



Dr. William O. Reed, Jr. M.D.

Patient Demographic Sheet

<p>_____ Patient's Full Legal Name</p> <p>_____ Street Address</p> <p>_____ City, State and Zip</p> <p>_____ Date of Birth</p> <p>_____ Age</p> <p>_____ Social Security No.</p> <p>(_____)_____ Home Phone</p> <p>(_____)_____ Work Phone</p> <p>(_____)_____ Cell Phone</p> <p>_____ E-mail Address</p> <p>Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed</p>	<p>_____ Referring Physician's Name</p> <p>_____ Street Address</p> <p>_____ City, State and Zip</p> <p>(_____)_____ Phone Number</p> <p>(_____)_____ Fax Number</p> <p>_____ Primary Care Physician's Name</p> <p>_____ Street Address</p> <p>_____ City, State and Zip</p> <p>(_____)_____ Phone Number</p> <p>(_____)_____ Fax Number</p>
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Patient Insurance Information

<p>_____ Primary Insurance</p> <p>_____ Policyholder's/Subscriber's Name</p> <p>_____ Date of Birth</p> <p>_____ Social Security Number</p> <p>Relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other</p>	<p>_____ Secondary Insurance</p> <p>_____ Policyholder's/Subscriber's Name</p> <p>_____ Date of Birth</p> <p>_____ Social Security Number</p> <p>Relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other</p>
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EMERGENCY CONTACT: _____

NAME: _____ RELATIONSHIP: _____

(_____) _____ (_____) _____ (_____) _____

Home Phone Number Work Phone Number Cell Phone Number



Employment Information	Spouse Information	
Employer's Name _____	Spouse's Name _____	
Employer's Street Address _____	Spouse's DOB _____	Social Security Number _____
Employer's City, State and Zip _____	(____) _____ Home Phone	(____) _____ Work Phone
(____) _____ Employer's Phone #	(____) _____ Employer's Fax #	(____) _____ Cell Phone
		_____ E-mail Address

Patient Confidentiality

I hereby authorize the release of medical information to _____ (Relationship)

I hereby authorize Dr. William O. Reed, Jr., M.D., to leave information on my voicemail at (check all that apply):
 Home Work Cell

PATIENT SIGNATURE: _____ **Date:** _____

Authorization Agreement

I authorize the release of my medical records as needed to any physician, facility, or other provider of services that Dr. William O. Reed, Jr., M.D., asks to participate in my medical treatment.

PATIENT SIGNATURE: _____ **Date:** _____

Assignment of Benefits/Financial Agreement

I hereby authorize Dr. William O. Reed, Jr., M.D., to bill my insurance company for payment of benefits on my behalf. I authorize Dr. William O. Reed, Jr., M.D., to release medical information required by my insurance company to process my claims. Dr. William O. Reed, Jr., M.D., will submit my claims and reconcile my account by the terms of their contract with my insurance company. I understand and agree that I am responsible for all fees for services provided to me by Dr. William O. Reed, Jr., M.D., not covered by my insurance. I agree to provide Dr. William O. Reed, Jr., M.D., with current insurance, personal address and billing information and will notify Dr. William O. Reed, Jr., M.D., of any changes in a timely manner.

I, the patient, understand I am responsible for complying with all requirements of my insurance plan and any failure to do so may result in denial or non-payment of healthcare claims, and that I will be financially responsible for all fees for services provided by Dr. William O. Reed, Jr., M.D., and its representatives.

PATIENT SIGNATURE: _____ **Date:** _____

Medigap Authorization

I hereby authorize payment of my Medigap to Dr. William O. Reed, Jr., M.D., for all claims filed on my behalf. This authorization applies to all services until it is revoked by me or my representative.

BENEFICIARY SIGNATURE: _____ **Date:** _____

Medicare Number _____ Medigap Insurer _____

Phone _____ Address _____

PATIENT SIGNATURE: _____ **Date:** _____



Dr. William O. Reed, Jr. M.D.

History and Physical

Name _____ Date of Birth _____

Age _____ Sex/Gender _____ Height _____ Weight _____ Right-handed Left-handed

Complaint: _____

Date of Injury or Onset of Illness: _____

Previous Test(s): (Mark all that apply) X-Ray MRI EMG CT Scan Other _____

Past Medical History: Are you now or have you ever been treated for any of the following:

	Yes	No	Explain:
High blood pressure	_____	_____	_____
Diabetes	_____	_____	_____
Cancer	_____	_____	_____
Heart Problems	_____	_____	_____
Chest Pain	_____	_____	_____
Asthma	_____	_____	_____
Epilepsy/Seizure	_____	_____	_____
Stroke	_____	_____	_____
Thyroid	_____	_____	_____
Bleeding Disorder	_____	_____	_____
Hepatitis	_____	_____	_____
Jaundice	_____	_____	_____
AIDS/HIV	_____	_____	_____

FEMALES ONLY—Next 2 questions

Could you be pregnant? Yes _____ No _____

Date of last menstrual period: _____

ALLERGIES: Are you allergic to any medicine, tapes or iodine? If yes, please list: _____

MEDICATIONS: Are you currently taking any medications? If yes, please list: _____

PAST SURGICAL HISTORY: Please list previous surgeries (include year): _____

Do you smoke: Yes No If yes, how much per day? _____

Do you drink alcohol: Yes No If yes, how much per day? _____



Name _____ Date of Birth _____

Family History: Is there any family history of health problems, such as:

	Yes	No	Explain:
Diabetes	_____	_____	_____
Cancer	_____	_____	_____
High Blood Pressure	_____	_____	_____
Stroke	_____	_____	_____
Other	_____	_____	_____

Review of Systems: Do you have any complaints with the following?

	Yes	No	Explain:
Sleep	_____	_____	_____
Eyes	_____	_____	_____
Heart	_____	_____	_____
Lungs	_____	_____	_____
Bowels	_____	_____	_____
Bladder	_____	_____	_____
Skin	_____	_____	_____
Headaches	_____	_____	_____
Allergies	_____	_____	_____
Depression/anxiety	_____	_____	_____
Weight loss/gain	_____	_____	_____
Numbness/tingling	_____	_____	_____

Patient's Signature: _____ Date: _____

DO NOT WRITE BELOW THIS LINE. TO BE COMPLETED BY PHYSICIAN

HEENT _____
Neck _____
Chest _____
Heart _____
Lungs _____
Abdomen _____
Neurologic _____
Extremities _____
Other _____

Physician's Signature: _____ Date: _____



Dr. William O. Reed, Jr. M.D

Pain Assessment

Name _____

Date of Birth _____

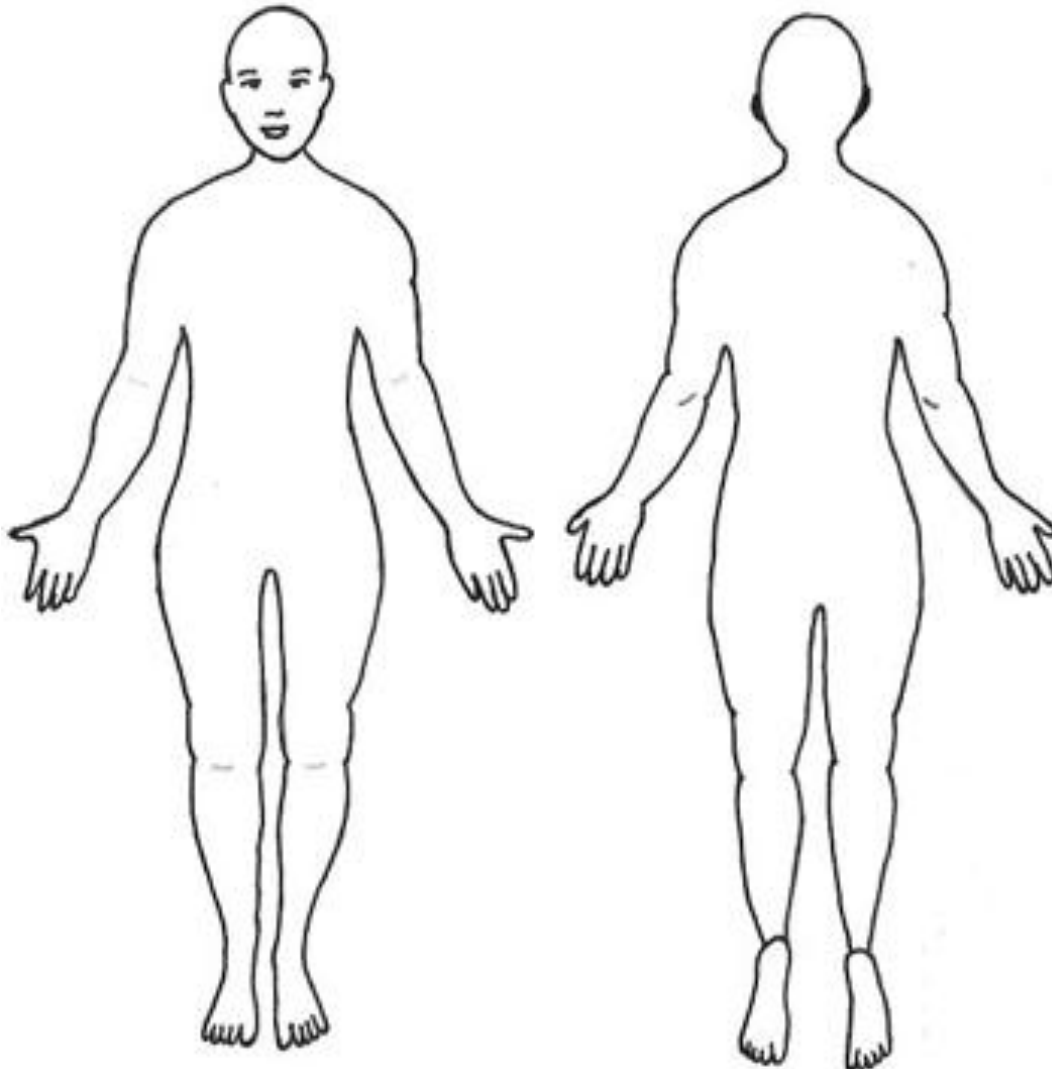
Patient Identification Number _____

Date of Visit: _____

Where is your pain now?

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Include all affected areas. Just to complete the picture, please draw in your face.

	^ ^ ^ ^		0 0 0 0		= = = =		X X X X		/ / / /
Ache	^ ^ ^ ^	Numbness	0 0 0 0	Pins/Needles	= = = =	Burning	X X X X	Stabbing	/ / / /
	^ ^ ^ ^		0 0 0 0		= = = =		X X X X		/ / / /





Name _____

Date of Birth _____

How bad is your pain now?

Please make an "X" along the line to show how far from normal toward the worst possible situation your pain has taken you.

- | | | |
|---|-------------------------|--------------------------------|
| 1. How bad is your <u>back</u> pain now? | _____ | _____ |
| | no pain | worst possible pain |
| 2. How bad is your <u>leg</u> pain now? | _____ | _____ |
| | no pain | worst possible pain |
| 3. How bad is your pain at <u>night</u> ? | _____ | _____ |
| | no pain | worst possible pain |
| 4. Does the pain interfere with your lifestyle? | _____ | _____ |
| | no problem | total change in lifestyle |
| 5. How good are pain killers for your pain? | _____ | _____ |
| | complete relief | no relief |
| 6. How stiff is your back? | _____ | _____ |
| | no stiffness | worst possible stiffness |
| 7. Does your pain interfere with walking? | _____ | _____ |
| | no problem | cannot walk |
| 8. Do you hurt when walking? | _____ | _____ |
| | no pain | worst possible pain |
| 9. Does your pain keep you from standing still? | _____ | _____ |
| | stand as long as I want | cannot stand at all |
| 10. Does your pain keep you from twisting? | _____ | _____ |
| | no problem | cannot twist |
| 11. Does your pain allow you to sit in an upright hard chair? | _____ | _____ |
| | sit as long as I like | cannot use a hard chair at all |
| 12. Does your pain allow you to sit in a soft chair? | _____ | _____ |
| | sit as long as I like | cannot use a softchair at all |
| 13. Do you have back pain when lying in bed? | _____ | _____ |
| | no pain | no relief at all |
| 14. How much does your pain limit your normal lifestyle? | _____ | _____ |
| | no limit | cannot do anything |
| 15. Does your pain interfere with your work? | _____ | _____ |
| | no problem | totally cannot work |
| 16. How much have you had to change your work place because of back pain? | _____ | _____ |
| | no change | constantly changing |



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Medication Refill Policy

Prescription refills are NEVER available on weekends or holidays.

The patient is responsible for planning his/her medication needs so as not to run out on weekends, long weekends or holidays.

Use of the answering service over weekends and holidays is reserved for emergency medical needs.

We require a 48-hour notice for all prescription refills.

I have read and understand the above policy regarding medication refills.

Patient's or Guardian's Signature

Date



Dr. William O. Reed, Jr. M.D.
OFFICE POLICIES

Name _____

Date of Birth _____

Payment in full is due at time of service. It is not our policy to bill. We accept Cash, Check, MasterCard and Visa.

Thank you for choosing Dr. William O. Reed, Jr., M.D., as your orthopaedic provider. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Office Policy that we require you read and sign prior to any treatment. All patients must complete our demographic, insurance and medical forms prior to seeing a provider. Remember that appointment times are guidelines only. The physician will spend as much time as needed to fulfill each individual patient's needs. This and emergency cases can lead to a slight delay in the daily schedule.

Medication Refills: Our office WILL NOT refill any prescriptions after 4:30 p.m., on weekends, or on holidays. If you are taking any pain medication, we cannot give out any more than 30 pills in a 7-day period.

X-Rays: All x-ray requests need to be made at least 72 hours in advance. This includes x-rays taken here as well as x-rays brought or sent here from another facility. All x-rays taken at this facility are a part of our permanent records and are the property of this office. If you wish to take your x-rays to another licensed physician, copies will be made available at a charge of \$17 per film to be paid in advance. This assures payment is received prior to copies being made and will give our radiology technician adequate time to get your films copied.

Medical Records: Original records WILL NOT leave this office. A release must be completed and signed by the patient or guardian of the patient prior to copies of records being sent.

Workers' Compensation Patients: You must fill out your portion of the forms completely in order for us to file to your Workers' Compensation insurance. Social Security Number, Date of Injury, and a description of the injury is a must in order for the insurance to recognize our billing. The case manager, insurance company or your employer must make all appointments that are not scheduled immediately following each visit. This includes any changes in scheduled appointments.

Regarding Insurance: We may accept assignment of insurance benefits. However, we do require any co-pay or remaining portion of the bill to be paid in full at the time of service. We cannot bill your insurance company unless you give us accurate insurance information in full, including a copy of your card at or before your first visit. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 45 days, the balance is your responsibility, whether your insurance company pays or not. Please be aware that some supplies that are used are considered non-covered by many insurance plans and will be your responsibility. Regarding insurance plans in which we are a participating provider, all co-pays are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not a participating provider, payment for additional services or any remaining balance will become your responsibility. If your balance becomes delinquent and we are forced to turn your account over to collections, you can be terminated from the practice.

Release of Information and Authorization to Pay Insurance Benefits: This facility may disclose all or any part of the record of the patient to any group or organization which is or may be liable for or responsible for payment of all or part of the facility's charges, including but not limited to, insurance companies, medical or hospital service companies, Workers' Compensation carriers, employers and welfare funds. I certify that the information given by me in applying for payment under Title XVIII or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about the patient to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized Basic Benefits, as well as Major Medical Benefits, be made on behalf of the patient directly to said providers.

Pre-certification/Authorization/Referrals: Referrals for office visits and radiology is the patient's responsibility. Our staff will assist you in any way we can, but if you are seen without referral, payment will be expected from you. Pre-certification for surgery will be done by our staff providing we have all of your insurance information. Our office will initiate authorization for additional tests or therapy and we will assist you in scheduling these tests and/or therapy.

Usual and Customary Rates: You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Minor Patients: The adult (parent or guardian) accompanying the minor is responsible for the bill and/or getting the correct insurance information to our office. We do not contact or bill third parties. Unaccompanied minors here for non-emergency treatment will be rescheduled, unless consent form and payment arrangements have been taken care of prior to treatment.

Disability/Insurance Forms: There is a \$35.00 fee for filling out a Disability Form. These are done in the order they are received and will be sent to the patient or insurance when completed.

Patient's Signature: _____ Date: _____



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RADIOLOGIC STUDIES

Dear Valued Patient:

The physician you are visiting must have all radiology studies performed in the past five years available at your appointment.

You must personally pick up and bring the actual films or CD's containing all performed studies when you come to the office. The reports alone are not satisfactory for diagnosis and decision-making purposes. Your physician must have the actual films or CD's with the relevant studies and the radiologist's interpretation.

This means you must either leave the facility with the studies in hand after your tests, or return to the facility later to pick up the studies and bring them to the office upon your scheduled visit.

Do not, under any circumstances, allow or believe that the facility will see to the delivery of your studies. Do not delegate this responsibility, or you will risk the next appointment with your physician being unproductive.

If you can obtain the radiologist's report, please do so. However, we can usually obtain the report by fax or e-mail quickly. The more important files you must carry yourself to the appointment to be sure they are available for your physician.

Please acknowledge the understanding of this important request by signing below.

Patient's Signature

Date



Dr. William O. Reed, Jr. M.D.

MISSED APPOINTMENT FEE

There will be a \$50.00 charge for appointments that are not rescheduled or canceled within 24 hours prior to the appointment.

MISSED APPOINTMENT FEE AGREEMENT

I understand that I am responsible for the \$50.00 fee to Dr. William O. Reed, Jr., M.D., if I do not give a 24-hour notice prior to my appointment.

Patient's Name (Printed)

Patient's Signature

Date