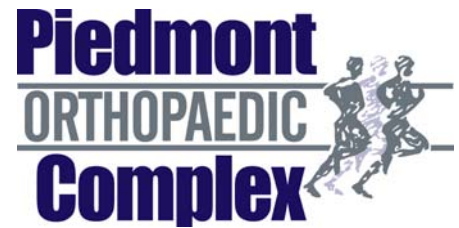


Patient: \_\_\_\_\_

Appointment Date: \_\_\_\_\_

Appointment Time: \_\_\_\_\_ AM / PM

Provider:   \_\_\_ Bill Barnes, M.D.       \_\_\_ Jeffrey Burnette, M.D.  
              \_\_\_ Layne Myers, M.D.    \_\_\_ Paul Peterson, PA-C  
              \_\_\_ Pamela Onderko, D.P.M.

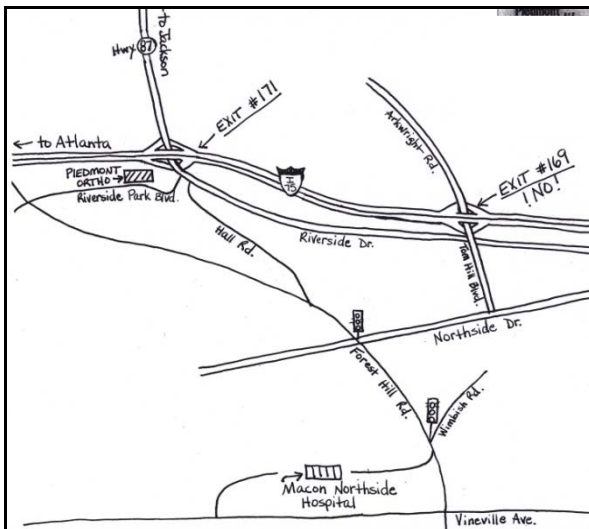


4660 Riverside Park Blvd  
Macon, GA 31210  
(478) 474-2114

Dear Patient:

Welcome to the Piedmont Orthopaedic and Sports Medicine Complex! Thank you for making an appointment; we appreciate the trust you have placed in us to deliver the highest quality medical care. We have provided the checklist below with helpful hints to make your appointment run as smoothly as possible. We know your time is valuable, and following these tips will assist you in having the necessary information prior to your visit and will help us maintain your appointment time.

- ✓ Complete the attached patient information sheets (in ink) prior to coming to the office.
- ✓ Arrive by your check-in time
- ✓ Bring any X-Ray, MRI, or reports that pertain to your condition
- ✓ Remember to bring copies of all current insurance coverage if applicable, as well as a method of payment for services, co-payments, etc.
- ✓ Prepare and provide to your physician a list of your current medications and their dosage
- ✓ If for any reason you cannot make your appointment, be sure to call to reschedule with at least 24 hours notice.
- ✓ Please do not wear perfume/cologne on the day of your appointment.



Directions to our office:

Take I-75 to exit 171, and go south on Riverside Drive. On the right, you will see our sign between car dealerships, and turn right on Riverside Park Blvd. Follow the road around, and our building is the first on the right.

Thank you,  
Piedmont Orthopaedic and Sports Medicine Complex

# Patient Information Form

Patient's Legal Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Preferred Name/Nickname: \_\_\_\_\_ Gender:  M  F

Address: \_\_\_\_\_  
Street Apt/Suite City, State Zip

Preferred Phone Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_  Cell Phone  Home Phone  Work Phone

Secondary Phone Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_  Cell Phone  Home Phone  Work Phone

E-mail Address: \_\_\_\_\_ Student Status:  FT  PT  N/A

How did you hear about our practice? \_\_\_\_\_

Referring Physician (if applicable): \_\_\_\_\_

*If the patient is a dependent, please indicate the responsible party:*

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apt/Suite City, State Zip

Preferred Phone Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_  Cell Phone  Home Phone  Work Phone

Secondary Phone Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_  Cell Phone  Home Phone  Work Phone

## Primary Insurance Information:

Primary Insurance: \_\_\_\_\_ ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Subscriber's DOB: \_\_\_\_\_ Relationship: \_\_\_\_\_

## Secondary Insurance Information:

Primary Insurance: \_\_\_\_\_ ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Subscriber's DOB: \_\_\_\_\_ Relationship: \_\_\_\_\_

**\*Note: We require that you bring a copy of any insurance card you wish us to bill on your behalf to an insurance company to your first visit. If you have lost your card, please contact your insurance carrier to receive a new one. \***

# Patient 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: \_\_\_\_\_

Does your injury limit your mobility?  Yes  No Are you in pain?  Yes  No

How did the injury occur? \_\_\_\_\_

## Allergies and Medications:

Are you allergic to latex?  Yes  No

Are you allergic to any medications?  Yes  No

If YES, which ones? \_\_\_\_\_

Please list ALL prescription drugs and any OTC medications/vitamins you are currently taking, and their dosage.

_____	_____
_____	_____
_____	_____
_____	_____

## Hospitalizations/Surgeries:

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# Patient Information Form

Patient's Legal Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**Have you or any of your immediate family members been diagnosed with any of the following?**

Condition	Self	Mother	Father	Sibling
Diabetes	<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	<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"/>
Thyroid	<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: )	<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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Indicate any additional pertinent family history here:

# Patient Information Form

Patient's Legal Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Please list ALL current care providers:**

Primary Care Provider: \_\_\_\_\_ Ph#: \_\_\_\_\_

Cardiologist: \_\_\_\_\_ Ph#: \_\_\_\_\_

Endocrinologist: \_\_\_\_\_ Ph#: \_\_\_\_\_

\_\_\_\_\_ Ph# \_\_\_\_\_

\_\_\_\_\_ Ph# \_\_\_\_\_

**Social History:**

Marital Status:  Single  Married  Divorced  Widowed  Life Partner

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

Employment:  Employed  Self-Employed  Unemployed  Retired

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

Alcohol Consumption:  Never  Social Drinker (\_\_\_\_ drinks/week)  Heavy Drinker (\_\_\_\_ drinks/day)

**Review of Symptoms:**

Please review the list of systems below. Please place a checkmark next to areas where you have positive results or are experiencing symptoms. Then, circle the symptom(s) that applies.

✓	<u>Constitutional</u>	Weight loss, Poor appetite, Fatigue, Weight Gain, Insomnia, Night Sweats
	<u>Eyes</u>	Blurry Vision, Eye Pain, Discharge, Redness, Decreased Vision, Dry Eyes, Double Vision
	<u>ENT</u>	Sore Throat, Hoarseness, Ear Pain, Hearing Loss, Discharge, Nose Bleed, Tinnitus, Sinusitis
	<u>Cardiovascular</u>	Heart Murmur, Poor Circulation, Foot/Leg Swelling
	<u>Respiratory</u>	Chronic Cough, Coughing Blood, History of Tuberculosis
	<u>Gastrointestinal</u>	Nausea, Vomiting, Diarrhea, Constipation
	<u>Genitourinary</u>	Urinary Frequency, Blood in urine, Incontinence, Urinary Retention, Frequent UTIs
	<u>Skin</u>	Rash, Hives, Hair Loss, Skin Loss, Ulcers/Open Wounds, Itching, Nail Changes
	<u>Musculoskeletal</u>	Joint Pain, Muscle Aches, Muscle Weakness, Bone Pain, Joint Swelling, Back/Neck Pain
	<u>Psychiatric</u>	Anxiety, Depression, Alcohol/Drug Dependence, Use of anti-depressants
	<u>Endocrine</u>	Goiter, Heat/Cold Intolerance, Increased Thirst, Increased Sweating
	<u>Neurological</u>	Seizures, Tremors, Migraines, Numbness, Dizziness/Vertigo, Loss of Balance
	<u>Hem/Lymphatic</u>	Low Blood Count, Prolonged Bleeding, Blood Clots, Transfusions
	<u>Allergic/Immun</u>	Allergic Reactions, Hay Fever, Frequent Infections, Hepatitis, HIV, Positive TB Skin Test

# Patient Information Form

Patient's Legal Name: \_\_\_\_\_

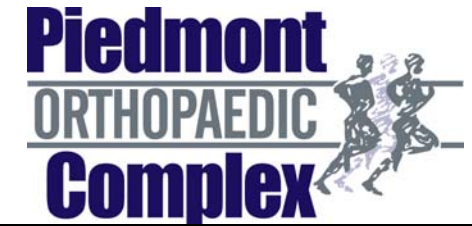
DOB: \_\_\_\_\_

# Financial Policy

We would like to thank you for choosing Piedmont Orthopaedic Complex as your medical provider for all of your sports medicine, physical therapy, and orthopaedic needs. To keep you informed of our current office and financial policies, we ask that you read and sign our financial acknowledgement prior to treatment. Please keep this document for your records, and know that it is also always available to you at our website ([www.piedmontortho.com](http://www.piedmontortho.com)).

- ✓ In order to maximize your coverage and reduce insurance fraud, we request you provide your medical insurance cards and your state-issued photo ID at the time of service.
- ✓ 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 expected portion at the time of service. If you are not able to pay at the time of service, you will be asked to reschedule your appointment.
- ✓ If you are unable to produce your insurance card(s) at their first visit, and we are unable to quickly and easily obtain proof of coverage, you will be asked to reschedule your appointment.
- ✓ Should your insurance company require a referral from your primary care provider, it is your responsibility to obtain that referral prior to the appointment time. Please present this to our check in staff at the time of service.
- ✓ Patient accounts will be in default if payment is not received within 45 days of the statement being mailed. You will receive a statement every 28 days. If for some reason you cannot pay the amount billed to you in full, please contact our office to make payment arrangements.
- ✓ It is not the responsibility of Piedmont's staff or care providers to determine custody or responsibility of children's medical bills. We consider the parent or guardian bringing the child in for treatment to be the responsible party unless somehow otherwise indicated.
- ✓ If you are not able to make your appointment, please contact our office at least 24 hours in advance.
- ✓ Patients that do not have insurance coverage may ask our staff for additional information regarding our self-pay fee schedule.
- ✓ If your injury is due to a motor vehicle accident (MVA), we will ONLY bill your health insurance. It is your responsibility to work with your car insurance carrier and/or attorney to determine the best way to handle your balances.
- ✓ If your injury relates to a workman's compensation claim, we will file and retrieve necessary authorizations for you for procedures. It is your responsibility to work with Piedmont's Workman's Compensation Coordinator if you have questions related to your claim.
- ✓ Returned checks will be re-run to ensure there wasn't a timing issue with the bank. However, a check denied twice will result in a \$35 fee being charged to your account.
- ✓ For your convenience, we accept all forms of payment, including cash, checks, and all major credit cards.
- ✓ Forms requiring our office's signatures and/or completion will cost \$15 due at the time the form is provided to Piedmont. Completion of these forms can take up to 14 days.
- ✓ If overpayment occurs more than \$5, Piedmont will refund your account within one month of the overpayment.

# Patient Policy and Financial Responsibility Agreement



<p><b>Medication Policy:</b></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"><li>✓ 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.</li><li>✓ We do not refill prescriptions for patients who have not been seen by a provider in our practice within the previous six (6) months.</li><li>✓ We do not fill narcotics if you fail to keep your appointment or you have not been evaluated in the previous eight (8) weeks.</li><li>✓ 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.</li><li>✓ Lost or stolen medication <u>will not</u> be refilled or replaced under any circumstances.</li><li>✓ Medications will not be refilled until your account balance is current.</li><li>✓ Once your orthopaedic problem has been treated and you are discharged from this practice, you will no longer receive prescriptions from our clinic.</li></ul>	<p><b>Authorization to Release Information:</b></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><b>Authorization to pay:</b></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><b>Acceptance of Financial Responsibility:</b></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. <u>Insurance is filed as a courtesy to you, but you are ultimately responsible for your balances.</u> 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><b>Notice of Privacy Practices:</b></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: \_\_\_\_\_