ORTHOPEDIC Centers of America

BRAMLETT ORTHOPEDICS

Patient Information

200 Montgomery Highway, STE 200
Birmingham, AL 35216
Phone: 205-783-5900
Fax: 205-783-5906

Patient Information

Name (Last, First, Middle)		Social Security Number	Date of Birth	Age	Sex
Local Address		City, St, Zip	Secondary Billing Address (if necessary)		
Marital Status	Home Phone	Day /Cell Phone	Email Address		
Emergency Contact	Relation to Patient	Emergency Number			
Primary Care Physician		Do you have power of attorney? ☐ Yes ☐ No	Do you have an advanced directive/Living Will? ☐ Yes ☐ No		

How did you hear about us?:

☐ TV ☐ Newspaper ☐ Radio ☐ Internet ☐ Word of mouth ☐ Facebook ☐ Instagram ☐ Referring Physician (Physician's Name: ___________________________)

Employee Information / Pharmacy Information

Employee Information	Pharmacy Information
Primary Employer	Pharmacy Name
Address	Pharmacy Address
City, St, Zip	Pharmacy City, St, Zip
Work Phone	Pharmacy Phone

Responsible Party Information (if different than above)

Name (Last, First, Middle)	Social Security Number	Date of Birth	Age	Sex
Local Address	City, St, Zip	Secondary Billing Address (if necessary)		
Home Phone	Day /Cell Phone		Relationship to Patient	

Primary Insurance

Name of Insurance Company	Address(Street, City, St, Zip)	CoPay
Policy Holder Name	Social Security Number of Policy Holder	DOB
Contract #	Group#	Effective Date

Secondary Insurance (if applicable)

Name of Insurance Company	Address(Street, City, St, Zip)	CoPay
Policy Holder Name	Social Security Number of Policy Holder	DOB
Contract #	Group#	Effective Date

Workers Compensation (if applicable)

Is this a workers compensation case? Yes _____ No _____	If Yes, Date of Injury / /
Employer:	

I hereby assign to Bramlett Orthopaedic, LLC all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered and agree to pay any applicable collection fees if my bill is placed with a collection agency/attorney.

Signature of Patient/Guardian:____ Date:___________________________________

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Authorization For Release of Protected Health Information (PHI)

Bramlett Orthopaedic, LLC is committed to the protection of our patients' personal health information. However, we recognize that individuals other than themselves attend to many of our patients' healthcare needs. In accordance with HIPAA regulations, we ask that you take a moment to give us the names of individuals with whom we are able to discuss your medical appointments, condition, treatment options, insurance payment information, or other information necessary to our responsibility in your treatment. Please list the names (and phone numbers, if readily available) of any individuals with whom we may have communication, which may include all, or part of your protected health information. If you fail to list any names, we will not discuss your medical information with anyone other than yourself.

Contact:	**Relationship to Patient:**	**Telephone Number:**
______________________	________________________	________________
______________________	________________________	________________
______________________	________________________	________________

I understand that this authorization will expire in one (1) year unless marked otherwise. I understand I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying Bramlett Orthopaedic, LLC. in writing. By signing below, I release Bramlett Orthopaedic, LLC (its employees, agents, officers, and directors) from all liabilities and responsibilities for disclosure of information as stated above to the extended indicated and authorized pursuant to this signed authorization.

____________________________ ____________________
Print Name (Patient or Guardian) Date

____________________________ ____________________
Signature (Patient or Guardian) Relationship to Patient

I understand that if I refuse to sign this form, Bramlett Orthopaedic, LLC may not provide services to

PAYMENT POLICY

Thank you for choosing Bramlett Orthopaedic, LLC. We are committed to providing you with high quality and affordable health care. Due to recent changes in healthcare plans, we believe it necessary to answer your questions regarding patient and insurance responsibility for services rendered. The following is our current payment policy. We encourage you to ask us any questions you may have. Please read the following information and sign below acknowledging your acceptance of this policy.

1. ***Insurance* -** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, you will need to have a current card so that we may verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. ***Co-Payments and Deductibles* -** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment and/or deductible at each visit.

3. ***Coverage changes*** - If your insurance changes, please notify us before or on your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay within 30 days, you will be responsible for the balance.

4. ***No-Show Fee-*** We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly “full” appointment book. If an appointment is not cancelled at least 24 hours in advance you will be charged $25 fee; this will not be covered by your insurance company.

Our practice is committed to providing the very best orthopedic treatment to our patients. Our charges are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns. Our billing office toll free number is **1-866-535-7631**

I have read and understand the payment policy and agree to abide by its guidelines:

__________________________________ ______________________

Signature of Patient or Responsible Party **Date**

Photo Consent and Release Form

Without expectation of compensation or other remuneration, now or in the future, I hereby give my consent to Bramlett Orthopaedic, LLC, its affiliates and agents, to use my image and likeness and/or any interview statements from me in its publications, advertising or other media activities (including the Internet). This consent includes, but is not limited to:

(a) Permission to interview, film, photograph, tape, or otherwise make a video reproduction of me and/or record my voice;

(b) Permission to use my first name; and

(c) Permission to use quotes from the interview(s) (or excerpts of such quotes), the film, photograph(s), tape(s) or reproduction(s) of me, and/or recording of my voice, in part or in whole, in its publications, in newspapers, magazines and other print media, on television, radio and electronic media (including the Internet), in theatrical media and/or in mailings for educational and awareness.

This consent is given in perpetuity, and does not require prior approval by me.

□ Agree □ Disagree

Name: ____

Signature:____

Date: __________________

The below signed parent or legal guardian of the above-named minor child hereby consents to and gives permission to the above on behalf of such minor child.

Signature of Parent
or Legal Guardian: ________________________ Print Name: ________________________

The following is required if the consent form has to be read to the parent/legal guardian:
I certify that I have read this consent form in full to the parent/legal guardian whose signature appears above.

_______________ ________________________________

Date Signature of Organizational Representative

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Patient Information & Profile

Name (Last, First, Middle)	Date of Birth:	Email Address
Chief Complaint - Why are you here today?		Date of accident/injury/start of pain?
If this was an accident, how did it occur?		
What makes your condition worse?	What makes your condition better?	
Have you been treated for this condition? If so, please describe		
Primary Physician:	Referring Physician:	

Medications/Pharmacy

Please list all medications including vitamins and over-the-counter drugs you are currently taking. Include Name, Strength, Frequency

Pharmacy Name/Address/Phone:

Medical History

Please list any health or similar conditions we should be aware of: (such as High Blood Pressure, Diabetes, Cancer, Stroke, Heart Attack, Blood Clots)

Cardiology

Do you have a pacemaker? ______ Year ______

Do you have heart stents? ______ Year ______

Allergies

Please list any medications or substances you are allergic to and how you are affected:

Surgeries

Please list all past surgeries and their approximate date

Surgery ______ Year ______

Surgery ______ Year ______

Surgery ______ Year ______

Surgery ______ Year ______

Surgery ______ Year ______

Hospitalizations (other than surgeries)

Please list all past hospitalizations and their approximate date

Reason ______ Year ______

Reason ______ Year ______

Reason ______ Year ______

Family History

Please list all medical illnesses affecting your mother and father or close relatives

Father ______ Alive/Deceased ______

Mother ______ Alive/Deceased ______

Other ______ Alive/Deceased ______

Social History

Do you currently smoke? ______________________ Frequency? ______________________

Do you consume alcohol? ______________________ Frequency? ______________________

What is your current weight? ______________________ Height? ______________________

Review of Systems - Check any of the following that apply to you:

General

- ________ Weight/Change
- ________ Fever/Chills
- ________ Blood Clots
- ________ Urinary Frequency
- ________ Lumps/Masses
- ________ Dizziness
- ________ Itching/Rash
- ________ Diabetes
- ________ Thyroid Problems
- ________ Cancer
- ________ Glasses/Contacts
- ________ Sleep Disorder
- ________ CPAP

Ear-Nose-Throat

- ________ Change in Vision
- ________ Glaucoma
- ________ Ringing in Ears
- ________ Dentures
- ________ Lens Implants
- ________ Nasal Obstruction
- ________ Hoarseness
- ________ Hearing

Cardiovascular

- ________ Heart Disease
- ________ Chest Pain
- ________ High Blood Pressure
- ________ Low Blood Pressure
- ________ Mitral Valve Prolapse
- ________ Heart Attack
- ________ Pacemaker
- ________ Heart Stents

Respiratory

- ________ Cough
- ________ Pleurisy/Pneumonia
- ________ Asthma
- ________ Tuberclosis
- ________ Chronic Bronchitis

Neurologic

- ________ Seizures
- ________ Paralysis
- ________ Numbness/Weakness
- ________ Stroke
- ________ Memory Loss
- ________ Mental Problems
- ________ Depression

Gastrointestinal

- ________ Acid Reflux
- ________ Nausea
- ________ GI Ulcers
- ________ Diarrhea
- ________ Constipation
- ________ Hemorrhoids

Hematologic

- ________ Anemia
- ________ Leukemia
- ________ Hepatitis
- ________ HIV
- ________ Immune Problems

Musculoskeletal

- ________ Joint Swelling
- ________ Joint Pain

Genitourinary

- ________ Kidney Stones
- ________ Incontinence
- ________ Blood in Urine
- ________ Urinary Infections

______________________________ ______________________

Print Name (Patient or Guardian) Date

____

Signature (Patient or Guardian)