Appalachian Shoulder Specialists
Suzanne E. Hall, M.D.
Fellowship Trained Shoulder Specialist,
Board Certified Orthopaedic Surgeon

1507 Haywood Rd. Suite E
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.

Completing your forms ahead will make your first visit easier and give you a chance to collect the information you need. Attached you will find 5 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 Pardee Outpatient Kayden Building or Pardee Hendersonville 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 any of the above locations, we will 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 $300.00 and $510.00 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 of $75 will be charged to patients (not their insurance carrier) for missed / No-show office appointments. 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** ☐ **Widowed**

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 (If different than patient)

Name _____
Last First Middle Initial

Home Phone# _____

Mailing Address _____

_____
City State Zip Code

Relationship to patient: _____

INSURANCE INFORMATION
▼COMPLETE INFORMATION BELOW ▼

Please bring your insurance cards to your visit

Primary Ins: _____

Policy Holder's Name: _____

Policy Holder's Date of Birth: _____

Policy ID#_____

Secondary Ins: _____

Policy Holder's Name: _____

Policy Holder's Date of Birth: _____

Policy ID#_____

Where did you hear about our office? Referred by _____

Word of Mouth ___, Internet search___, Newspaper Ad____
Other_____

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

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

☐ If injured: **Date of Injury** _____

Was injury in NC? _____

OR:

☐ **Date Pain Started** _____

FINANCIAL RESPONSIBILITY / CONSENT FOR TREATMENT

Patient's deductible and co-pay are due at time of each visit.

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. Our **Notice of Privacy Practices** is available in our office**.** I certify the information on this form is true to the best of my knowledge.
I give permission to **Appalachian Shoulder Specialists** 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. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

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

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

1. _____ 4. _____
2. _____ 5. _____
3. _____ 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:** _____ **Local Pharmacy**_____

Medical History: At any time have you ever had?

Town/Phone_____

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

☐ Stroke

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

☐ Peripheral Vascular Disease

☐ High blood pressure

☐ High cholesterol

☐ 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 ☐ Incontinence ☐ UTI's

☐ Prostate disease (Males)

☐ Peripheral Neuropathy

☐ Ears, nose, throat, or mouth problems

☐ Joint dislocations or Double jointed

☐ 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 Decline is fine)

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

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**

OR ☐ **Decline to answer all**

Employment: ☐ Full Time ☐ Part Time Occupation: _____

Employers Name: _____

Employers Phone#: _____

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

Retirees: Prior Occupation_____

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/Activities: ☐ Weightlifting ☐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 Shoulder Specialists 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: _____

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

Physician Name: _____

Phone #: _____

You may leave a message on: (Please check below)

□ my home phone

□ my cell phone

□ my work phone

►Patient Name: _____

Please Print

►Patient Signature: _____

Or Guardian's Name

►Date: _____

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

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Financial Policy for Orthopedic Procedures

Patient Responsibility:

- **Office visit for co-pay**/deductible is due and payable on the day of the visit.
- **Hospital co-insurance** is estimated and due on the date of the Surgical Discussion.
- **NO SHOW appointments** have a $75 charge billable to the patient if we have not received 24hr phone notification of an appointment cancelation.

Appalachian Shoulder Specialist's Responsibility:

- Our staff will review your benefits with your insurance plan as a courtesy to you.
- You will be informed by phone and/or letter of the anticipated amount owed for any Pardee hospital upcoming procedures. Pardee Hospital will bill you directly for any facility charges.
- The amount quoted is an estimate we provide to you based upon benefits given to us by your insurance plan. This is **NOT** a guarantee. The actual amount may differ. We will bill you for any remaining balance after your insurance claim is paid.
- Should your individual circumstances dictate that a refund is due to you following your procedure or office visit, we will process and refund you in a prompt manner.

I have read and understand the above agreement.

Print Name_____

Signature_____ Date_____