Coastal Orthopedics and Sports Medicine

Patient Information – In order to better serve you we need the following information.

Today's Date: ______________________
Patient Name: ______________________ **Birth date:** ________________**Age:** ___________
SSN: _______________________ ☐**Male** ☐**Female** **Home Phone:** _____________________
Address 1: ____
Address 2: ____
City: ________________________ **State:** ________________ **Zip:** _____________________
Check the box(s) that apply: ☐**Minor** ☐**Single** ☐**Married** ☐**Divorced** ☐**Widow** ☐**Separated**

Patients or Parents Home Phone: _____________ **Work:** ____________ **Cell:** ____________
Business Address: ____
City: ________________________ **State:** ________________ **Zip:**______________________
Spouse or Parents Name: ____
Employer: ___________________________________ **Work Phone:** ____________________
Emergency Contact: _______________________________ **Phone:** ____________________
Family Physician or Primary Doctor: ____
Person Consulting/Referring you to us: ____

Responsible Party:
Person responsible for this account: _______________ **Relationship to patient:** __________
Address (if different from above)**:** ______________________ **Phone:** ____________________
Drivers License: ______________________________ **Birth date:** ______________________
Employer: ___________________________________ **Work Phone:** ____________________

Insurance Information:
Name of Insured: ______________________________ **Relationship to patient:** ___________
SS# of the insured: ____________________________ **Birth date:** ______________________
Employer Info (if different from above)**: Name of Employer:** _________________________
Address: ____ **Phone:** ____________________
Name of Insurance Company: ____
Address: ____
Your Deductible Amount: _____ **How much have you used:** _____ **Copay Amount:** ______

Do you have additional Insurance? ☐**Yes** ☐**No** If yes, complete the following section.

Name of Insured: ______________________________ **Relationship to patient:** ____________
SS# of the insured: ____________________________ **Birth date:** ______________________
Employer Info (if different from above)**: Name of Employer:** _________________________
Address: ____ **Phone:** ____________________
Name of Insurance Company: ____
Address: ____
Your Deductible Amount: _____ **How much have you used:** _____ **Copay Amount:** ______

I authorize the release of any information concerning my (or my dependent's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor. I understand that I am responsible for the total amount charged for all services rendered.

X____ **Date:** _________________________
Signature of patient, or parent or guardian if minor

Coastal Orthopedics and Sports Medicine (Medical History)

Your Name: ____________________________ **Birth Date:** ___________ **Hand Dominance:** ☐ Right ☐ Left

1. I made the appointment today for my (pick one) ☐ Right ☐ Left : ☐ shoulder ☐ elbow ☐ hand ☐ neck ☐ upper back ☐ lower back ☐ hip ☐ knee ☐ ankle ☐ foot ☐ Other: ___________________________________

2. My Primary complaint is: ☐ pain ☐ deformity ☐ numbness ☐ weakness ☐ fracture ☐ Other: __________

3. I came here: ☐ Not having prior treatment ☐ Having tried treatment at home ☐ Referred from ER ☐ Sent in consultation from another physician: Name of physician: ____________________________________

4. I was injured at: ☐ Home ☐ Work ☐ School ☐ Playing Sports ☐ N/A ☐ Other: ______________________

5. Previous x-rays or MRI: ☐ Have been taken. ☐ Have not been taken.

6. Date of injury was _______________. If it was not an injury, when did your symptoms first appear? _________ days / weeks / months / years ago

7. Allergies: ☐ No known drug allergies ☐ Other: ____

8. Past Medical History (Check all that apply)

☐ Aids / HIV
☐ Arthritis
☐ Asthma
☐ Bipolar
☐ COPD/Emphysema
☐ Depression
☐ Diabetes, type I or II
☐ Heart Attack / Disease
☐ High Blood Pressure
☐Ulcer
☐ Other: __________________________
☐ None Apply

10. Social History

Do you smoke? ☐Yes ☐ No
Have you in the past? ☐Yes ☐ No

Do you drink alcohol? ☐Yes ☐ No
Have you in the past? ☐Yes ☐ No

Do you exercise regularly? ☐Yes ☐ No
What is your job? ________________________

Is your faith / religion an important part of your life? ☐Yes ☐ No

Is prayer important to you? ☐Yes ☐ No

☐ Other: ________________________________

13. Review of Symptoms (Check if you have recently had)

☐ Fever, Chills
☐ Neck Pain
☐ Chest Pain
☐ Shortness of breath with walking
☐ Short of breath-rest
☐ None Apply
☐ Blood in stools
☐ Rash
☐ Seizures
☐ Diabetes
☐ Depression
☐Easy Bleeding

9. Past Surgical History (Check all that apply)

☐ Appendectomy
☐ Bone and Joint Surgeries ______________________
☐ Gall Bladder Removal
☐ Heart Surgery or Cath. ________________________
☐ Hysterectomy
☐ Tonsillectomy
☐ Tubal Ligation
☐ No Previous Surgery
☐ Other: __________________________

11. Family History (Check all that apply)

☐ History of Arthritis
☐ History of Heart Disease
☐ History of Osteoporosis
☐ None Apply
☐ History of Cancer
☐ History of Deformities
☐ Other: ____________

12. Medications (Fill in Medications) ☐ None Apply

____
____
____
____
____
____

Preferred Pharmacy: __________________________

X ______________________________ ___________
Patient's or Guardian's Signature **Date**

______________________________ ___________
Physician or PA's Signature Date

Coastal Orthopedics
& SPORTS MEDICINE

www.coastalorthoandsports.com
455 S. Main Street, Suite 106
Hinesville, GA 31313
T: (912) 877-3226, F: (912) 877-3254
10164 Ford Avenue, Suite B
Richmond Hill, GA 31324
T: (912) 756-3599, F: (912) 756-5397

Christopher M. Vaughn, M.D., Brodie E. McKoy, M.D., Crystal K. Cotrell,

Patient Name____
It is our office policy to inform you of our patient payment procedure. Please review the section below that is applicable to you and number (7) (General Acknowledgement).

Financial Policy

_____1. **Patient With Insurance:** You are responsible for deductibles, copays, noncovered services, coinsurance and items considered "not medically necessary" by your insurance company. Please pay co-payments and coinsurance amounts as services are rendered. The remaining balance should be taken care of within one (1) month of notice from insurance company. If you or your insurance carrier makes payment exceeding your balance, reimbursement will be remitted. If payment cannot be made at each visit, notify the front-desk staff to make other arrangements prior to being seen.

_____2. **Worker's Compensation Patient:** As a Worker's Compensation patient you may be covered by insurance if your injury is reported at work and verified with your employer. Be sure to inform the office personnel that your injury resulted during employment. Patient is ultimately responsible for balance.

_____3. **Personal Injury (Accident):** If you are a personal-injury patient, our office does not bill "3d Party" insurance claims. All charges for the services rendered will be your responsibility and are expected as services are provided.

_____4. **Medicare:** Our office will submit your Medicare charges to Medicare and your secondary insurance. You are responsible for deductibles, copays, and any noncovered services.

_____5. **Insurance we do not participate with:** We will file with your insurance for you. You are responsible for deductibles, co-pays, non-covered services, coinsurance and items considered "not medically necessary" or out of network by your insurance company. Please make co-payments and deductibles for your care at each patient visit. If cash, check, or normal credit card payment cannot be made at each visit, our office participates with CareCredit Inc. Please see paragraph six below for further information about CareCredit. If payment arrangements cannot be finalized we will inform you how to locate an "in-network" provider.

_____6. **Patient Without Insurance (Self Pay):** Please make payment for your care at each patient visit. If cash, check, or normal credit card payment cannot be made at each visit, our office participates with CareCredit Inc. If you have an existing CareCredit account we will process your incurred charges through them. If you do not have a CareCredit account we will assist you in applying for this service. The service allows you to apply for no interest credit plans for up to eighteen months or low interest extended payment plans of twenty-four to sixty months. The front-desk staff will provide you with additional information and assist you in completing a CareCredit application. The result for your application must be known prior to your visit. Individual payment arrangements can only be considered when requested by one of our healthcare providers.

_____7. **General Acknowledgement:** I understand that if my account has a balance I will be billed monthly for the balance. If a financial arrangement is approved for me, I will still receive a statement for the balance of my account. Failure to keep my account current by meeting the terms above, or of the financial agreement (if approved), will result in my account being assessed a fee of the greater, $5 or 5% of the balance, each month I fail to meet the terms.

ASSIGNMENT

_____ I request that payment of authorized Medicare benefits be made either to me or on my behalf to Coastal Orthopaedics and Sports Medicine for any service furnished me by that provider. Medicare Number ____________

_____ The signature below authorizes payment of mandated Medigap benefits to Coastal Orthopaedics and Sports Medicine. Medigap ____________ Policy Number _______________ Group Number ________________

_____ I assign the benefits from my insurance carrier(s) to this clinic for the medical/surgical benefits I am entitled to.

RELEASE OF INFORMATION

_____ I authorize Coastal Orthopaedics and Sports Medicine to release to my insurance carrier(s) and/or CMS (formerly HCFA) and its agents and/or my Medigap insurer any information, including Protected Health Information, as needed to determine benefits or benefits payable for related services.

I have read and agree to the Financial Policy, Assignment, and Release of Information paragraphs stated above that apply to me.

X

Patient or responsible party signature | Date

Person signing on behalf of patient | (print name) | Reason patient can't sign

Relationship to Patient | Address | Phone

Financial Arrangement Statement

__ I have an approved CareCredit account. I authorize Coastal Orthopaedics and Sports Medicine to add charges to my CareCredit account as they are accumulated for my family member or myself.

__ Being disapproved for CareCredit, I agree to make ____ payments. At a minimum, payments will be made monthly in the amount of $____________. If payment is unable to be made, I will call patient accounts at 877-3235 to inform them and discuss next payment. I understand my account will be assessed a fee each month I fail to meet this agreement as described on the reverse.

__ I authorize Coastal Orthopaedics and Sports Medicine to charge my credit card monthly on or about the 1st or 15th in the amount of $__________(or less for remaining balance) for dates of service from ___/____/___ to ___/___/___.

Cardholder signature | Date

Patient Name

Cardholder Name

Cardholder Address

City | State | ZIP

___ Visa ___ MasterCard ___ Discover ___ American Express

Credit Card Number | Expiration Date

I have read and agree to the financial policy stated above that applies to me and to the financial arrangements as outlined on this form.

X

Patient or responsible party signature | Date

Person signing on behalf of patient | (print name) | Reason patient can't sign

Relationship to patient | Address | Phone

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Christopher M. Vaughn, M.D., Vaughn A. Frigon, M.D., Brodie E. McKoy, M.D.,
Crystal K. Cotrell, P.A.C.

Consent Agreement

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, ___________________________, understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses. Treatment, and any plans for future care or treatment. I understand that this information serves as:

A bases for planning my care and treatment
A means of communication among the many health professionals who contribute to my care
A source of information for applying my diagnosis and surgical information to my bill
A means by which a third-party payer can verify that services billed were actually provided, and
A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken actions in reliance thereon.

I wish to have the following restrictions to the use or disclosure of my health information:

I fully understand and (circle one) accept / decline the terms of this consent.

X____ Date: ____________________

Liberty Regional Medical Center
Hinesville, GA 31310
(912) 369-9400

Date: ________________

RELEASE OF INFORMATION and FINANCIAL AGREEMENT

I / We hereby acknowledge and agree with the following:

1. Service Provider. The x-ray technician providing services at Coastal Orthopedics and Sports Medicine is an employee of Liberty Regional Medical Center (LRMC). I understand that I will be billed for the technical charges associated with these services by LRMC and that Coastal Orthopedics will bill me only for the professional interpretation of the x-rays.

2. Release of Information. I / We authorize the release of insurance and demographic information, as well as treatment notes associated with all x-ray services from Coastal Orthopedics to LRMC as required to process my insurance and / or bill me appropriately.

3. Guaranty of Payment. I / We, both jointly and individually, shall be fully responsible for payment of the patients' bill, based on the hospital's posted charges, which I / We agree are fair and reasonable for the services that has or will be provided to the patient whose name appears below. The hospital may demand full payment of the patient's bill at any time, but the hospital is not required to do this. Even if the hospital doesn't demand immediate payment, my / our obligation to make such payment remains the same.

4. Insufficient insurance coverage. If any insurance coverage which the patient may have; such as Blue Cross, Medicare, Medicaid, Worker's Compensation or other coverage rejects the patient's claim, or allows only part of the claim, I / We shall be responsible for immediate payment of the balance due, as determined by the hospital.

5. Agreement. I / We have read, understand, and received a copy of this agreement. I / We further agree this release of information and financial agreement is valid for all services rendered for a period of one full year from the above date, at which time it shall expire.

______________________________	______________________________
Name of Patient	Name of Person Guaranteeing Payment
______________________________	X______________________________
Account Number	Signature of Person Guaranteeing Payment
______________________________	______________________________
Home Address of Person Guaranteeing Payment	Telephone Number
______________________________	______________________________
Witness	Employer's Name / Telephone Number