NEW PATIENT INFORMATION

*****PLEASE GIVE ANY XR, CT, or MRI DISCS TO FRONT DESK*****

LAST NAME_____ **FIRST NAME**_____

SSN_____ **BIRTH DATE**_____ **Circle:** Male Female **Gender Identity:** _____

RACE_____ **LANGUAGE**_____ **Circle:** Hispanic Non-Hispanic

MARITAL STATUS: Single Married Divorced **EMAIL**_____

STREET ADDRESS _____ **CITY** _____ **STATE**_____ **ZIP** _____

HOME PHONE_____ **CELL** _____ **WORK** _____

EMERGENCY CONTACT_____ **PHONE**_____

PHARMACY_____ **PRIMARY CARE PHYSICIAN**_____

PRIMARY INSURANCE _____ **SECONDARY INSURANCE** _____

POLICY HOLDER NAME_____

BIRTHDATE_____ **SSN**_____ **RELATIONSHIP TO PATIENT**_____

Are you at a Skilled Nursing Facility? NO YES, Name of Facility_____

If you have Medicare, are you working? NO YES **If you have Medicare, are you disabled?** NO YES

How did you hear about us? _____

Fill this section out about your illness or injury

What is the reason for your visit today? _____

_____**Circle:** Left Right

What date did the injury happen? _____

Where did it happen? (circle) SCHOOL HOME WORK AUTO CRASH OTHER_____

Is this a worker's compensation injury? NO YES **Was an incident report filed with supervisor?** NO YES

Is there legal action or an attorney concerning this injury? NO YES, attorney name_____

ONLY fill this section out if the patient is a CHILD or FULL TIME STUDENT

MOM'S NAME_____ **DAD'S NAME**_____

GUARDIAN NAME_____ **RELATIONSHIP TO PATIENT**_____

I acknowledge that by providing insurance information, I have asked and promised to pay for services provided in exchange for this information. I assign to Lowcountry Orthopaedics & Sports Medicine a member of Arcis Healthcare, LLC, all health insurance benefits available for services provided to me. I understand that fees for services provided by Lowcountry Orthopaedics & Sports Medicine a member of Arcis Healthcare, LLC, are my responsibility and I agree to pay any balance left unpaid by any insurance company or third party entity immediately upon notification of said balance. If I do not have insurance, I understand that I am responsible for any incurred expenses in their entirety.

PATIENT/GUARDIAN SIGNATURE_____ **DATE**_____

FINANCIAL POLICY FOR LOWCOUNTRY ORTHOPAEDICS (LCO), a member of ARCIS HEALTHCARE

Payment for Services

Copays will be collected at check-in, as well as any balance due on the account. We will pre-collect the estimated patient responsibility amounts for surgeries, procedures, and MRI services

Insurance

Insurance information will be updated once a year and we may request your card at each visit. Please notify of any change in carrier, coverage, or cards. Failure to disclose policy changes may result in claim denial and financial charges will become the patient's responsibility. The patient is responsible for knowing the benefits and limitations of their insurance plan.

Referrals

LCO is a specialty practice. If your plan(s) require a referral from your primary care physician (family or regular doctor) for specialty services to be covered, please make sure one has been provided prior your appointment. Patients who do not have a required referral can either reschedule or be self pay.

Copays, Deductibles, Co-insurance and Payment for Services

Any outstanding account balances will be collected at check-in. Many insurance plans require that we collect copays, deductibles and coinsurances, and if these are unable to be paid at the time of service, a $10 processing fee will be added. In addition, we will collect payments for any services that insurance does not cover at the time of service. Prepayment is required for any estimated costs for surgeries, procedures, and MRI. LCO does not take secondary payer adjustments. If you have a Health Savings Account, Health Reimbursement Account, or Flexible Spending Account, we will provide documentation to receive reimbursement, however payment is still required at the time of service. The patient is responsible for any copays, deductibles, coinsurances, and any other services that are not covered, including Durable Medical Equipment (braces, etc.), casting, and drug screening.

Uninsured Patients

A $300 deposit is required for all uninsured patients prior to the appointment. This deposit will be applied to the charges for the visit and any overages must be paid in full at check-out. If you cannot pay the balance, a payment plan can be arranged.

Past Due Balances

Balances that are not paid within 30 days are considered in default. If your insurance company has not responded within 30 days, we may request your assistance in obtaining payment or request that you make a payment. Balances not paid within 90 days will be forwarded to a collections agency, and any associated fees will be added to your account. Any balances must be paid in full or subject to a payment plan before any additional services will be rendered.

No Show and Late Cancellation Fees

If you cannot keep an office appointment, cancellation must be made within 48 hours, or a $25 fee will be charged. Other fees for late cancellations/no shows include MRI ($150), Epidural steroid injections ($150), EMG/NCV ($150), surgical procedures ($150).

Disability or FMLA Forms

A $20 fee will be charged for EACH form completed by our legal department, and may take up to 15 days to process. Payment must be made, and the Claimant Information for Disability Benefits form must be submitted before any request is processed.

Medical Records and Imaging

LCO requires a Medical Records Release form to process your request. We use an outside company, Recordquest, for medical records requests. You may contact them at 888-300-7410 or PO Box 2017, Mount Pleasant, SC 29465 or www.recordquest.com/contactus.aspx . Personal copies of X-ray and MRI will cost $15 per disk and may take up to 48 hours to process. Medical records/images will be forwarded to another medical office at no cost.

Electronic Prescribing

LCO uses escribing and may access my prescription history to provide the most accurate medication list.

I understand that I am financially responsible for account balances, copays, deductibles, coinsurances and any services that are not covered, including DME, drug screening, and casting.

I understand that I will be charged a fee for any missed appointments or late cancellations.

I understand there is a fee for personal copies of medical records and imaging, disability or FMLA forms.

Patient/Guarantor Signature_____ **Date**_____ **(Rev 10.19.2023)**

NOTICE OF PRIVACY PRACTICES AND HIPAA PRIVACY AUTHORIZATION

The Privacy rights and Practices of Lowcountry Orthopaedics, a member of Arcis Healthcare, LLC were established to protect the privacy of our patients medical records as required by Section 164.520 of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. This restricts the release of medical information to the purpose of treatment, payment, and healthcare operations. This law allows the types of agencies listed below to disclose your medical records. **The release of healthcare information to any other source is prohibited without the written consent of the patient or guardian.**

- **Physical Therapy**
- **Pharmacy**
- **Hospital**
- **Coroner/Funeral Director**
- **Surgical Facility**
- **Judicial proceeding**
- **Law Enforcement**
- **Public Health or Safety Threat**
- **Report abuse or neglect**
- **Physician Training**
- **Workers Compensation**
- **Health Insurance Company**
- **Physician Consult**
- **Lab Testing Facilities**
- **Health Inspection**
- **Military/Veterans Affairs**

You have the right to:

- Request restrictions on certain uses and disclosures of your medical records
- Inspect and request changes to your medical records
- Obtain a copy of your medical record (fee is charged)
- Find out what disclosures of your records have been made
- Receive confidential communications
- Ask questions about the privacy policy or file a complaint with Lowcountry Orthopaedics or the Secretary of Health and Human Services without fear of any reprisals if you believe your privacy rights have been violated

Please indicate the following to assist us in ensuring the privacy of your medical records

1. **I give my permission for Lowcountry Orthopaedics to leave messages concerning my medical records and appointment reminders on the following (please circle all that apply)**

   Cellular Voicemail With family members Work Voicemail

   Home Answering Machine Text Message Email

2. **I consent to receive calls from Lowcountry Orthopaedics concerning healthcare information at the phone numbers provided. I accept financial responsibility for charges by my phone carrier for these calls. I understand this consent is not required to be a patient and I may revoke it at any time. _____ YES _____ NO**

3. **Can you be contacted at your place of employment? _____ YES _____ NO**

4. **The following people have my permission to speak with Lowcountry Orthopaedics and its affiliates regarding my medical records and financial account.**

   NAME_____ RELATIONSHIP_____

   NAME_____ RELATIONSHIP_____

5. **If patient is a CHILD or FULLTIME STUDENT, please list any other individual that can authorize treatment for your child in the event that you cannot attend to the appointment or that may bring them to their visits *(consent will expire in one year from date signed)***

   NAME _____ RELATIONSHIP _____

   NAME _____ RELATIONSHIP _____

6. **Electronic prescribing shows all medications a patient has received within the last 13 months, which enhances safety and reduces errors. As of 2012, Lowcountry Orthopaedics began using this in conjunction with our electronic medical record software. This service is permitted and protected by HIPAA.**
   Lowcountry Orthopaedics Associates, a member of Arcis Healthcare, LLC is required by law to abide by the terms outlined in this notice. However, Lowcountry Orthopaedics reserves the right to change the terms of this Privacy Notice and make the new provisions effective for all protected health information that we maintain. **Any changes to this notice will be posted and distributed during office appointments. For additional questions or to report a problem, please contact our HIPAA Security Professional at 843-569-5488.**

Patient/Guardian Signature_____ **Date**_____

Witness_____ **Date**_____

Athena ID: _____ **Patient Name:**_____

Primary Care Provider (PCP): _____

Pharmacy & Location: _____ **Did you Receive a Flu Vaccine?** Yes _____ No _____ Date: _____

Drug Allergies: _____

Surgical Procedures: _____

_____

Weight	**Lbs.**
Height	**Ft.** **In.**

Medications (if you have a list, please give to Medical Assistant, and skip this): _____

_____

FAMILY HISTORY: Please circle any that your parent was diagnosed with							
Father	Arthritis	Asthma	Cancer	Stroke	Diabetes	HIV/AIDs	Sickle Cell/ Trait
	Kidney Disease	Mental Disorder	Bleeding Disorder	Heart Attack	High Blood Pressure	High Cholesterol	
Mother	Arthritis	Asthma	Cancer	Stroke	Diabetes	HIV/AIDs	Sickle Cell/ Trait
	Kidney Disease	Mental Disorder	Bleeding Disorder	Heart Attack	High Blood Pressure	High Cholesterol	

SOCIAL HISTORY: Please circle the answer that best describes you						
Smoking Status	Never Smoke		Former Smoker			Currently smoke
Smoking	½ pack/day	1 pack/day	1.5 pack/day	2 pack/day		2 + pack/day
Medical Power of Attorney	Yes	No	**Advance Directive/ Living Will**	Yes	No	
Alcohol Intake	None	1-4 drinks/week	5-9 drinks/week	> 10 drinks/week		
Marital Status	Married	Single	Divorced	Separated	Widowed	Domestic Partner
Work History	Disabled	Homemaker	Retired	Student	Unemployed	
Current Job		**Employer**				
Hand Dominance	Right Handed			Left Handed		

MEDICAL HISTORY: Please circle all conditions you have been diagnosed with					
Acid Reflux	Coronary Artery Disease	Glaucoma	Kidney Disease	Osteoporosis	Sickle Cell Anemia
Anemia	Chronic Bronchitis	Gout	Kidney Failure	Pacemaker	Sleep Apnea
Arthritis	Depression	Heart Attack	Kidney Stones	Panic Attack	Stroke
Asthma	Diabetes	Heart Disease	Leg/Foot Ulcers	Vascular Disease	Thyroid Problem
Anxiety	High Cholesterol	Hepatitis	Liver Disease	Phlebitis	Tuberculosis
Blood Clots	Emphysema / COPD	Hernia	Lung Disease	Poor Circulation	Ulcers
Bleeding Disorder	Fibromyalgia	High Blood Pressure	Mental Disorder	Pulmonary Embolism	Urinary Tract Infection
Blood Transfusion	Fracture	HIV/AIDs	MRSA/VRE	Rheumatoid Arthritis	
Cancer	Gallbladder Trouble	Insomnia	Migraines	Seizures / Epilepsy	

Review of Symptoms: (PLEASE CIRCLE SYMPTOMS YOU ARE CURRENTLY EXPERIENCING)

Constitutional: Fever Night Sweats Weight Gain Weight Loss Difficult exercising

Eyes: Dry eyes Irritation Change in vision

Ears: Difficult hearing Ear pain

Nose: Frequent nosebleeds Nose/sinus problems

Mouth/Throat: Sore throat Bleeding Gums Teeth problems Mouth ulcers Oral Abnormalities Snoring Dry Mouth

Cardiovascular: Chest pain Heart Murmur Palpitations Shortness of Breath when Walking Arm pain or exertion Shortness of Breath when Lying Down

Gastrointestinal: Abdominal pain Vomiting Loss of appetite Diarrhea Vomiting blood

Genitourinary: Incontinence Difficult Urinating Blood in urine Painful Urination Increase urinary frequency

Musculoskeletal: Muscle aches Muscle Weakness Back pain Joint pain Swelling in extremities

Skin: Abnormal Mole Jaundice Rash Itching Dry Skin Growth/lesions

Neurologic: Loss of consciousness Weakness Numbness Seizures Dizziness Headaches Migraines Restless legs

Psychiatric: Depression Sleep Disturbance Alcohol abuse

Endocrine: Fatigue Increased Thirst Hair loss Increased hair growth Cold intolerance

Hematologic/Lymphatic: Swollen glands Easy Bruising Excessive bleeding

Allergic/Immunologic: Runny nose Sinus Pressure Itching Hives Frequent sneezing

Respiratory: Coughing Wheezing Shortness of breath Coughing up blood