3. **How did your problem start? (give details as needed)**

1 Job Injury	4 Suddenly
2 Car Accident	5 Gradually
3 Sports Injury	6 Other (explain): _____
4. **How long have you had this problem, approximately?** _____
(give # of days, weeks, months or years)
5. **Is your problem:**

1 Improving	2 Worsening	3 Staying the Same
-------------	-------------	--------------------
6. **Does your pain or problem awaken you from sleep?** 1 Yes 2 No
7. **Is your pain or problem intermittent?** 1 Yes 2 No **constant?** 1 Yes 2 No
8. **What worsens your problem? (give details as needed)**

1 Exercise	5 Repetitive Motions	9 Nothing
2 Sitting	6 Overhead Activities	10 Other: _____
3 Standing	7 Coughing, Sneezing, Straining	
4 Walking	8 Rest	
9. **What helps your problem?** 1 Rest 2 Nothing 3 Other (give details) _____
10. **Are your regular activities limited specifically because of your problem?** _____
11. **Have you had this problem before now?** 1 No 2 Yes When? _____ For how long _____
12. **Have you had previous medical treatment for this? (give details and general dates)**

1 None	5 Injection _____
2 Yes	6 Physical Therapy _____
3 Emergency room _____	7 Surgery _____
4 Physician _____	8 Other: _____
13. **What tests have you had?**

1 X-rays	4 Nerve Test (EMG)
2 CT Scan	5 Ultrasound
3 MRI	6 Other: _____
14. **What medicines are you taking specifically for this problem?** _____
15. **Are you on or planning to apply to any of the following programs because of your problem?**

A. Disability 1 Yes 2 No	B. Worker's Compensation 1 Yes 2 No
---------------------------------	--
16. **What is your occupation?** _____
17. **What is your present work status?**

1. Not Working	Date last worked: _____
2. Light Duty	For how long? _____
3. Regular Job	

(please go to next page)

18. If you are working, does your job require the following?

- | | | |
|-------------------------------|----------------------------------|---------------------------------------|
| 1 Very Little Lifting (0-10#) | 6 Frequent Squatting or Kneeling | 11 Repetitive motions w/hands or arms |
| 2 Light Lifting (11-20#) | 7 Climbing | 12 Repetitive motions w/feet or legs |
| 3 Medium Lifting (21-50#) | 8 Extended Walking | |
| 4 Heavy Lifting (over 50#) | 9 Continuous Standing | |
| 5 Frequent Bending & Lifting | 10 Sitting | |

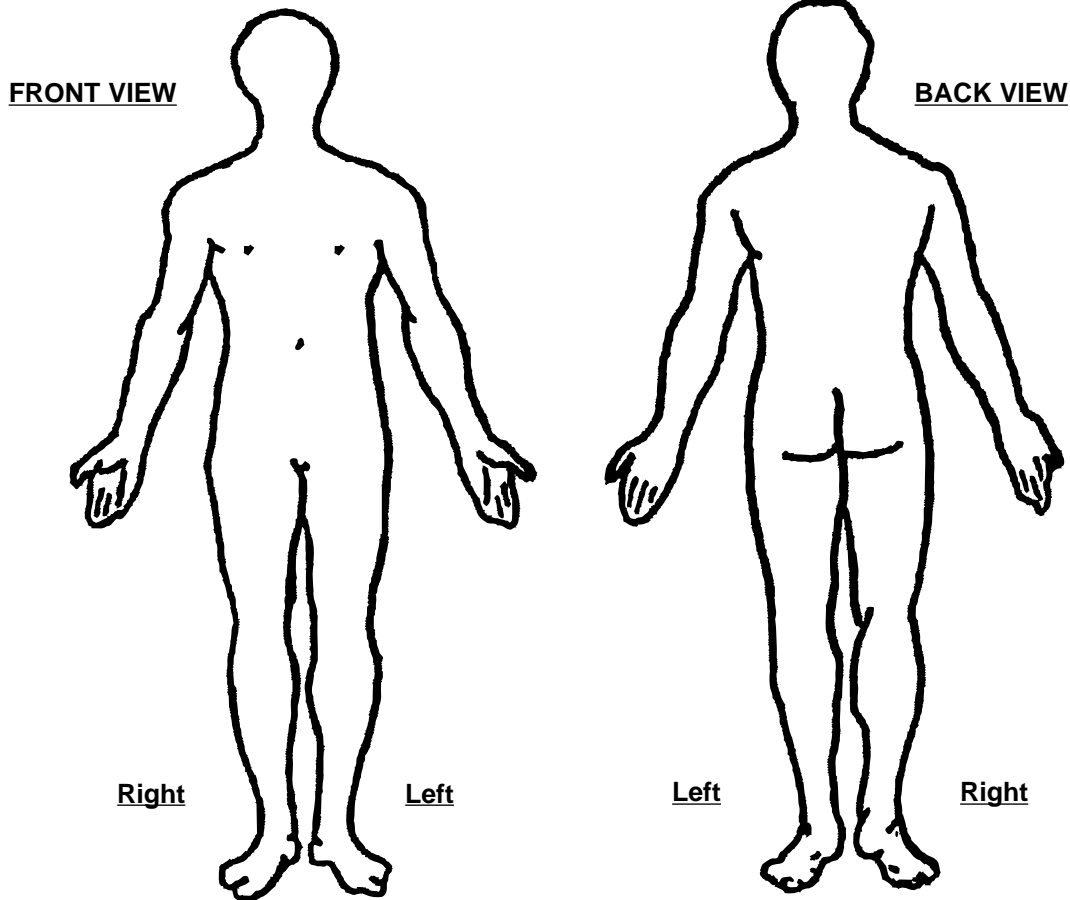
19. Please mark the appropriate box showing how bad your pain or problem is now.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
No Problem	10	20	30	40	50	60	70	80	90	Worst Problem

20. Where is your pain or problem now?

Mark the areas on your body where you feel the sensations described below, using the appropriate symbol. Mark the areas of radiation. Include all affected areas. To complete the picture, please draw in your face. Please place an X on the body form where the pain is worst now.

- | | | | | |
|---------------|-----------------|-----------------------|----------------|-----------------|
| Aching
△△△ | Numbness
=== | Pins & Needles
○○○ | Burning
□□□ | Stabbing
/// |
|---------------|-----------------|-----------------------|----------------|-----------------|



21. Please write in any other pertinent details about your problem: _____

22. Are there any other acute problems or crises in your life now?
 1 No 2 Yes (explain) _____

X _____
 SIGNATURE OF PATIENT, PARENT OR GUARDIAN

 DATE

X _____
 DOCTOR'S INITIALS



NOTICE OF PRIVACY POLICIES FOR RALEIGH ORTHOPAEDIC CLINIC AND RALEIGH ORTHOPAEDIC REHABILITATION SPECIALISTS

NOTICE OF PRIVACY POLICIES as required by the Privacy Regulations created as a result of the Health Information Portability and Accountability act of 1996 (HIPAA). These Privacy Standards are to be implemented by April 14, 2003.

This notice describes how medical information about you may be used and disclosed and how you can get access to information. Please review carefully.

Introduction

Our practice has always been dedicated to maintaining the privacy of your medical record, now referred to as, Protected Health Information (PHI). We at Raleigh Orthopaedic Clinic and Raleigh Orthopaedic Rehabilitation Specialists (later referred to as ROC/RORS) have and will continue to maintain the privacy of your PHI. As a part of caring for you, we will create records regarding you and the treatment and services you receive. Effective April 14, 2003, we are required by law to maintain in our practice concerning your PHI. By Federal and State Law, we must follow the terms of the Notice of Privacy Policies that we have in effect at the time.

Understanding Your Health Record/Information

Each time you visit ROC/RORS a record of your visit is made. Typically, this record contains your symptoms, examination, and any tests, diagnoses, treatment, and a plan for future care of treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professional who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third party payer can the services we provided and for which they were billed,
- A tool to help educate our staff,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of our community, state and nation,
- A source of data for planning and marketing,
- A tool which we can assess our performance and the care we render and the outcomes we achieve

Understanding what is in your record and how your PHI is used helps you to: ensure the accuracy, better understand who, what, when, where and why others may access your health information, and make more informed decisions when authorizing disclosures to others.

Your Health Information Rights

As in the past your health record is the physical property of ROC/RORS, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon written request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Request communications of your health record by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent action has already been taken

Our Responsibilities

Raleigh Orthopaedic Clinic and Rehabilitation Specialists are required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties, and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate PHI by alternative means or at alternative locations

We reserve the right to change our practice and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will provide you with a revised copy on your next visit to our office.

We will not use or disclose PHI without your authorization, except as described in this notice. We will also discontinue to use or disclose your PHI after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the practice's Privacy Officer, or with the Office of Civil Rights, US Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office of Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
US Department of Health and Human Services
200 Independent Avenue, S.W.
Room 509F, HHH Building
Washington, DC 20201

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine your course of treatment that should work best for you. Your provider will document in your record his or her recommendations. Members of your health care team will then record the actions they took and their observations. In that way, the provider will know how you are responding to treatment.

We will also provide the physician that referred you and or that you identified with copies of various reports that should assist him or her in treating you once you are discharged from our care team.

We will use your health information for payment

For example: A bill may sent to you or a third-party payer. The information on or accompanying the bill will often include information that identifies you, as well as your diagnosis, procedures and supplies used.

We will use your health information for our regular health operations.

For example: Physicians in this practice, members of the medical staff, the risk or quality improvement manager, or members of the quality improvement committee may use information in your health record to access the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare team and services we provide.

Business Associates: There are some services provided in our organization through contacts with business associates. Examples include services provided by physicians in an emergency department or radiology center, certain laboratory tests, and copy services we used when making copies of your health record. When these services are contracted, we may disclose your PHI to our business associates so they can perform the job we have asked them to do and bill you or your third-party payer for their services rendered. To protect your health information, however, we will require the business associate to appropriately safeguard your information, through a business associate agreement.

Notification: We may use or disclose your PHI to notify or assist in notifying a family member, personal representative, or another person responsible for your care, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Workers Compensation: We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law Enforcement: We may disclose your PHI for law enforcement purposes as required by law or in response to valid subpoena.

Federal Law makes provision for your PHI to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.



**3515 Glenwood Avenue
Raleigh, NC 27612**

**222 Ashville Avenue
Cary, NC 27511**

**1325 Timber Drive East
Garner, NC 27529**

**10880 Durant Road
Raleigh, NC 27614**

Phone: 919-781-5600

Fax: 919-863-6829

Website: www.raleighortho.com

Email: HIPAA@raleighortho.com

RALEIGH ORTHOPAEDIC CLINIC PATIENT FINANCIAL POLICY AND SIGNATURE ON FILE

AUTHORIZATION TO RELEASE INFORMATION:

I authorize the release of medical information to my primary care or referring physician and as necessary to process insurance claims, including claims for disability benefits, insurance applications and prescriptions. I authorize transmission of medical information by fax.

Name: _____ Date of Birth: _____ / _____ / _____

Patient SSN# _____ / _____ / _____

Responsible Party Signature _____ Date _____ / _____ / _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

I have received a copy to review of the Notice of Privacy Practices for Raleigh Orthopaedic Clinic, P.A. (ROC) and Raleigh Orthopaedic Rehabilitation Specialists (RORS).

Patient or Responsible Party
Signature _____ Date _____ / _____ / _____

RX REFILLS

"I agree that Raleigh Orthopaedic Clinic may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes."

Responsible Party Signature _____ Date _____ / _____ / _____

ACCEPTANCE OF FINANCIAL RESPONSIBILITY

I acknowledge full financial responsibility for services rendered by ROC/RORS, regardless of insurance coverage and whether or not there was an accident with another party at fault. If hospitalization, surgery, or office surgery is indicated, the patient is responsible for furnishing current insurance information to the office prior to hospitalization or surgery X _____ (initial).

INSURANCE PATIENTS

ROC/RORS will file your insurance. I authorize my health insurance company to utilize the medical information as reasonably necessary for the proper administration of the health plan. I hereby assign ROC/RORS any payments of medical benefits for services rendered to myself or dependents. Co-payments: ROC/RORS are required by your insurance to collect your co-payment. If you do not have your co-payment your appointment will be rescheduled, unless an exception is made by the physician. If an exception is made, a \$25 processing fee will be added to your visit (this fee is above any allowed amount by your insurance and will not be filed to your insurance). The processing fee, plus the co-payment must be paid prior to your next visit. I have read and understand that I am responsible for paying the annual deductible, co-payment, coinsurance and any charges for non-covered services as determined by my insurance X _____ (initial).

SELF PAY PATIENTS

Patients will need to make a \$175 deposit prior to seeing the physician, and self pay patients with a back condition will need to make a \$250 deposit prior to seeing the physician X _____ (initial).

OUTSTANDING BALANCES

Any patients having an outstanding balance with a collection agency will not be able to make an appointment until the balance is paid in full. Any third party costs associated with collecting past due accounts will be added to the patient's account X _____ (initial).

Thank you for selecting Raleigh Orthopaedic Clinic for your Orthopaedic care. In order to better communicate with our patients, we are now offering email updates to enhance our communications concerning patient appointments and to provide patient education and news regarding our clinic and the Athletic Performance Center. Your email address will NOT be shared with anyone.

Authorization for Release of Medical Information	
Raleigh Orthopaedic Clinic is authorized to release protected health information about the above patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.	
Person/Entity to Receive Information Check each person/entity below that you approve to receive information	Description of Information to be Released Check type of information below that can be provided to person/entity
<input type="checkbox"/> Voicemail Phone#(s): _____ <input type="checkbox"/> Email Address: _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical Information <input type="checkbox"/> Medications
<input type="checkbox"/> Spouse (Provide Name)	<input type="checkbox"/> Financial <input type="checkbox"/> Medical Information
<input type="checkbox"/> Parent(s) (Provide Name)	<input type="checkbox"/> Financial <input type="checkbox"/> Medical Information
<input type="checkbox"/> Others(s) (Provide Name)	<input type="checkbox"/> Financial <input type="checkbox"/> Medical Information

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forwards

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

Date _____

Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation)