Suzanne E. Hall, M.D.

Appalachian Orthopaedics

Fellowship Trained Shoulder Specialist,
Board Certified Orthopaedic Surgeon

1027 Fleming Street, Suite B (Lower Level), Hendersonville, NC 28791
Phone (828) 697-1944 Fax (828) 697-3661

Welcome to our practice

App. Date: ___________________ **ARRIVE** @: _________________ App. Time: _______________

We value our patient's time and try very hard to stay on schedule.
If you arrive 15 min. or more after your **ARRIVAL** time, the appointment will be rescheduled.

We hate forms too but doing them ahead will make your first visit easier and give you a chance to collect the information you need. Attached you will find four pages to be completed. Please bring them, along with your Insurance Cards and Photo ID

Photo IDs are now required due to the "Red Flag Rule"
(New requirements from the government for fighting identity theft)

If you had X-rays, an MRI, or a Nerve Conductive Study/EMG and they were **NOT** done at Pardee Hospital or the Kayden Building or Pardee Urgent Care please obtain the CD and written report and bring them to the office at least 2 days prior to your appointment. **If not received prior to your appointment you will need to reschedule to a later date.**
If taken at Pardee Hospital or the Kayden Bldg or Pardee Urgent Care we are able to access them by computer. In that case, you do **not** need to bring the CD and written report.

If Self Pay, (Those without Health Insurance)
Your first visit will typically be between $200.00 and $300.00 depending on what services are performed.
Payment is required in full at each visit

If Second Opinion or Previous Surgery elsewhere, please obtain copies of the X-rays/MRIs on CD and the Operative report if surgery has already been done. These should be brought at least 2 days prior to your first visit so that they can be carefully reviewed. **If not received prior to your appointment you will need to reschedule to a later date.**
The previous physician's office notes can be very helpful. It is your choice whether you wish to provide those or not before your first visit.

We do not file any Liability Claims (example: Car Accident or Fall at K-Mart) we will give you the information needed for you to give to the Insurance Company. We need your payment at the time of each office visit.

A No Show Fee will be charged to patients (not their insurance carrier) for missed / No show office appointments. A charge of $75.00 will be billed to the patient. This charge MUST be paid before another appointment can be scheduled. This policy helps to ensure that our patients who need to be seen by our doctor can obtain an appointment with us in a timely manner.

We look forward to providing you with quality Orthopaedic care.
If you have any questions feel free to call at (828) 697-1944

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Name ____
Last First Middle Initial

Social Security #: ________________________________

Date of Birth: __________________________ Age: ___________

Marital Status

☐ **Male** ☐ **Female** / ☐ **Married** ☐ **Single**

Home Phone #: ____

Cell Phone #: ____

Mailing Address: ______________________________________

Apt/Unit: ____

____
City State Zip Code

Driver's License No. _______________________ State: ________

Primary Care Physician: _________________________________

Phone Number: ____

Responsible Party Information (<u>If different than patient</u>)

Name ____
Last First Middle Initial

Home Phone# ______________________________________

Mailing Address ____________________________________

____
City State Zip Code

Relationship to patient: ____________________________

<u>INSURANCE INFORMATION</u>

▼COMPLETE INFORMATION BELOW ▼

Primary Ins: ____

Policy Holder's Name: ____________________________________

Policy Holder's Date of Birth: ______________________________

SS# If Needed To File Claim: ______________________________

Secondary Ins: ____

Policy Holder's Name: ____________________________________

Policy Holder's Date of Birth: ______________________________

SS# If Needed To File Claim: ______________________________

Where did you hear about our office? Referred by ______________________
Word of Mouth __, Internet search___, Phone book___, Newspaper Ad____
Other________________

☐ **<u>Date</u> of Injury** _______________________________
State Injury Occurred ____________

Reason for today's visit: ☐ **Right or** ☐ **Left** _______________________

or

Treated Previously? ☐ **Yes or** ☐ **No**

☐ **<u>Date</u> Pain Started** ___________________________

<u>ABOUT X-RAYS</u>: All x-rays taken on the property of Suzanne E. Hall, M.D. X-rays are part of your medical file and must be maintained as part of your medical records. The costs of x-rays include shooting the film, supplies, processing, and interpretation. Copies can be provided at a minimal additional cost when necessary. Review of x-rays by another physician is permitted. Request must be made in writing, allowing enough time to mail the x-ray. Please provide complete name and address of physician when requesting x-rays.

<u>FINANCIAL RESPONSIBILITY/MEDICAL RECORDS/CONSENT FOR TREATMENT</u>

I have read and fully understand the financial policy established by Suzanne E. Hall, M.D. I agree that insurance payments to be paid to Appalachian Orthopaedics, Suzanne E. Hall, M.D. on my behalf. I understand that I am financially responsible for all charges not paid by insurance with exception of approved Medicaid and approved Worker's Comp accounts. In the case of a minor, the child's guarantor is responsible for the account. **<u>Patient's portion of charges and co-pays are due at time of service.</u> I have received a copy of Suzanne E. Hall, M.D. Notice of Privacy Practices** and have the right to review the notice prior to signing this consent. Suzanne E. Hall, M.D. reserves the right to revise Notice of Privacy Practice at anytime. The notice is available at the front desk of our clinic. I certify the information on this form is true to the best of my knowledge. I give permission to **Appalachian Orthopaedics** to provide health care to myself or the above named dependent.

► **Patient Name (Please Print)** _____________________________________ **Date:** ______________________

► **Patient Signature:** ____

Guardian's Signature (if patient is a minor) _____________________________ **Relationship:** ______________

MEDICAL HISTORY

Patient Name: ______________________________ Date: ________________

Current Medications / Dosages

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____

☐ **NOT ON ANY MEDICATIONS** ☐ **SEE ATTACHED LIST**

List drug allergies or problems with medications **(Problem: nature of allergic reaction)**

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

☐ **NO DRUG ALLERGIES OR PROBLEMS** ☐ **SEE ATTACHED LIST**

Previous Surgery	Year of surgery	Complications
1.		
2.		
3.		
4.		
5.		
6.		
7.		

☐ **NO PREVIOUS SURGERIES** ☐ **SEE ATTACHED LIST**

Height: ________________ **Weight:** ________________

Medical History: At any time have you ever had?

☐ Diabetes ☐ **Type 1** **or** ☐ **Type 2**

☐ Stroke

☐ Heart problems: ☐ **A-Fib** ☐ **Coronary Artery Disease**

☐ High blood pressure

☐ High cholesterol

☐ Blood transfusion

☐ Anemia

☐ Blood clots / DVT

☐ Bleeding disorder

☐ Breathing problems ☐ **Asthma** ☐ **COPD** ☐ **Other**

☐ Liver disease/hepatitis

☐ Glaucoma

☐ Stomach ulcers ☐ GERD

☐ Bowel/intestinal problems

☐ Kidney disease/stones

☐ Treatment for Drug or Alcohol Problems

☐ Cancer: ________________________________

☐ Urinary problems: ________________________

☐ Prostate disease (Males)

☐ Gynecological disease (Females)

☐ Ears, nose, throat or mouth problems

☐ Joint dislocations or Double jointed

☐ Previous fractures: ________________________

☐ Balance problems

☐ Marfan's disease

☐ Skin disease

☐ Neurological disorder: ______________________

☐ HIV/AIDS

☐ Thyroid trouble

☐ Hearing Aids

☐ Mental health disorders: ____________________

☐ Gout ☐ Rheumatoid Arthritis

☐ Other: ________________________________

☐ **NONE OF THE ABOVE**

Patient Name: ___________________________________ **Date:** _____________

Do you have an Advance Care Plan ? : ☐ no ☐ yes Please provide us with a copy.
Do you have a designated Power of Attorney? ☐ no ☐ yes Name:________________________

Family History: Have any of your blood relatives had?

☐ Heart Disease ☐ High Blood Pressure ☐ Cancer ☐ Diabetes ☐ Rheumatoid Arthritis
☐ Malignant Hyperthermia ☐ **None of the above**

The Government requires us to ask the following questions (Please Answer All Three or Declined is fine)

1. Race: ☐ **American Indian or Alaska Native** ☐ **Asian** ☐ **African American**
☐ **Native Hawaiian or Other Pacific Island** ☐ **White** ☐ **Other Race** **or** ☐ **Declined**

2. Ethnic Group: ☐ **Hispanic or Latino** ☐ **Not Hispanic or Latino** **or** ☐ **Declined**

3. Language: ☐ **English** ☐ **Spanish** ☐ **Arabic** ☐**Chinese** ☐ **French** ☐ **German**
☐ **Japanese** ☐ **Russian** ☐ **Vietnamese** **or** ☐ **Other**

Employment: ☐ Full Time or ☐ Part Time Occupation: ___________________________

Employers Name: ____

Employers Phone#: ____

☐ **Retired** ☐ **Disabled** ☐ **Unemployed** ☐ **Homemaker** ☐ **Child/Student**

Number of children _________ **Do you live alone?** ☐ Yes or ☐ No

This information helps Dr. Hall determine what hobbies you can continue doing or should temporarily stop doing because of your pain or injury.

Hobbies: ☐ Weight lifting ☐Golf ☐ Kayaking ☐ Gardening ☐ Fishing ☐Musical Instruments
☐ Travel ☐ Bow Hunting ☐ Bicycling ☐ Motorcycling ☐ _________________________
☐ ________________________

The Government requires us to ask the following questions about Smoking

Current Smoker: ☐ **No** ☐ **Yes** ______ **Packs/Cans a day** ☐ **Cigarettes** ☐ **Cigars** ☐ **Smokeless Tobacco**

Former Smoker: ☐ **No** ☐ **Yes** ______ **Year Stopped** ☐ **Cigarettes** ☐ **Cigars** ☐ **Smokeless Tobacco**

Alcohol use: ☐ **Never** ☐ **Rare** ☐ **Social** **How many times** _______ **a** ☐ **Day** ☐ **Week** ☐ **Month**

Patient Name: ___________________________________ Date: _____________

HIPAA PERMISSION RELEASE

Individuals listed below are those with whom Appalachian Orthopaedic employees may discuss my account, medical diagnosis, test results, pathology reports, medications, or other information regarding my health care.

►Emergency Contact Name: _______________________________________

Phone Number: ________________________ Relationship: ________________

Name: ____

Phone Number: _________________________ Relationship: _______________

Name: ____

Phone Number: _____________________ Relationship: _____________________

Name: ____

Phone Number: ______________________ Relationship: ____________________

Physician Name: ____

Phone #: ________________________

If you were NOT referred by your primary care physician and would like us to send today's office note to them, please list their full name & phone number above.

Please check below – You may leave a message on:

☐ my home phone

☐ my cell phone

☐ my work phone

►Patient Name: ____

Please Print

►Patient Signature: _______________________________________

Or Guardians Name

►Date: ________________________

Please review to make sure all information has been completed. Thank You

SEH 12-2014