ATLAS

ORTHOPAEDICS *total orthopaedic care*

Duncan Wells, M.D., P.C. 970 Woodstock Pkwy. Suite 310 Woodstock, GA 30188 770-517-2257 Fax 1-877-447-4190

Patient Name:_____ Date:_____

Birth Date:_____ Sex M / F SS#_____-_____-_____ Marital Status:_____

Address:_____City,State:_____Zip:_____

Height:_____ Weight:_____ Email Address: _____

Home# ( )_____ -_____ Cell# ( )_____ -_____ Work# ( )_____ -_____

Is your visit due to a JOB-RELATED Injury or Automobile Accident? YES NO

Employer Name:_____Employer Phone#:_____

Primary Care Physician:_____Phone#:_____

Has another member of your family been treated by Dr Wells before? _____ Name:_____

How did you hear of us?_____

Who to Contact for An Emergency (*different household*)

Name:_____ Relationship:_____

Home# ( ) _____-_____ Cell# ( ) _____-_____ Work# ( ) _____-_____

Person Responsible for Bill (Complete only if not the patient) Relationship to Patient:_____

Guarantor Name:_____Date of Birth:_____/_____/_____

Address:_____City,State:_____Zip:_____

SS#_____-_____-_____ Home#:( )_____-_____ Cell#: ( )_____-_____

Employer Name:_____Employer Phone:( )_____-_____

Primary Insurance: Insurance Company:_____

Policy Holder:_____ Date of Birth: _____/_____/_____

ID#: _____ Group#: _____

Secondary Insurance: Insurance Company:_____

Policy Holder:_____ Date of Birth: _____/_____/_____

ID#: _____ Group#: _____

_____ I authorize Duncan Wells M.D., P.C., to release to my insurance carrier(s) and / or CMS (formally HCFA and its agents) any information needed to determine benefits or benefits payable for related services.

X_____ Date:_____

Patient or responsible party Signature

Patient Name:_____ **Date:**_____

Chief Complaint:

Body part being seen for:	Laterality: (circle) Left Right Bilateral
WAS THERE AN INJURY? (circle) YES NO	*If so, explain what happened below:*
Current symptoms:	
Date symptoms began:	
If there is pain, where is it located?	
What activities or positions make your symptoms worse?	

Medical History:

Check if you have had any of these **medical problems** in the PAST:

MAJOR ILLNESS	YES	NO	**MAJOR ILLNESS**	YES	NO
Anemia			Liver Disease		
Arthritis			Kidney Disease		
Heart Arrythmia / Palpitations			Loss of Vision		
Asthma			Mitral Valve Prolapse		
Bleeding Problems			Neuropathy		
Blood Clots			Paralysis		
Cancer: Type_____			Peripheral Vascular Disease		
Chest pain / Angina			Pneumonia		
Diabetes			Psychiatric Illness		
Gall Bladder Disease			Pulmonary Embolism		
Gastric Ulcers			Reflux		
Glaucoma			Skin Ulcer/Breakdown		
Heart Attack			Steriod Use		
Heart Failure			Stroke		
Heart Murmur			Thyroid Disease		
Hepatitis B			Tuberculosis-TB		
Hepatitis C			Urinary Infections		
High Blood Pressure			Valve Disorders (heart)		
HIV/Aids			Wound Healing Problems		
Immune Deficiency			Orther:_____		

Please list any **operations / surgeries** you have had:

SURGERY/REASON		**YEAR**	**SURGERY/REASON**		**YEAR**
1)			5)		
2)			6)		
3)			7)		
4)			8)		

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Patient Name:_____ **Date:**_____

Please list any Medications that you are currently taking:
Attach a current medication list if needed.

MEDICATION AND DOSE
1)
2)
3)
4)
5)

MEDICATION AND DOSE
6)
7)
8)
9)
10)

Do you have any allergies to medications/substances? Yes No
If YES, please list below:

ALLERGIES
1)
2)
3)
4)
5)

ALLERGIES
6)
7)
8)
9)
10)

FAMILY MEDICAL HISTORY: Please list major illness that affect immediate family:

MAJOR ILLNESS	RELATION
1)	
2)	
3)	
4)	
5)	

SOCIAL HISTORY: Complete all sections below that apply to your lifestyle.

Alocohol use: Yes No Drinks per week: _____
Cigarette use: Yes No Packs per day: _____ Yrs:_____
Illicit Drug use: Yes No Type: _____
Smokeless Tobacco use: Yes No Years: _____

REVIEW OF SYMPTOMS: Please mark any of the symptoms that apply to you TODAY:

SYMPTOM	YES	NO	SYMPTOM	YES	NO
Tarry Stools			Frequent Urination		
Vomiting			Urgent Urination		
Abdominal Pain			Painful Urination		
Chest Pain			Muscular Weakness		
Irregular Heart Beat			Numbness or Tingling		
Rapid Heart Beat			Joint Pain or Swelling		
Swelling of Legs			Muscle Pain or Swelling		
Cough			Frequent/Easy Bruising		
Shortness of Breath			Cuts that don't stop Bleeding		
Rash			Anxiety		
Wound Healing Problem			Depression		
Fever/Chills			OTHER:		

Agreement of Accuracy: The information provided in this history form is true and complete to the best of my knowledge.

X_____
Patient Signature Date

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PATIENT NO SHOW AND COPAY POLICY

- No shows and cancellations with less than 24 hrs. notice are a significant problem for medical practices.
- We like to spend time with our patients and the physicians time is specially allotted for him to care for each patient.

We understand that things occasionally come up and that appointments are sometimes forgotten; therefore, we do not charge for the first no show. **For all additional no shows, there will be a $25.00 no show fee for any missed appointments. Also, there will be a $250.00 cancellation fee for missed surgery appointments not cancelled within 5 business days of your surgery date. This charge is not covered by insurance.**

Our practice does not see walk in appointments. To schedule an appointment, call 770-517-2257. Our administrative staff will schedule your follow-up appointments. Same day appointments will only be scheduled on an emergency basis.

Patients arriving on time are seen at their appointment times. Patients arriving on time will be seen ahead of those arriving late. If you arrive more than 15 minutes late, we may need to reschedule your appointment. Call ahead if you are going to be late. We will advise you if there is a need to reschedule. TO AVOID DELAYS PLEASE ALWAYS ARRIVE ON TIME FOR APPOINTMENTS.

Patients will be seen for the issue or injury they discussed when scheduling their appointment. If a patient has multiple problems that are not discussed at the time of scheduling, we may need to schedule more time or arrange another appointment for those issues. Please advise what issues you would like addressed when scheduling appointments.

I request that payment of authorized insurance carrier benefits be made on my behalf to Duncan Wells, M.D., P.C., for any services rendered to me by Atlas Orthopaedics. In insurance carrier assigned cases, Atlas Orthopaedics agrees to accept the reimbursement of said insurance carrier as full payment of charges submitted. The patient is responsible only for the deductible, copay, coinsurance, or non-covered services.

Necessary forms will be completed to help expedite your insurance carrier payments. However, the patient is responsible for all fees regardless of insurance coverage. Fees are payable at the time of examination. Should the patient fail to pay as agreed above then the patient shall be liable for all costs and expenses incurred by Atlas Orthopaedics, including all finance charges and all attorney fees and court costs.

I understand that in the event I fail to make payment to my account in full, it will be turned over to collections and a 27% collection fee will be charged. This balance is the responsibility of the patient.

We accept VISA, MC, DISCOVER, AMEX, CHECKS AND CASH. Please make sure you are given a receipt when paying with cash.

If you have any questions in reference to these policies or any questions in general about our practice, please feel free to contact us at 770-517-2257. You may also contact our office manager via email at atlasorthobilling@gmail.com. We appreciate your confidence in our practice.

Patient Signature _____ Date _____

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I request to make payment of benefits from the insurance company authorized in my name to Duncan Wells, M.D., P.C., for any service I am provided. I hereby authorize the release or use of my individually identifiable health information (protected health information or PHI) and medical information by Duncan Wells, M.D., P.C., in order to carry out treatment, payment, or health care operations. You should review the Pactice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this consent form.

We reserve the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revise notice by writing our practice or requesting a copy from our front desk staff.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or health care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

I authorize Atlas Orthopaedics, Dr. Wells and his staff, to disclose medical information or talk with the following people regarding my medical treatment:

Authorized Person_____ Phone Number_____

Authorized Person_____ Phone Number_____

I authorize Atlas Orthopaedics, Dr. Wells and his staff, to release information to me in the following manners:

	PLEASE INITIAL by each method you consent to:
VIA MAIL:	
MAIL TO HOME ADDRESS	_____
MAIL TO WORK ADDRESS	_____
VIA HOME / CELL TELEPHONE:	
OK TO LEAVE DETAILED MESSAGE	_____
LEAVE CALL BACK NUMBER ONLY	_____
VIA WORK TELEPHONE:	
OK TO LEAVE DETAILED MESSAGE	_____
LEAVE CALL BACK NUMBER ONLY	_____
VIA EMAIL:	_____

OK TO EMAIL TO:
Preferred email address: _____

Signature: _____ Date: _____

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PAIN MEDICATION AND REFILL POLICIES

Due to newly published guidelines by the American Medical Association and the Academy of Orthopaedic Surgeons, below is our policy for PAIN MEDICATION AND REFILLS. Narcotic pain medication will be given for a 4-week post-operative period ONLY, and on rare occasions pre-operatively. Pain medication for conditions that do NOT require surgery will only be given for acute, SHORT-TERM pain. If you are suffering from chronic pain, Dr. Wells will refer you to a pain management specialist for treatment and appropriate medication management.

1. I agree to allow **48 HOURS** for prescription refills.
2. I understand that a follow-up visit may be required from Dr Wells in order to obtain a refill.
3. I agree to take all medication EXACTLY as prescribed by Dr Wells. I will NOT change the dosage or alter the time schedule without first speaking to Dr Wells or his nurse.
4. Prescription medication WILL NOT be refilled after business hours or on the weekends. Our office is closed on Friday.
5. Patients may be terminated from the practice without notice for noncompliance in taking of their medications, obtaining narcotics from another physician while under the care of Dr Wells or altering/forgoing a prescription. **THIS IS A FELONY AND WILL BE PROSECUTED TO THE FULL EXTENT OF THE LAW.**
6. Atlas Orthopaedics/Duncan Wells MD WILL NOT refill prescriptions that have been lost of misplaced.
7. I understand that I must keep all scheduled appointments as recommended by Dr Wells.
8. I will not combine any narcotic medication with the consumption of alcohol or any illegal substance.
9. Only one pharmacy will be used for prescriptions. I will notify the office immediately if my pharmacy changes!

Pharmacy of choice: _____ Phone: _____

I have read the above prescription polices and I understand and agree to abide by them. I understand that I refuse to sign this policy form, Dr Wells may refuse to prescribe medication.

Patient Name: _____ **Date:** _____

Signature: _____

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