James M. Grimes, MD
ORTHOPAEDICS

REGISTRATION FORM

(Please Print)

Today's date:	Email:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Ethnicity:	Birth date: / /	Age:	Sex: M F O

Street address:	Social Security:	Primary phone no.: ( )

P.O. Box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ Online ❑ Other

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Is this patient covered by insurance? ❑ Yes ❑ No

Name of primary insurance: ❑HMO ❑PPO

Subscriber's name:	Subscriber's S.S.	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: Self Spouse Child Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: Self Spouse Child Other

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Primary phone ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

(PLEASE PRINT)

Today's Date: _____ **GENERAL INFORMATION**

Patient Name: _____ Pharmacy:_____
Age: _____ Date of Birth: _____ Pharmacy Phone: _____
Weight: _____ Height: _____ Primary Care _____
Chief complaint or problem (Reason for Visit):

_____

Have you had this problem before? Yes❑ No ❑ When:

Medications you are currently taking:

Prescription Name	Dose
1.	
2.	
3.	
4.	

Allergies: (eg. Drug, Food)

Medication	Reaction
1.	
2.	
3.	
4.	

Are you currently taking drugs not prescribed to you:
Yes❑ No❑ If yes describe_____

Immunizations Current: Yes No
(MMR, Hepatitis, Tetanus)

Prior Major Illnesses and Injuries

Surgical History

Type of Surgery/Procedure	**Date/Year**

Tobacco Use: Yes❑ No❑ Occasionally❑ Socially❑
Packs per day:_____ Year stopped smoking_____

Alcohol Use: Yes❑ No❑ Occasionally❑ Socially❑
Illegal Drugs: Yes❑ No❑ Occasionally❑

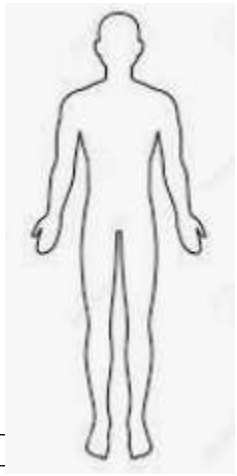
Have you had any of the following:	Yes	No			Yes	No
Abdominal Bleeding				Dizziness		
COPD/ Asthma				Stroke		
Shortness of Breath				Thyroid Disorder		
Heart Palpitations/Murmurs				Kidney Disease		
Coronary Artery Disease				Ulcer		
High blood pressure				Seizures		
Skin Cancer				Back problems		
Arthritis				Varicose Veins		
Diabetes				Other		
Anemia						

Family History:

Mother: Age _____ Living _____ Deceased _____
(Cause of Death) _____
_____

Father: Age _____ Living _____ Deceased _____
(Cause of Death) _____

(PLEASE PRINT)



Miscellaneous Questions:

Do you consider your health to be: Excellent❑ Good❑ Fair❑ Poor❑

Do you exercise? Yes ❑ No ❑ What type of exercise? _____.

Consumption of caffeine-containing beverages (coffee, tea, cola): _____# of cups per day.

Have you lost or gained weight recently? Yes❑ No❑ Usual Weight _____

Additional Information: (Please use this area to describe any history not discussed above)
_____
_____

Area of the body you seek care for today:_____ **Side**: Right❑ Left❑

On a scale of 0-10 (10 is the worst) how severe is your pain today (circle) 0 1 2 3 4 5 6 7 8 9 10

Is your pain: Sharp❑ Dull❑ Stabbing❑ Throbbing❑ Aching❑ Burning❑ Constant❑ Comes and goes❑
Swelling❑ Bruising❑ Numbness❑ Weakness❑ Popping❑ Clicking❑
Does your pain wake you at night? Yes❑ No❑
Since starting is your pain: Better❑ Worse❑ About the same❑
What makes your pain worse? Standing❑ Walking❑ Lifting❑ Exercise❑ Twisting❑ Lying in bed❑
Bending❑ Squatting❑ Kneeling❑ Stairs❑ Sitting❑
What makes your pain better? Rest❑ Elevation❑ Ice❑ Heat❑ Other _____

What tests if any have you have done for this problem? X-rays❑ MRI❑ CT❑ EMG/NCS❑
Other _____ Where were these tests done _____
What medication have you taken for this problem including OTC?_____
Are you currently under the care of pain management? Yes❑ No❑ Providers name is so:_____

What day did you last work? _____
Are you currently receiving or plan to apply for: Disability❑ Workers' comp❑ Unemployment❑

Additional Concerns: _____
_____
_____

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I_____ certify that the above information is correct to the best of my knowledge. I will not hold the provider or members of the staff responsible for any errors or omissions that I have made in the completion of this form.

_____ _____
Patient Name/Legal Guardian Date

_____ _____
Reviewed By Physician Date

This consent form allows James M. Grimes, MD to use and disclose information about me protected under the Health Insurance Portability and Accountability Act of 1996. This information may be used or disclosed to carry out treatment, payment or health care operations.

James M. Grimes, MD has provided me with a Notice of Privacy Practices, which more completely describes such uses and disclosures. It provided this notice prior to my signing this form in accordance with my right to review its practices before signing consent.

I understand that the terms of the Notice of Privacy Practices may change and that I may obtain revised notices by contacting the Privacy Officer at James M. Grimes, MD

_____ I hereby authorize that James M. Grimes, MD may leave messages on my voicemail to confirm Initial appointments, and/or may speak with other members of my household and leave messages with them regarding my appointments. ___ cell phone ___ home phone ___work phone

_____ I hereby authorize that James M. Grimes, MD may disclose my health information to any person(s) who accompany me to my appointment and are present with me in the clinic while I meet with my healthcare provider(s).

_____ I hereby authorize that James M. Grimes, MD may disclose my personal health information to the person who I have listed as my emergency contact.

_____ I hereby authorize that James M. Grimes, MD may disclose my personal health information to the Initial following person(s):

Name	Telephone Number	Relationship to Patient

I understand that at any time I have the right to revoke this consent provided that I do so in writing, but that……may still use information to complete any actions that it began prior to my revoking consent and which rely on my protected health information. I understand that James M. Grimes, MD may refuse service if I revoke this consent.

I understand that I have the right to request – now and in the future – how protected health information is used or disclosed to carryout treatment, payment and health care operations, and must be provided by me in writing. I understand that while James M. Grimes, MD is not required to agree to my requested restrictions, if it does agree, it is bound by that agreement.

I understand that James M. Grimes, MD may refuse me services if I refuse to sign this consent.

By my signature below, I affirm the above information.

Signature of Patient _____ **Date**_____

Signature of Parent (if minor) / Authorized Representative_____ **Date**_____

Office/Financial Policies

Thank you for choosing us as your health care provider. Our staff and physicians are committed to providing you the best service we can. The following is a statement of our office policies which we request you read and sign.
All patients are required to complete our registration forms, provide us with a valid medical insurance card and a photo ID. Please notify us immediately should your insurance plan ever change.

Co-pays and payment for services are due at the time services are rendered. For your convenience, we accept cash, checks, and major credit cards. There will be a $25.00 service charge for any returned checks.

If you have insurance, we will help you receive your maximum allowable benefits; however you remain responsible for your co-pay and for payment if your claim is rejected. Sixty (60) days from the date of service is a reasonable amount of time for the insurance company to decide as to whether they will pay any of your bills. You will be responsible for the entire bill that has not been paid within the sixty (60) day period.

Prescriptions: We ask 24-48 hours for the provider to authorize and for the staff to process prescription requests and refills. Please do not call multiple times for the same prescription.

Appointments: If you are calling to make an appointment and your insurance requires a referral to be seen, please allow at least 3 business days prior to any appointment to assure we receive the authorization from your primary care provider. If you choose to be seen without proper authorization, you will be given a waiver to sign stating you are aware authorization has not been received. You will then be responsible for all charges and your insurance company will not be billed.
Should you arrive late for your appointment, you may be asked to reschedule, or you may have to wait to be seen between or after other patients who have arrived on time.
Unless canceled at least 24 hours in advance, we reserve the right to charge a No Show/Late cancellation fee of up to $25.00.

Records: there is a fee for copied medical records. We will notify you of the records fee prior to providing them as the fee is determined by the number of pages. Please allow 5-7 business days for the records to be ready.

If you have any questions concerning your account, please feel free to ask our patients receivable coordinator.

I,_____have read, understand and agree to the

office policies of James Grimes MD Orthopaedics.

_____ _____
Patient Signature Date

_____ _____
Responsible Party Date

_____ _____
Witness Date

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____	_____
Signature of Patient or Personal Representative	Date:
_____	_____
Printed Name of Patient or Personal Representative	Relationship to Patient
_____	_____
Printed Name of Witness	Employee Job Title
_____	_____
Signature of Witness	Date