MRN:_____

Northview Orthopaedic Associates

Orthopaedic Surgery | Open MRI | Ambulatory Surgery Center

Patient History

Name:_____ **Age:**_____ **Marital Status**(circle): S M W D

Weight_____ **Height**_____ **Occupation:**_____

Patient is living with: ☐ Self ☐Both Parents ☐Spouse ☐Mother ☐Father ☐Other ☐ Left Handed ☐ Right Handed

Do you have any Family History of the following: ☐ Heart disease ☐ Cancer ☐ Rheumatoid Arthritis ☐ Osteoporosis

☐Cigarettes: Packs/day:_____ ☐Cigar/Pipe ☐Dip/Snuff ☐Drugs: Type:_____ ☐ Alcohol: Drinks per week:_____

Do you currently have the flu/COVID-19 or experiencing flu/COVID-19 like symptoms? ☐ Yes ☐ No
Explain:_____

Current Problem

1. List the area of the problem:_____

2. How did the problem begin? ☐Lifting ☐Twisting ☐Falling ☐Car Accident ☐Unknown ☐Other:_____

3. Date of injury, first occurrence, or became recently worse:_____ Onset: Gradual or Sudden

4. Have you been hospitalized for this problem?_____ **Dates & Hospital:**_____

6. Have you had any of the following tests for this condition? Dates & Location:_____

☐ **X-Rays** ☐ **MRI** ☐ **CT Scan** ☐ **Bone Scan** ☐ Other:_____

Medical History

Have you ever been diagnosed as having any of the following? Please check where applicable:

☐ Seizures	☐ Tuberculosis	☐ Arthritis
☐ High Blood Pressure	☐ Sleep Apnea	☐ Gout
☐ Elevated Cholesterol	☐ COPD	☐ Thyroid disorder
☐ Stroke	☐ Asthma/ Bronchitis	☐ Kidney Disease
☐ Heart Attack	☐ Depression/ Anxiety	☐ Sedentary Life Style
☐ Irregular heartbeat	☐ Chemical Dependency	☐ Anesthesia Complications
☐ HIV or Hepatitis	☐ GERD/ Acid reflux/ Ulcers	
☐ Cancer	☐ Diabetes	

Other:_____

Do you have a pacemaker or stents in your heart? **YES** **NO**

Are you on blood thinning medication? **YES** **NO** **-If yes, please also notify nurse.**

7. Are you currently or in the past 6 months being seen by any of the following? Check where applicable:

☐ Speech Therapist	☐ Chiropractor
☐ Dentist	☐ Medical Doctor
☐ Psychologist/Psychiatrist	☐ Physical/Occupational Therapist
☐ Osteopath	☐ Other:_____

8. Have you ever had a fracture or dislocation? _____ **What body part?**_____

9. Are you pregnant or is there a possibility that you are pregnant? ☐ Yes ☐ No

10. Do you have any metals or plastics in your body? ☐ Rods ☐ Pins ☐ Plates ☐ Metal from gunshot ☐Staples

☐ Artificial Joints ☐ Screws If so, where?_____

MRN:_____

Primary Care Doctor: _____

Name of your pharmacy: _____

List any past surgical procedures or hospitalizations with dates: _____

_____

_____

_____

Current Medications: _____

_____

_____

_____

List known drug allergies & reactions:_____

Are you allergic to Latex? **YES** **NO**

I, _____, hereby give my permission for the staff to administer treatment and perform such procedures as may be deemed necessary in the diagnosis and treatment of my condition. I hereby assign all disability, surgical, medical and major medical insurance benefits to Northview Associates and/or Appalachian Physical Therapy for services rendered unless prior arrangements have been made. I hereby authorize the release of any medical information necessary to process this claim, the ability to obtain any information needed for my medical care, and also authorize payment of medical benefits to Northview Associates and/or Appalachian Physical Therapy. A photocopy of this authorization and assignment shall be considered as valid as the original. I understand that regardless of any insurance coverage I might have, I am personally responsible for ALL charges to this account.

_____ _____

Signature **Date**

Review by Clinician: _____ Date: _____ Reviewed by Doctor: _____ Date: _____

MRN:_____

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Patient Information:

Patient Name_____ Date of Birth:_____ Gender: M or F

Marital Status: M S D W Race:_____ Ethnicity:_____ Primary Language:_____

Patient SSN#:_____ Email Address:_____

Primary Phone #:_____ Secondary Phone #:_____

Mailing Address:_____

City:_____ State:_____ Zip:_____

Physical Address (if different):_____

City:_____ State:_____ Zip:_____

PCP:_____ Referring M.D. _____

Emergency Contact:_____ Phone #:_____

Is patient in Skilled Nursing Facility? Yes or No/ Name of Nursing Facility:_____

Is patient currently under Hospice Care? Yes or No/ Name of Hospice Company:_____

Is patient employed? YES NO / Full Time or Part Time - Employer Name & Phone#:_____

Are you in school? YES/NO -- Full Time/Part Time

Guarantor Information: (Guardian or Person responsible for your bill if not yourself. Ex: Under 18)

Guarantor Name:_____ Rel to Patient:_____ D.O.B_____

Address:_____City:_____State:____

Zip:_____ Phone #:_____Work #:_____

Guarantor SSN:_____ Are you employed? YES NO / Full Time or Part Time

Insurance Information (Complete Policy Holder information is needed to properly file claims)

Primary Insurance Type:_____ID#:_____

Policy Holder:_____**D.O.B**:_____SSN:_____Rel to Patient:_____

Secondary Insurance Type:_____ID#:_____

Policy Holder:_____D.O.B:_____SSN:_____Rel to Patient:_____

Is the insurance through Policy Holder's employer? **YES NO** Is this a work related injury? YES NO

If Medicare is secondary, please list why:_____

HIPAA: Acknowledgment of Privacy Practices

The HIPAA Privacy Rule provides federal protections for personal health information held by covered entities and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of personal health information needed for patient care and other important purposes.

I list the following Authorized Individuals to have access to my medical records and their relationship to me:

Name:_____ Relationship to patient:_____

Name:_____ Relationship to patient:_____

_____ _____

Patient or Guardian's Signature ***Today's Date***

Please see back side

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FINANCIAL POLICY

- You and you alone are ultimately responsible for your bill. (Including Auto and Work Comp Claims)
- We file claims to your insurance carrier as a courtesy.
- As a courtesy, we verify your insurance benefits prior to your appointment. Knowing your insurance benefits is your responsibility. Any questions concerning your coverage should be directed to your insurance company. We encourage you to contact your insurance company directly for verification that the information we received is correct.
- Payment in full is required at the time of service. If your insurance company requires a co-payment, this must be paid at the time of service. Co-insurance will be collected before you leave.
- "No Shows" or appointments canceled less than 24 hours prior to visit will be charged a fee of $25.00. The same guidelines will apply to MRI and surgery appointments with the fee being $50.00.
- It is your responsibility to notify us of ***any*** changes in your billing information. We will update your information yearly and you will be required to repeat some forms.
- Returned checks are subject to a $30.00 return check fee. Declined credit cards are subject to a $40.00 declined credit card fee and any additional fees charged to Northview Associates by your credit card or processing company.
- You are responsible for the timely payment of your account. If you are turned into a collection agency, you will be responsible for paying your balance in full and a 35% surcharge for collection agency fees.

Financial Responsibility for Non-Coverage

I, _____, understand that if services and/or supplies are not covered by my insurance, I will be financially responsible for these services and/or supplies.

Acknowledgment of Patient Payment Responsibilities:

By signing below, I acknowledge that I received The Notice of Privacy Practices on the date indicated below, authorized one or all of the designated parties above to act as a Designated Individual within the stipulations listed above, and was counseled on my payment responsibilities in accordance to the billing policies and procedures. Furthermore, I acknowledge that all I have read and understand my responsibilities and that all fields have been filled out with the correct information.

_____

Patient's Name (Please Print)

_____

Patient or Guardian's Signature

_____

Today's Date

Northview Associates
70 Ansley Drive
Dahlonega, GA 30533

Telephone: 706-864-7904
Fax: 706-864-0432

HIPAA Privacy Rights Request Form

PATIENT INFORMATION

_____ Date

_____ _____
Name (Last, first, middle initial) Date of Birth

_____ _____ _____ _____
Street address City State ZIP Code

_____ _____ _____
Primary phone number Other phone number E-mail address

Type of Request ☐ **From Northview Associates** ☐ **To Northview Associates**

☐ Discharge Summary ☐ History and Physical ☐ Operative Note
☐ Consultation (s) ☐ Pathology Report ☐ Lab
☐ X-ray / MRI report ☐ X-ray / MRI Films or Discs ☐ All Records
☐ Other (Specify) _____

This Information may include, but not limited to, treatment related to psychiatric or psychological, drug and/or alcohol, or Acquired Immune Deficiency Syndrome/HIV.

I understand that this consent is subject to revocation by me any time, and unless an earlier date is specified, the consent will automatically expire 90 days after the date below. I also understand that this information may be bound by Title 42 of Code of Federal Regulations governing the confidentially of alcohol and drug abuse patient records. Re-disclosure of this information to any party than the one listed is prohibited without additional written consent on my part.

Additional Information:

_____
_____
_____
_____

Patient/Guardian _____ Date _____

Relationship if not
signed by patient_____ Date _____

Witness Signature _____ Date _____