EL-AMIN
ORTHOPAEDIC & SPORTS MEDICINE INSTITUTE

PATIENT INFORMATION

Name:	Date of Birth:	☐ Male ☐ Female
Address:		
City:	State:	Zip Code:
SSN:	Home Phone:	Cell Phone:
Email address:		
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated		
Check all that apply: ☐ DECLINE		
Race: ☐ Asian ☐ Black ☐ Hispanic	Ethnicity: ☐ Latino ☐ Not Latino	
Preferred Language: ☐ English ☐ Spanish ☐ Sign Language ☐ Other (list here)		

INSURANCE INFORMATION

Primary Insurance Carrier:	
Policy Number:	Group Number:
Subscriber name:	Subscriber Date of Birth:
Patient relationship to subscriber: ☐ Self ☐ Child ☐ Spouse	Subscriber gender: ☐ Male ☐ Female
Secondary Insurance Carrier (if applicable):	
Policy Number:	Group Number:
Subscriber name:	Subscriber Date of Birth:
Patient relationship to subscriber: ☐ Self ☐ Child ☐ Spouse	Subscriber Gender: ☐ Male ☐ Female

Is this visit due to workers comp or personal injury case? ☐ Yes ☐ No

Employer:	Employer Phone:	
Covering Entity:	Phone Number:	
Address:		
City:	State:	Zip:
Claim Number:	Adjuster Name:	

I authorize El-Amin Orthopaedic & Sports Medicine Institute to furnish information to insurance carriers concerning my illness, condition, accident, or injury and treatment. I hereby assign to Dr. El-Amin Sports Medicine all payments for medical services rendered to me or my dependent(s) which I have not already paid. I acknowledge that all of the above information is true and correct and that it has been furnished to El-Amin Orthopaedic & Sports Medicine Institute with full knowledge that I, the patient, or my dependent, will be liable for all said services rendered and that I, the patient, or my dependent will be contractually bound to pay for said services including all costs of collection and a reasonable attorney's fee should collection become necessary.

Patient/Guardian Signature: **Date:**

PATIENT INJURY/TREATMENT INFORMATION

Reason for today's visit: ☐ **Right** ☐ **Left** (ex. Left shoulder)

Please describe your pain as: ☐ ACHING ☐ BURNING ☐ SHARP ☐ DULL ☐ WORSENING ☐ IMPROVING
☐ FREQUENT ☐ OCCASIONAL ☐ OTHER (please list here)___________________

Is your pain? ☐ MILD ☐ MODERATE ☐ SEVERE ☐ NONE

Please rate your pain on a scale from 1 – 10: ______________

Date of onset: ____ / ____ / ____

Associated symptoms - Check **ALL** that apply: ☐ POPPING/CLICKING ☐ CATCHING/LOCKING ☐ GRINDING
☐ SWELLING ☐ STIFFNESS ☐ WEAKNESS ☐ TINGLING
☐ NIGHT PAIN ☐ NUMBNESS ☐ INSTABILITY ☐ RADIATING

What makes symptoms worse?	What makes symptoms better?

Have you ever had a previous injury or symptoms involving this body part in the past? ☐ Yes ☐ No

Please indicate previous treatments for this problem: ☐ NONE ☐ STEROID INJECTION ☐ PHYSICAL THERAPY
☐ SURGERY ☐ CHIROPRACTIC ☐ OTHER:

Recent testing for injury: ☐ X-Ray ☐ MRI ☐ CT Scan ☐ Bone Scan ☐ Other: ___________________________

Facility Name:____ Date: ______________________

PATIENT HEALTH INFORMATION

Patient Height: ______ft. ______in. Weight: ____________lbs.

Please list medication allergies: ☐ NONE

List of current medications (include over the counter meds) ☐ NONE

Preferred Pharmacy: **Pharmacy Phone:**

FAMILY HISTORY

☐ First-Degree relatives have no current problems or disabilities

MOTHER: ☐ Living ☐ Deceased ☐ Anesthesia Complications ☐ Bleeding Disorder ☐ Arthritis
☐ Heart Disease ☐ Diabetes ☐ Cancer: ________________________
☐ Malignant Hyperthermia ☐ Other:____________________________________

FATHER: ☐ Living ☐ Deceased ☐ Anesthesia Complications ☐ Bleeding Disorder ☐ Arthritis
☐ Heart Disease ☐ Diabetes ☐ Cancer: ____________________
☐ Malignant Hyperthermia ☐ Other:____________________________________

SOCIAL HISTORY

Alcohol Use: ☐ NONE ☐ Occasionally ☐ Daily

Tobacco Use: ☐ NEVER ☐ Current smoker ☐ Previous smoker

SURGICAL HISTORY

Please check **ALL** that apply:

☐ NONE

Orthopaedic: ____

Eyes / ENT: ☐ Cataracts ☐ Tonsils ☐ Sinus Surgery ☐ Thyroid

Heart: ☐ Bypass Valve Replacement ☐ Stent Placement ☐ Angioplasty ☐ Pacemaker

GI: ☐ Appendix ☐ Gallbladder ☐ Hernia ☐ Gastric Bypass

OB/Gyn: ☐ C-section ☐ Hysterectomy ☐ Tubal Ligation

Urologic: ☐ Prostate ☐ Vasectomy ☐ Bladder

Vascular: ☐ Carotid ☐ Aneurysm ☐ Leg Bypass

Other: ____

History of surgical infection? ☐ YES ☐ NO If yes, explain______________________________________

History of failed surgery? ☐ YES ☐ NO If yes, explain______________________________________

History of anesthesia complication? ☐ YES ☐ NO If yes, explain ________________________________

MEDICAL HISTORY

Do you currently or have a history of any of the following? Check **ALL** that apply: ☐ NONE

Condition	YES	NO	Condition	YES	NO
Anemia			Hepatitis A / B / C (circle one)		
Anxiety Disorder			High Blood Pressure		
Arthritis			HIV / AIDS		
Asthma			Hyperthyroidism		
Bleeding Disorder			Hypothyroidism		
Blood Clots			Irregular Heartbeat		
Cholesterol, elevated			Kidney Disease, Stage:		
Circulatory Disease			Lyme Disease		
COPD			Osteoporosis		
Depression			Other mental illness:		
Diabetes / Insulin dependent			Parkinson's Disease		
Diabetes / Non-insulin dependent			Rheumatoid Arthritis		
Emphysema			Seizures		
Fibromyalgia			Sleep Apnea		
Glaucoma			Stomach Ulcers		
Gout			Stroke		
Heart Disease			Substance Abuse:		
Heartburn/Reflux			Urinary Infections		
Cancer (date/type)					
Other:					

REVIEW OF SYSTEMS	
Check **ALL** that apply:	☐ NONE
General Health:	☐ Weight Loss ☐ Weight Gain ☐ Fever ☐ Night Sweats ☐ Fatigue
ENT:	☐ Headaches ☐ Difficulty Swallowing ☐ Nose Bleeds
Cardiovascular:	☐ Chest pain ☐ Palpitations ☐ Fainting
Respiratory:	☐ Shortness of Breath ☐ Wheezing ☐ Coughing
Gastrointestinal:	☐ Heartburn ☐ Nausea ☐ Constipation ☐ Diarrhea
Urinary:	☐ Urinary frequency ☐ Urgency ☐ Burning/Pain ☐ Incontinence
Musculoskeletal:	☐ Joint pain ☐ Swelling ☐ Stiffness ☐ Muscle Pain
Skin:	☐ Skin changes ☐ Poor healing ☐ Rash ☐ Itching
Neurological:	☐ Numbness/Tingling ☐ Unsteady gait ☐ Dizziness ☐ Tremors
Hematologic:	☐ Easy bleeding ☐ Bruising

El-Amin Orthopaedic & Sports Medicine Institute Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information Your protected health information will be used by El-Amin Orthopaedic& Sports Medicine Institute or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information You may request a restriction on the use or disclosure of your protected health information. El-Amin Orthopaedic& Sports Medicine Institute may or may not agree to restrict the use or disclosure of your protected health information. If El-Amin Orthopaedic& Sports Medicine Institute agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation or consent is received will not be affected.

Reservation of Right of Change Privacy Practices El-Amin Orthopaedic& Sports Medicine Institute reserves the right to modify the privacy practices outlined in this notice. A revised Notice of Privacy Practices may be obtained by forwarding a written request to El-Amin Orthopaedic& Sports Medicine Institute, 3855 Pleasant Hill Rd, Duluth, GA 30096.

Signature I have reviewed this consent form and give my permission to El-Amin Orthopaedic& Sports Medicine Institute to use and disclose my health information in accordance with it.

____ _________________________________
Name of Patient Date

____
*Signature of Patient/Parent (if minor)/Representative Relationship to Patient

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HIPAA Disclosure Consent

You agree, in order for us to service your account or to collect monies you may owe, El-Amin Orthopaedic & Sports Medicine Institute and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. You agree that you have read this disclosure and agree that El-Amin Orthopaedic & Sports Medicine Institute, its employees and/or our agents may contact me as described above. With this consent, El-Orthopaedics may share my Protected Health Information (PHI) in the following methods:

Leave a message on home phone? YES / NO ______________________________________
Home Phone Number

Leave a message on cell phone? YES / NO ______________________________________
Cell Phone Number

Send an email? YES / NO ______________________________________
Email address

I authorize El-Amin Orthopaedics & Sports Medicine Institute to release/disclose my PHI including test and imaging results, diagnoses and treatments to the following individuals:

Name	Relationship	Phone Number
__________________________________	__________________	_________________
__________________________________	__________________	__________________

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

___________________________________ __________________
*Signature of Patient/Legal Guardian Date

____
Print patient’s name

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FINANCIAL POLICY

Payment is required at the time services are rendered unless other arrangements have been made in advance by you and/or your insurance carrier. This includes applicable and estimated co-insurance, copays and deductible amounts determined by your insurance policy, provided we are in-network with your plan. El-Amin Orthopaedic & Sports Medicine Institute accepts cash, personal checks (in-state only), VISA, MasterCard, Discover and American Express. There is a $30 charge for all returned checks.

Patients with an outstanding balance more than sixty (60) days old MUST make arrangements for payment prior to scheduling future appointments. If payment arrangements are not made and the account is more than ninety (90) days delinquent, the account will be charged a 30% fee on amount due and WILL be turned over to a collection agency. You will not be allowed to make an appointment until your account is paid in full after being sent to collections.

INSURANCE

As a courtesy to you, we will bill your insurance company. We will attempt to determine eligibility on the date of your appointment. As such, d**eductibles, co-insurance and co-pays are expected at time of service.** We will also forward claims to all secondary insurances along with the appropriate EOB from the primary carrier. Please make sure to inform the registration staff of any and all insurance policies as well as provide them with all insurance cards. If you do not have your insurance card(s) with you, your account will be considered “Self-pay” until you provide us with your insurance cards. If your account is classified as “Self-pay”, the terms of our Self-pay Policy will apply.

SELF-PAY

Self-pay accounts are required to pay $125.00 at time of check-in. Additional charges may apply depending on treatment rendered, such as casting or injections. We designate accounts Self-Pay under the following circumstances:

- Patient is covered by an insurance plan in which our practice does not participate.
- Patient does not have a valid insurance referral on file, such as HMO or TriCare Prime.
- Patient does not have health insurance coverage.

REFUNDS

If an overpayment is made on your account, refunds will be processed. If your treatment is ongoing, we will apply the overpayment to any future balances, at your request. We will provide you with an authorization instructing us on the handling of your overpayment.

MISSED APPOINTMENTS / LATE CANCELLATIONS

Missing or arriving late for appointments without advance notice can cause delays for other patients. As a courtesy we ask you to contact the practice 24 hours in-advance if you will not be able to keep your scheduled appointment date and time. If you find that you must be late, please contact us as soon as possible so that we can determine if we need to reschedule your appointment. Extensive or excessive tardiness may result in discharge from the practice.

Patient Name: ____ Date: ___________________

Signature of patient/parent/guardian/designee: _____________________________________

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Pain Prescription Policy

No narcotic pain relievers will be prescribed at the time of initial consultation. The referring physician should manage all pain medication until a final treatment plan has been recommended by this office. It is unlikely that a final treatment plan can be recommended at the initial visit since most patients will not have had all the necessary diagnostic testing required to form an accurate diagnosis (i.e., MRI, X-rays, EMG, CT scan, etc.).

Once the final diagnosis has been made, this office will recommend a treatment plan that may or may not include the short-term use of narcotic pain medication.

In the event surgery has been recommended, this office will render the post-operative pain management. **Narcotic pain management in the post-operative period may not exceed 6 weeks.**

In the event a non-operative treatment plan has been recommended, pain management can be rendered by either the primary care physician (PCP) or by the non-surgical specialist to who the patient is referred for further care.

Pharmacies monitor patient use of narcotic pain medications and contact the prescribing physician(s) if a patient is receiving narcotic pain medication from more than one physician. If this office receives notification, from any source, that a patient is receiving narcotic pain medication from more than one physician, prescribing of such medication by this office will be immediately suspended.

Under no circumstances will narcotic pain medication be prescribed beyond a 90-day period. If narcotic pain management is required beyond 90 days, then a referral to a Chronic Pain Specialist will be made. In the event of suspected narcotic abuse, further prescriptions of narcotic pain medications will not be prescribed. In the event of documented narcotic abuse, further prescriptions will not be prescribed, and the patient may be discharged from care.

IF A REQUEST FOR A NARCOTIC PRESCRIPTION REFILL HAS BEEN MADE BY TELEPHONE, THE PHYSICIAN MUST REVIEW YOUR CHART PRIOR TO WRITING PRESCRIPTION. THEREFORE, YOUR REQUEST MAY NOT BE PROCESSED IMMEDIATELY. IT IS THE POLICY OF THIS OFFICE TO COMPLETE ALL LEGITIMATE REQUESTS WITHIN 48 BUSINESS HOURS. THEREFORE, REQUESTS MADE ON FRIDAY MAY NOT BE COMPLETED UNTIL THE FOLLOWING WEEK. ALL NARCOTIC PRESCRIPTIONS MUST BE PICKED UP AT THE OFFICE.

Patient/Parent/Guardian, by signing this form, you agree that you have read and understand the above statements.

Signature: ____ Date: ______________

Printed Name: ____