

Carolina Musculoskeletal Institute, PA
Patient Information Form

First Name: _____ MI: _____ Last Name: _____
Date of Birth: _____ Age: ____ Sex: M or F (please circle one) SS#: _____ - _____ - _____
Mailing address: _____ Street address: _____ Apt # _____ City: _____ State: _____ Zip: _____
Home Phone: () _____ Cell Phone: () _____ Work: () _____
Email address: _____
Employer/School: _____ Occupation: _____
Employer/School Address: _____
Name of Spouse: _____ DOB: _____ SS#: _____
Marital Status: M S W D (please circle one) Spouse's Employer: _____ Spouse Employer Phone #: () _____
In case of an emergency, please notify _____ Phone #: _____
Family/Primary Care Doctor: _____ Referring Doctor: _____

Guarantor Information

Mailing Address: _____ City: _____ State: _____ Zip: _____ Phone _____
Street Address: _____ Apt#: _____ City: _____ State: _____ Zip: _____
Mother's Name: _____ Date of Birth: _____ SS#: _____ - _____ - _____
Mother's Employer: _____ Phone #: () _____
Father's Name: _____ Date of Birth: _____ SS#: _____ - _____ - _____
Father's Employer: _____ Phone #: () _____

Pharmacy Name: _____ **Address #:** _____ **Phone #:** _____

Primary Insurance: _____ **ID #:** _____ **Grp #:** _____

Insured Name: _____ **Insured DOB:** _____ **Insured SSN#:** _____

Secondary Insurance: _____ **ID #:** _____ **Grp #:** _____

Insured Name: _____ **Insured DOB:** _____ **Insured SSN#:** _____

Name of RESPONSIBLE party for the patient's bill: _____ **DOB** _____ **SSN #** _____

(Note: Must be self, parent, or legal guardian)

PLEASE READ AND SIGN EACH SECTION

I. Financial Policy & Payment Responsibility: Payment for medical services is the responsibility of the patient or, in the case of a minor, the signed responsible party. Our office will file for insurance benefits for plans in which we **do participate**. Payment for deductible, co-insurance, and co-payment amounts will be collected from the patient at the time of service. If you are unable to pay your co-payment or co-insurance amounts, your appointment may be rescheduled. If your insurance plan does not pay your medical services within 30 days, all charges may be due and payable in full from the patient. Your help in seeing that your insurance pays for your medical services within the specified time period is appreciated. I hereby acknowledge and accept full and final responsibility for payment of charges for medical services rendered. I understand that if payments for services rendered by this practice are not met, my account could be referred to an outside collection agency for further collection activity.

If the patient no shows, or cancels their appointment more than three times, their treating physician reserves the right to discharge the patient from the practice.

Patient or Responsible Party Signature: _____ **Date:** _____

II. Consent for Treatment & Medical Release Authorization: I hereby consent to treatment for myself, my child, or named minor, for whom I am legally responsible. I authorize Carolina Musculoskeletal Institute, PA to release any medical information to any referring physician, other health care providers, hospitals and medical facilities, and to my insurance carriers for the purpose of treatment, payment and health care operation. The release of medical information for insurance claims, the release of past medical payment history, if requested, is authorized. I understand that the practice of medicine is not an exact science and that diagnosis and treatment may involve risk I furthermore, authorize Carolina Musculoskeletal Institute, PA to release any of my medical or financial information to the following people.

Name _____ Relationship _____
Name _____ Relationship _____
Name _____ Relationship _____

Patient or Responsible Party Signature: _____ **Date:** _____

III. Assignment of Insurance Benefits: I hereby assign and authorize payment to Carolina Musculoskeletal Institute, PA of all medical and surgical benefits to which I am entitled, including health insurance benefits, major medical benefits, and third party liability coverage including personal injury protection (PIP) benefits and other medical payment coverage for which I am entitled. This assignment will remain in effect until revoked by me in writing. A photocopy of this form is to be considered as valid as an original. I hereby authorize Carolina Musculoskeletal Institute, PA to release all information necessary to secure payment of insurance benefits. **I understand that I am financially responsible for all charges whether or not paid by said insurance(s).**

Patient or Responsible Party Signature: _____ **Date:** _____

IV. Drug Screen Policy: The physicians of CMI may order a random urine drug-screening test at their discretion in the following cases: patients receiving pain medication for 90 days or more, and for patients that are referred to CMI from any Pain Management Physician.

Patient or Responsible Party Signature: _____ **Date:** _____

V. Privacy Practices: I acknowledge receipt of Carolina Musculoskeletal Institute, P.A. Notice of Privacy Practices.

Patient or Responsible Party Signature: _____ **Date:** _____

Carolina Musculoskeletal Institute, PA
410 University Parkway
(803) 644-4264
Pain Management 2600 Fax Number (803) 649-3333
Podiatry Suite 2600 Fax Number (803) 649-0042
Aiken, SC 29801
www.CMI.md

APPOINTMENT CANCELLATION / NO SHOW

Please note: The suite number has changed for Podiatry location

It is the goal of Carolina Musculoskeletal Institute to provide quality medical care to our patients in a timely manner. In order to do so we ask that you read and sign this Appointment Cancellation/No Show Policy. This policy enables us to better utilize available appointments for our patients in need of medical treatment.

If you are unable to keep your scheduled appointment or need to reschedule your appointment, please contact our office 24 hours in advance. By cancelling or rescheduling your appointment early allows us to reallocate this time to other patients who are in need of medical treatment. If you miss an appointment (no- show) it will be recorded in your medical record. The second no- show appointment will result in a letter being mailed to you stating that you have missed two appointments and the third no- show appointment, reschedule or cancelled appointment will result in your dismissal from the practice.

While we understand that situations may arise preventing you from arriving for your scheduled appointment on time, we do ask that you contact our office if you are going to be late. If you are more than 15 minutes late and do not notify our office your appointment may be cancelled.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you may have. We thank you in advance for your cooperation.

By signing below you acknowledge that you have read and understand the Cancellation/No Show Policy of Carolina Musculoskeletal Institute, PA

Patient Signature

Date

Print Name

Witness



CAROLINA
MUSCULOSKELETAL
INSTITUTE

New Patient Intake Form

Information

Today's date: _____

Your name: _____ Date of birth: _____

Referring physician: _____

Preferred pharmacy: _____

Pain History

What is the reason for your visit today? _____

When did the pain begin? _____

What caused your current pain episode? _____

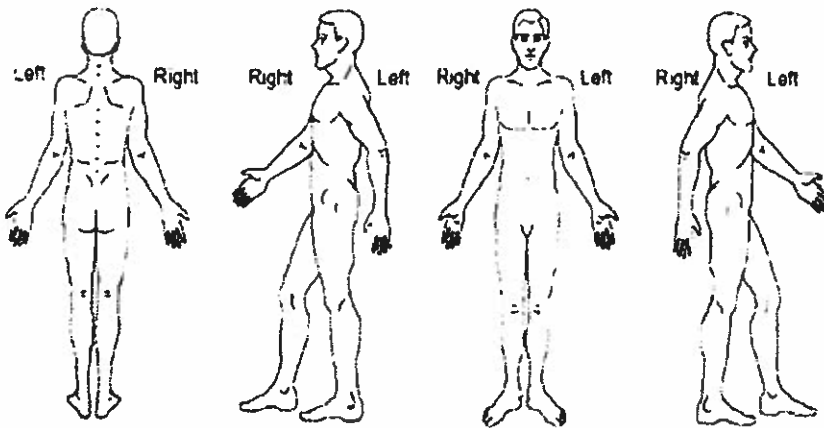
What factors worsen your pain? _____

What factors improve your pain? _____

Describe the character of your pain (dull, burning, throbbing, etc.). _____

If '0' is no pain and '10' is the worst pain you can imagine, how would you rate your pain?

Right now _____ The worst it gets _____



Use this diagram to mark the location(s) of your pain.

Prior Treatment:

Please circle any of the following treatments you have attempted for pain relief:
spine surgery chiropractor physical therapy brace support

Have you attempted physical therapy? Y/N Date: _____

Have you attempted chiropractic care? Y/N Date: _____

Please list any medications that you have tried:

Past Medical History

Please list any medical conditions you are being treated for:

Please list any surgical procedures you have had:

Are you currently taking any blood thinners or anticoagulants (eliquis, plavix, xarelto, Coumadin/warfarin)? Yes No If yes, which one? _____

Social History

Occupation: _____ When was the last time you worked? _____

Temporary disability Permanent disability Retired Unemployed

Alcohol Use: Never Occasional Daily History of alcoholism Current alcoholism

Tobacco use: Never Former Current

Please circle any of the following symptoms which you currently are experiencing:

Constitutional: Fevers Chills Weight gain Weight loss Exercise intolerance

Eye: Blurred vision Double vision Pain

Ears/Nose/Throat/Neck: Hearing loss, Sinus problems Frequent nose bleeds

Respiratory: Cough Shortness of breath Wheezing

Cardiovascular: Chest pain Palpitations

Gastrointestinal: Vomiting Constipation Abdominal pain

Musculoskeletal: Back pain Neck pain Joint pain Muscle pain

Neurological: Dizziness Headaches Weakness Loss of consciousness

Psychiatric: Depression Sleep disturbances Alcohol abuse Suicidal thoughts