Georgetown Orthopaedics

Dr. Mark Triana, D.O. Dr. Jesse Welter, D.O. Mark Galloway, P.A.-C

2185 North Fraser Street Georgetown, SC 29440

Tel: 843-527-1800 Fax: 843-527-6528

Patient Information:

Name (Last,First,MI) _____

SSN: ___-___-___ DOB: ___/___/___ Gender: ___Male ___Female

Marital Status: _____ Race/Ethnicity: _____ Student PT / FT Veteran Y / N

Billing Address: _____

City _____ State _____ Zip _____ Email address _____

Tel ( )___-___ Work ( )___-___ Alt/Cell ( )___-___ Ok to leave message? Y / N

Emergency Contact Name _____ Tel ( )___-___

Primary Care Physician _____ Referring Physician _____

Employer _____ Tel ( )___-___

Address _____

Primary Ins _____ ID#/Policy# _____

SecondaryIns _____ ID#/Policy# _____

Name of Policy Holder _____ DOB ___/___/___ SSN ___-___-___

Responsible Party/Guarantor Information (if different than above)

Name(Last,First,MI) _____

SSN: ___-___-___ DOB: ___/___/___ Relationship to Patient _____

Address: _____

Tel ( )___-___ Work ( )___-___ Alt/Cell ( )___-___ Email _____

Private Insurance Authorization or Assignment of Benefits/Information Release/Consent for Treatment

I, the undersigned, authorized payment of medical benefits to Georgetown Orthopaedics LLC for any services furnished to me by Georgetown Orthopaedics LLC. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to releaseto my primary care physician, insurance company, or the agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluation and administering claims of benefits. Payments for services are due at the time of services rendered. We accept cash, check, Mastercard and Visa. I understand, acknowledge and agree that I am being seen by a provider who is an employee of Mark E. Triana, D.O., P.A. and provides services to patients of Tidelands Health Group pursuant to an independent contractor arrangement. I further understand, acknowledge and agree that I am being treated by Tidelands Health Group and that Tidelands Health Group will have access to my medical records.

_____

(Signature of Patient/Guarantor/Guardian) (Date)

POLICY ON MEDICATION REFILLS

1. Georgetown Orthopaedics requires 48 hours for all prescription refills.
2. When calling in for a prescription, please leave your name, date of birth, medication, pharmacy name and phone number. Without this information your request will not be processed.
3. The patient must call in their own prescription refills. A friend or family member may pick up a prescription with proper identification, such as a drivers license and a written authorization from the patient.
4. If a prescription is to be called into your pharmacy, please check with that pharmacy 48 hours after your request. If your prescription needs to be picked up in the office, your doctor's clinical assistant will call you to let you know when it is ready.
5. Please do not call the office multiple times to see your prescription is ready. Please follow #4. Calling the office multiple times may only delay your request.

_____ _____

(patient signature) (date)

I agree to let certain individuals participate in discussions and decisions related to my medical care. Furthermore, I agree to let certain individuals pick up prescriptions in my absence. Therefore, I hereby give my permission for Georgetown Orthopaedics and Dr _____ and his/her staff to disclose medical information to the following individuals:

Name: _____ Relation: _____ Phone: _____
Name: _____ Relation: _____ Phone: _____
Name: _____ Relation: _____ Phone: _____

_____ _____

(patient signature) (date)

GEORGETOWN ORTHOPAEDICS

Patients Name: _____

Patient History Form

Date of Birth: _____

Social Security#: _____

Referring Physician: _____
Primary Care Provider: _____
Emergency Phone #: _____ Contact Person/Relationship: _____
Pharmacy: _____ Phone #: _____

Reason for Visit:

_____

Is this injury related to Work: Yes / No **Motor Vehicle Accident:** Yes / No
Date of injury/pain: _____
History of present injury/pain: (Location, Quality, Severity, Duration, Timing, Context, Modifying Factors, Assoc. Signs/Symptoms)

_____

_____

Surgical History: _____

_____

Medical problems: _____

_____

_____

Medications: ☐ None ☐ See Updated Med List

Medication	Frequency		Medication	Frequency	

Drug Allergies: _____

Family History of

Y	N		Family Member
☐	☐	Alzheimer's Dz	_____
☐	☐	Anemia	_____
☐	☐	Breast CA	_____
☐	☐	Cervical Cancer	_____
☐	☐	Colon CA	_____
☐	☐	Depression	_____
☐	☐	Diabetes	_____
☐	☐	Glaucoma	_____
☐	☐	Heart Dz	_____
☐	☐	Hyperchol	_____
☐	☐	High Blood Pr	_____
☐	☐	Ovarian CA	_____
☐	☐	Prostate CA	_____
☐	☐	Skin CA	_____
☐	☐	Stroke/TIA	_____
☐	☐	Thyroid Dz	_____

Social History

Do you smoke? Yes / No
_____ packs per week

Do you drink? Yes / No
_____drinks per week

Do you use recreational drugs?
Yes / No

Please circle one:

Right handed / Left handed

Social History

☐ Married ☐ Single ☐ Civil Union

☐ Divorced ☐ Widow(er)

☐ Lives Alone ☐ Separated

Occupation: _____

Religious Preference: _____

Advance Directive? ☐ Yes ☐ No
If Yes, Date: _____

Educ.: ☐ JHS ☐ HS ☐ College

☐ Other _____

Review of Systems: Are you experiencing any of the following chronic problems? If yes, please circle specific problems

General/Constitutional (weight gain/loss/change in appetite) Yes/No

Eyes (change in vision/glaucoma/cataracts) Yes/No

Ears, Nose, Throat (hearing loss/earaches/sore throat/swollen glands) Yes/No

Endocrine (intolerance to hot or cold/trouble sleep/ excessive thirst) Yes/No

Respiratory (change in breathing/cough/shortness of breath/sleep apnea) Yes/No

Cardiovascular (chest pain/irregular heartbeat/palpitations) Yes/No

Gyn/Breast (irregular periods/breast lump/breast pain/discharge) Yes/No

Gastroenterology (nausea/constipation/diarrhea/heartburn/change) Yes/No

Genitourinary (blood in urine/difficulty urinating/painful or frequent urination) Yes/No

Musculoskeletal (numbness/tingling/cramps/painful joint(s)) Yes/No

Vascular (trouble walking/blood flow to legs/painful extremities) Yes/No

Dermatology (moles/rash/itching/skin cancer) Yes/No

Neurologic (seizures/weakness/headaches/slurred speech) Yes/No

Psychiatric (anxiety/depression/mental illness/claustrophobia) Yes/No

Comments:

_____

_____

_____

Private Insurance Authorization for Assignment of Benefits/Information/Financial Policy:

I, the undersigned, authorize payment of medical benefits to Georgetown Orthopaedics, LLC for services furnished to me by Georgetown Orthopaedics, LLC. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my primary care physician, insurance company or the agent information concerning health care, advice, treatment or supplies provided to me.

This information will be used for the purpose of evaluating and administering claims of benefits. At Georgetown Orthopaedics, LLC, we are committed to providing you with the best possible care. If you have medical insurance, we will help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy.

Payment for services is due at the time services are rendered. We accept cash, personal checks, MasterCard and Visa. All HMO patients will need to bring a referral from your Primary Care Physician before being seen. Without this form, your insurance will not pay and you will be responsible for your bill.

You, the patient to whom services are rendered, are responsible for your account being paid. We will assist you by filing your insurance, but you will be personally responsible for payment of your account if payment is not received within sixty (60) days from your insurance company.

I have received a copy of the Notice of Privacy Practices from Georgetown Orthopaedics, LLC.

_____ _____

Patient or Guardian Signature Date

HIPAA Notice of Privacy Practices:

Georgetown Orthopaedics, LLC

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for the purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and relates to your past,present, future physical, or mental health condition and or related health care services.

- Uses and disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

- Treatment:

We will use and disclose your protected health information to provide, coordinate, or manage your health care and related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred, to ensure that the physician has the necessary information to diagnose or treat you.

- Payment:

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

- Healthcare Operations:

We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.We may use or disclose your protected health information in the following situations without your authorization. These situations include as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse and Neglect:Food and Drug Administration requirements; Legal Proceedings:Law Enforcement:Coroners,Funeral Directors, and Organ Donation:Research:Criminal Activity:Military Activity and National Security:Workers' Compensation:Inmates.

- Required Uses and Disclosures:

Under the law, we must make disclosures to you and when required by a Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164-500. Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization at any time in writing, except to the extent that your physician or the physician's practice has taken action in reliance on the use or disclosure indicated in the authorization.

- Your Rights:

The following is a statement of your rights with respect to your protected health information. You have the right to inspect or copy the following records: psychotherapy notes, information complies in reasonable anticipation of, or use in, a civil criminal, or administrative action or proceeding and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected healthy information not be disclosed to family members or frineds who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We, Georgetown Orthopaedics, LLC, reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and effective on or before April 14,2003.

We are required by law to maintain the privacy of, and provide individual with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our Compliance Officer in person or by phone.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

_____ Date: ____/____/____

Print Name

_____ Date: ____/____/____

Signature

Georgetown Orthopaedics, LLC

2185 N. Fraser Street
Georgetown, SC 29440
Tel: (843) 527-1800
Fax: (843-527-6528

Georgetown Orthopaedics, LLC
Financial Policy

Patient Responsibility:
Patients are responsible for payment in full on their account regardless of insurance coverage. Patients are responsible for presenting current insurance information at the time of service, and for understanding the provisions and the limitations of their insurance plan. Our doctors neither know, nor can they adjust their billing according to what is or is not covered.

If Georgetown Orthopaedics, LLC is a participating provider with the patient's insurance, the patient will be responsible for payment of any deductible and co-payment amount at the time of service. Georgetown Orthopaedics, LLC will accept assignment and bill the insurance company for the contracted fee. However, if the insurance company denies the charges or fails to pay any portion of the bill, the patient agrees to pay that portion immediately. Return checks are payable to Georgetown Orthopaedics, LLC will charge a fee of $30.00. Patients will have up to five business days to satisfy payment for the return check charge, and payment before services are rendered. If you have a returned check with our office you will be required to pay the returned check charge, the balance of your visit and all future appointments with cash or credit card only.

If Georgetown Orthopaedics, LLC is not a participating provider with the patient's insurance company, the patients will be responsible for payment of all charges in full at time of service.

- Many insurance companies DO NOT cover preventative services (routine exams).
- Patients are responsible for payment of all non-covered services.
- We will file secondary insurance for only those companies with which we have a contract. If your secondary insurance is one, which we are non-participating with, you will be responsible for the remaining balance at the time of service, and you will have to file your own claim.
- Some insurance companies require a referral to a specialty office. It is the patient's responsibility to know their policy, and if they need a referral or authorization before scheduling an appointment with our office. It is the patients' responsibility to make sure that these referrals and authorizations are taken care of before their appointment. Any visits that have not been referred properly or authorized will be deemed as patient responsibility.

Medicare:
Georgetown Orthopaedics, LLC accepts assignment of Medicare. Patients are responsible for their deductible and the 20% co-pay, as well as and all non-covered services provided.

Medicaid:
Medicaid is a federal and state funded program designed to provide coverage of medically necessary services for individuals that meet a minimum income criteria. This practice accepts Medicaid as payment in full upon receipts of a valid Medicaid card. Georgetown Orthopaedics, LLC patients will be required to see our billing department staff to discuss acceptance requirements.

Self-Pay:
Georgetown Orthopaedics, LLC will treat self-pay patients; however they are required to bring with them to their first appointment their total estimated payment in full by cash or credit card only. All future appointments will need to be paid in full as well. Patients will need to ask before they schedule, the estimated total of how much they will need to bring for their next appointment before leaving the office. There is no way we will be able to tell you the exact cost of your visit, until you are seen by the physician. All visits are simply estimates and fees could be more or less than actual estimate given to the patient over the phone. Balances that meet our financial requirements may be eligible to be places on payment plan.

Payment Plans:
If a patient meets the criteria requirements to be put on a payment plan, arrangements will be made before they leave the office. If payment arrangements are not upheld, the account will be turned over to our collection department and if not resolved, will be sent to a collection attorney. In addition, if the accounts are not upheld the physician's will not call in any more prescriptions, and no future appointments will be made until all balances are paid in full.

All account balances are to be paid in full before services are rendered. We reserve the right to re-schedule any appointments, and postpone prescription refills until balances are current. There will be a $25.00 no show fee for any missed, cancelled or no showed appointments without 24 hours notice.

I have read and agree to the above policy terms and conditions. I authorize the release of medical information or other information necessary to process insurance claims.

I authorize payment of medical benefits directly to Georgetown Orthopaedics, LLC for all services rendered.

I, _____ read and understand
(Patient Name)
Georgetown Orthopaedics, LLC financial policy.

_____ Date: ____/____/____
(Signature of Patient)