ALL materials in this packet must be submitted to our office to be established as a patient and candidate for surgery.

Your new patient packet should include the following:

1. Copy of your insurance card, front + back (page 2)
2. Patient information form (page 3)
3. Patient authorization forms (page 4-6)
4. Medical history form (page 7-10)
5. New hip questionnaire (page 11-15)
6. Recent x-rays (prescription on page 16)

^ 6 - Disregard if you've had xrays within the past 6 months. ^
^ 6 - Please exclude the xray prescription from your submitted package. ^

-In-state patients: The following materials are available in our office upon your initial visit. You MUST be seen in the office.

-Out-of-state patients: Submit this packet in its entirety, including xray CD and scan of insurance card, to:

Thomas P. Gross M.D.
Midlands Orthopaedics + Neurosurgery, P.A.
1910 Blanding St.
Columbia, SC 29201

PLEASE SCAN A COPY OF YOUR INSURANCE CARD, INCLUDING

FRONT AND BACK

MIDLANDS
orthopaedics
& NEUROSURGERY

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
GENDER:	DATE OF BIRTH:	SS#:

MAILING ADDRESS:	CITY:	STATE:	ZIP CODE:

HOME #:	MOBILE #: CONSENT TO TEXT: YES or NO	WORK #:

Email:	Contact preference: (please circle) Home # Cell # Work # Email Mail Portal

LANGUAGE: DECLINE TO ANSWER ☐	RACE: DECLINE TO ANSWER ☐	ETHNICITY: DECLINE TO ANSWER ☐

MARITAL STATUS:	Emergency Contact Name/Relationship:	Mobile #: Home #:

PATIENT'S EMPLOYER: OCCUPATION:	Referring Doctor: ☐ Self referred

GUARANTOR - PERSON RESPONSIBLE FOR THE BILL IF THE PATIENT IS A MINOR OR STUDENT:

LAST NAME:	FIRST NAME:	RELATIONSHIP:

MAILING ADDRESS:	CITY:	STATE:	ZIP CODE:

DATE OF BIRTH:	SS#:	HOME #:	MOBILE #:	WORK #:

INSURANCE INFORMATION *COPIES OF YOU INSURANCE CARDS ARE REQUIRED*

INSURNACE #1 (PRIMARY INSURANCE)		INSURANCE #2 (SECONDARY INSURANCE)	
INSURED'S NAME:	RELATIONSHIP TO PATIENT:	INSURED'S NAME:	RELATIONSHIP TO PATIENT:
SS# OF INSURED (IF DIFFERENT FORM PATIENT): ☐ SAME AS ABOVE		SS# OF INSURED (IF DIFFERENT FORM PATIENT):	
DATE OF BIRTH OF INSURED: ☐ SAME AS ABOVE		DATE OF BIRTH OF INSURED:	
INSURED'S EMPLOYER (IF DIFFERENT FROM PATIENT): ☐ SAME AS ABOVE		INSURED'S EMPLOYER (IF DIFFERENT FROM PATIENT):	

I acknowledge that by providing insurance information, I have asked and promised to pay for services provided in exchange for this information. I assign to Midlands Orthopaedics & Neurosurgery, PA , all health insurance benefits available for services provided to me. I understand that fees for services provided by Midlands Orthopaedics & Neurosurgery, PA, are my responsibility and I agree to pay any balance left unpaid by any insurance company or third party entity immediately upon notification of said balance. If I do not have insurance, I understand that I am responsible for any incurred expenses in their entirety.

Patient/Guarantor:______________________________ Date:__________________

MIDLANDS
orthopaedics
& NEUROSURGERY

1. **ACKNOWLEDGMENT OF RECEIPT OF PRIVACY POLICIES**: I have received a copy of the Midlands Orthopaedics & Neurosurgery, PA (MON), Notice of Privacy Policies detailing how my protected health information (PHI) may be used and disclosed as permitted under federal and state law. I understand that MON is permitted to disclose my PHI without my authorization to facilitate treatment, payment and health care operations.

2. **ePrescribe**: I understand that Midlands Orthopaedics & Neurosurgery, PA (MON), utilizes electronic health record software which incorporates ePrescribing technology. I understand that MON may access and use my prescription history through ePrescribing software for purposes of providing me appropriate treatment.

3. **ASSIGNMENT OF BENEFITS**: I assign to Midlands Orthopaedics & Neurosurgery, PA (MON), any insurance or other third party benefits available for health care services provided to me. I understand that MON has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to MON, I agree to immediately forward to the practice upon receipt all health insurance and other third-party payments that I receive for services rendered to me by MON.

4. **MEDICATIONS AND REFILL REQUESTS:** I understand that the providers of Midlands Orthopaedics & Neurosurgery, PA (MON), will not address requests for medications or refills of currently prescribed medications after regular business hours or on weekends. Requests for refills and/or changes to medications must be made during the normal business day. We apologize for the inconvenience, but "on-call" or "after-hours" staff members do not have access to the medical records needed to make decisions regarding medication changes or additions.

5. **PAPERLESS BILLING:** In an effort to reduce our environmental impact, Midlands Orthopaedics & Neurosurgery, PA (MON), issues paperless billing statements. I understand that by providing MON with my email address, I am automatically enrolled to receive paperless billing statements.

6. **CONSENT TO CALL:** I consent to receive calls from Midlands Orthopaedics & Neurosurgery, PA, and any affiliates, related to my protected healthcare information and other services at the phone numbers above, including my wireless number provided. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system. I understand that this consent is not required for me to be accepted as a patient and the consent may be revoked at any time.

I,_________________________acknowledge receipt and understanding of the items described on this

Authorization and Acknowledgement form.

____ ____________________

Patient/Guardian Signature *Date*

MIDLANDS orthopaedics & NEUROSURGERY

HIPAA PRIVACY AUTHORIZATION

I hereby authorize Midlands Orthopaedics & Neurosurgery, PA, to use and/or disclose the protected health information below to: [Name of individual, Address, and Telephone Number] (i.e. Spouse, Family member, Doctor, etc)

NAME	CONTACT INFORMATION

Authorization for Release of Information:

-Covering the period of health care from:

Date:______________________to ____________________ ***OR*** ☐ All past, present and future periods

-Covering the following protected health information:

☐ I hereby authorize the release of my complete health record.

☐ I hereby authorize the release of my complete health record with the exception of the following Information:

____

____

- I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned upon signing this authorization.
- I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

____

Signature of Patient or Personal Representative Date

____

Print Name of Patient or Personal Representative Relationship to Patient

MIDLANDS orthopaedics & NEUROSURGERY

Financial Policy

Thank you for choosing Midlands Orthopaedics & Neurosurgery, PA (MON). We are committed to the success of your medical treatment, and we strive to offer excellent care in a patient friendly environment. We recognize that healthcare is expensive, insurance requirements are frustrating and discussing payment arrangements when you don't feel well may be unpleasant. Nevertheless, prompt payment of charges helps us expedite your care so we ask you to review our financial policies. As your health care provider, our relationship is with you...our patient and not with your insurance company. Your insurance plan is a contract between you, your insurance company and/or your employer. Our office is a not a party to that contract or any possible restrictions imposed by it. While we will make every effort to obtain appropriate payment from your insurance carrier, payment for services rendered is ultimately your responsibility.

Payment for Services: Copays will be collected at check-in, as well as any balance due on the account. We will pre-collect the estimated patient responsibility amount for surgeries, procedures, and MRI services.

Insurance: You will be required to update your insurance information at least once each year, but we may ask you to provide your insurance card more frequently. Please notify our office immediately if you change insurance carriers, drop coverage, receive new cards or in any way experience a change to your coverage. Failure to do so may result in insurance claim denials that cause all charges to become your full responsibility. Please know the benefits, limitations, and responsibilities of your insurance plan.

Referrals and Authorizations: If your plan(s) require a referral from your primary care physician (family or regular doctor), please make sure one has been provided prior to your appointment. We must have a current referral to prevent your insurance carrier from denying payment for services you receive with us.

Co-pays, Deductibles, Co-insurance and Pre-determination of Benefits: We participate with many health plans and file charges with those plans as a courtesy. Most health plans require us to collect charges they deem to be patient responsibility in the form of co-pays, deductibles, and co-insurance. We must also collect payment directly from the patient for services the plan does not cover. If Midlands Orthopaedics & Neurosurgery, PA (MON) does not participate with your insurance plan, payment-in-full is required at the time of service.
Our charges are usual and customary for our area. If your insurance ultimately denies responsibility for services you receive, you are responsible for payment. If you have a Health Savings Account (HSA), Health Reimbursement Account (HRA) or a Flexible Spending Account, we will provide all documentation necessary for you to receive appropriate reimbursement; however, payment is still required at time of service.

Uninsured Patients: Payment is due at the time services are provided. A minimum deposit of $100.00 - $300.00 (determined by services required) will be required prior to the appointment. This payment will be applied to your total balance due upon check-out. We do offer a Prompt Pay Discount to uninsured patients who pay their entire balance at the time of service. If you are unable to pay your entire balance, an Account Specialist will assist you in establishing a payment plan.

Past Due Balances: Balances that are not paid within 30 days from the date of service are considered past-due. If your insurance company has not responded to our request for payment within 30 days, we will ask for your assistance in obtaining payment from the carrier and/or to make a payment on the balance. Balances that are not paid within 90 days of the date of service will be forwarded to a collection agency. By signing the below, you agree to allow MON and any collection or billing company to contact you by telephone or text message to any telephonic number provided including wireless or mobile telephone numbers. I agree to any method of contact to these numbers, such as a dialing service or prerecorded message. Collection agency and any associated legal fees may be added to the account. Patients with past-due balances will be required to make payment arrangements before additional services will be scheduled.

No-Show and Late Cancellation Fees: Because canceled appointment slots for surgeries, MRI and other procedures are difficult to fill without adequate notice, the following fees will be charged for appointments that are not cancelled at least 24 hours prior to the appointment time.

- MRI Appointments: $100.00
- Appointments for ESI (epidural steroid injection), EMG (electromyography), Tenex or surgical procedures:$150.00

Pataient/Guardian Signature Date

Printed Name of Patient/Guardian Date

MIDLANDS orthopaedics & NEUROSURGERY

GENERAL MEDICAL INFORMATION

Reason for your visit today? ____

Was this the result of an accident? ____ No _____ Yes If yes, DATE of accident and please describe.

Date:____________ ____

____

____

Where did the injury occur? _ Work_____Auto____Home___Other______________________________

Referring Physician Information: Name: Address: Phone:	**Family Physician Information** Name: Address: Phone:
Please provide your preferred pharmacy information. This will help us in the event we need to call in a prescription for you or send a prescription over a secure electronic connection to your pharmacy.	
Preferred Pharmacy: Name: Address: Phone:	**Mail-In Pharmacy:** Name: Address: Phone:

Height:_____________**Weight**:_________________

Current Pain Scale: (circle one number)

	MILD			MODERATE				SEVERE		
NO PAIN	1	2	3	4	5	6	7	8	9	10 SEVERE PAIN

ALLERGIES AND REACTIONS (list allergies to Medications, Metals or Latex)			
Name of Allergy :	Reaction:	Name of Allergy :	Reaction:

FAMILY HISTORY please check any that have occurred with a blood relatives			
	Relationship		**Relationship**
Blood Clots in Legs or Lungs		Heart Disease	
Bleeding Disorder		Aneurysm	
Osteoporosis		High blood pressure	
Osteoarthritis		Diabetes	
Rheumatoid arthritis		Nerve Disease	
Muscle or Bone Disease		Depression	
Cancer		Lupus	
Thyroid disease		Malignant Hypothermia	

Social History: *(please circle what applies to you)*

Are you a: Current Smoker Nonsmoker Former Smoker

Tobacco-years of use (current and former smokers):

If current smoker, how often do you smoke cigarettes? Every Day Some Days

If current smoker, how much do you smoke per day? ¼ PD ½ PD 1 PD 1 ½ PD 2PD 3PD

Cigar/pipe Use: Yes No

Chewing Tobacco: 1/day 2-4/day 5/day

Alcohol: None Occasional Moderate Heavy

Number of Children?

Marital Status: Married Single Divorced Separated Widowed Domestic Partner

Diet: Regular Vegetarian Vegan Gluten free Carbohydrate (limited) Cardiac Diabetic

Work History: Disabled Student Homemaker Retired

Are you currently employed? Yes No

Occupation:

Employer:

Type of work:

Surgical History/Broken Bones/Recent Hospitalizations:

Description:	Date:

Past Medical History: *(please circle all that applies to you)*		
AIDS/HIV	Fracture	Osteoarthritis
Anemia	Gallbladder	Osteoporosis
Anxiety	Glaucoma	Pacemaker or AICD
Asthma	Gout	Panic Attack
Atrial Fib (irregular heartbeat)	Heart Attack	Phlebitis
Bladder Disease	High Cholesterol	Pneumonia
Blood Clots in Legs or lungs	Heartburn/Gerd	Poor Circulation
Bronchitis	Heartburn/GERD	Pregnancy (Current or recent)
Cancer	Hepatitis B or C	Pulmonary Embolism
Cardiac Stents	Hernia	Restless Legs
Chronic Bronchitis	Irritable Bowel Syndrome	Rheumatoid Arthritis
Congenital Heart Defect	High Blood Pressure	Seizure Disorder
Depression	High Cholesterol	Emphysema
Diabetes	Sickle Cell Anemia/Trait	Kidney Disease
Eating Disorder	Enlarge Prostate	Kidney Stones
Insomnia	Epilepsy	Liver Disease
Stomach Ulcers	Migraines	Lupus
Stroke	Mitral Valve Prolapse	Tuberculosis
Thyroid Disorder	MRSA or VRE	
Fibromyalgia	Multiple Sclerosis	

Do you have sleep apnea? Yes or No
If yes, do you use C-PAP or Bi-PAP? Yes or No
Device Settings:

Do you have cardiac stents: Yes or No

If yes, please list date(s):____

Do you have a pacemaker or AICD? Yes or No
If yes, please dates:____

Other Medical History not mentioned above:

REVIEW OF SYSTEMS *(please circle what applies to you)*

Constitutional: fever night sweats weight gain weight loss difficulty exercising

Eyes: dry eyes irritation change in vision

Ears: difficulty hearing ear pain

Nose: frequent nosebleeds nose/sinus problems

Mouth/Throat: sore throat bleeding gums snoring
dry mouth mouth ulcers oral abnormalities teeth problems

Cardiovascular: chest pain arm pain on exertion
shortness of breath when walking
shortness of breath when lying down
palpitations heart murmur

Respiratory: coughing wheezing shortness of breath coughing up blood

Gastrointestinal: abdominal pain vomiting loss of appetite diarrhea vomiting blood

Genitourinary: incontinence difficulty urinating painful urination
blood in urine increase urinary frequency

Musculoskeletal: muscle aches muscle weakness joint pain back pain
swelling in extremities

Skin: abnormal mole jaundice rash itching dry skin growth/lesions

Neurologic: loss of consciousness weakness numbness seizures dizziness headaches
migraines restless legs

Psychiatric: depression sleep disturbance alcohol abuse

Endocrine: fatigue increased thirst hair loss increased hair growth cold intolerance

Hematologic/Lymphatic: swollen glands easy bruising excessive bleeding

Allergic/Immunologic: runny nose sinus pressure itching hives frequent sneezing

New Hip Patient Questionnaire

The purpose of this questionnaire is to objectively grade the severity of your hip problem as accurately as possible. All information is confidential. Questions are subjective. I ask patients to answer these questions when initially evaluating their hip and again at intervals after surgery to assess our results. We keep track of each hip separately in our database. Therefore, I would like to request that you fill out two separate forms if we are evaluating both hips today, even if both are identical. Thank you for your assistance in this matter.
– Dr. Thomas P Gross

Name: ____ Date____________

SECTION I - Introduction

1. This questionnaire is for the evaluation of my (side) hip.

○ Left ○ Right

2. I have had problems with my (side) hip(s).

○ Left ○ Right ○ Both

3. a. The most pain is in my (side) hip

○ Left ○ Right

b. When does this joint hurt? (Check all that apply)

☐ Sitting ☐ Resting ☐ On stairs
☐ Walking ☐ At night ☐ Standing

4. How long have you had this pain?

________________ years ______________ months

5. What activities cause this joint to hurt?

____

6. Have you had any previous injuries that have significantly affected this joint?

○ Yes; please explain: ____

○ No

7. Please indicate the location of the pain. (Check all that apply)

- ☐ No hip pain
- ☐ Groin
- ☐ Buttock
- ☐ Front of thigh
- ☐ Side of thigh
- ☐ Side of hip
- ☐ Lower back
- ☐ Opposite hip
- ☐ Other pain: ________________

8. List all PREVIOUS medications used to treat your pain.

a. Over-the-counter: ____

b. Prescriptions: ____

9. List all CURRENT medications used to treat your pain.

a. Over-the-counter: ____

b. Prescriptions: ____

10. How many sessions of physical therapy have you had to treat this issue?

____

11. Have you had any hip injections to treat your problem?

- ○ Yes; please explain how long this helped: ________________________________
- ○ No

12. Please list any previous surgeries you've had on your problematic joint.

____

13. Please list any other treatments you've had for your hip. How succesful was it?

____

____

14. What activities have you stopped due to hip pain?

____

15. What activities do you now find difficult because of hip pain?

____

16. Has an orthopaedic surgeon recommended surgery?

- ○ Yes; please explain what type of surgery: ______________________________________
- ○ No

17. What prompted you to contact us for evaluation?

____

18. Please list any additional notes or a brief narrative of your problem here.

____

____

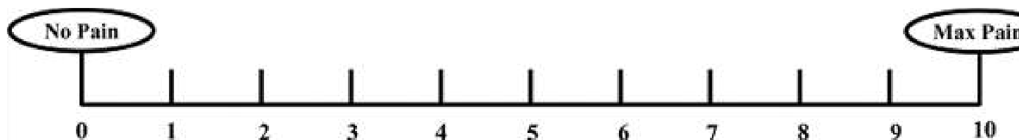
SECTION II - Clinical Function Score

1. What category most closely represents your pain level?

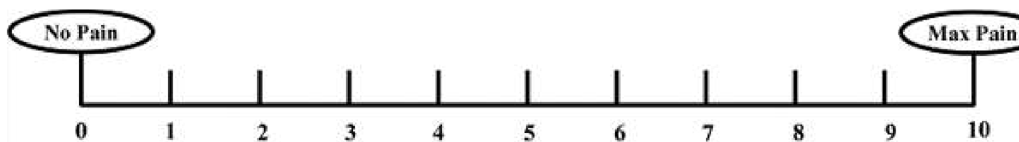
- ○ None, or so slight that I ignore it
- ○ Slight, occasional pain with no compromise in activity
- ○ Mild, pain with unusual/vigorous activity
- ○ Moderate, pain is tolerable
- ○ Severe, serious limitations to my lifestyle
- ○ Disabled

2. Visual Analog Pain score

a. Please circle your regular pain level on the following scale.



b. Please circle your highest hip pain level on the following scale.



3. Please indicate the severity of your limp, if any.

- ○ None
- ○ Slight
- ○ Mild
- ○ Moderate
- ○ Severe
- ○ Unable to walk

4. Please indicate your use of support, if any.

- ○ None required
- ○ Use of a cane or a stick for long walks or high activity only
- ○ Use of a cane or a stick almost always
- ○ Use of one crutch almost always
- ○ Use of two crutches or a walker
- ○ Unable to move across the room

5. I am able to walk _______________ without a break:

- ○ Over one mile/Unlimited
- ○ 6 blocks or roughly 30 minutes
- ○ 2-3 blocks or roughly 10-15 minutes
- ○ Indoor walking only
- ○ Bed and chair only

6. Which of the following describes how you take stairs?

- ○ Normally foot-over-foot without NEEDING the railing
- ○ Normally using the railing
- ○ Leading with non-painful hip one step at a time
- ○ Cannot take the stairs

7. I am able to put socks/shoes on….

- ○ With ease
- ○ With difficulty
- ○ Unable to put socks/shoes on without help

8. Under what circumstances can you sit comfortably?

- ○ Any chair/1+ hour
- ○ High chair/30 minutes
- ○ Unable to sit comfortably

9. Are you able to get in and out of a vehicle without help?

- ○ Yes
- ○ No

10. Please list any unrelated orthopaedic issues that you believe might effect your hip function score (i.e. bad back, arthritis in other hip, non-hip pain, etc.)

- ○ Yes; please list: ____
- ○ No

11. How is your hip joint now compared to before surgery?

○ Better than my normal, healthy, pre-arthritic/damaged hip

○ Feels just like my normal, healthy, pre-arthritic/damaged hip

○ Much better than before surgery, with minor aches and pains

○ Somewhat better than before surgery

○ About the same

○ Worse than before surgery

SECTION III - Activity Score

1. Which best describes your current level of activity? (Please circle one.)

1	Wholly inactive, dependent on others, and can not leave residence
2	Mostly inactive or restricted to minimum activities of daily living
3	Sometimes participates in mild activities, such as limited walking, housework, and shopping
4	Regularly participates in mild activities
5	Sometimes participates in moderate activities, such as swimming, or unlimited housework and shopping
6	Regularly participates in moderate activities
7	Regularly participates in active events, such as bicycling
8	Regularly participates in active events, such as bowling or golf
9	Sometimes participates in impact sports, such as jogging, tennis, skiing, acrobatics, ballet, heavy labor, or backpacking
10	Regularly participates in impact sports

END QUESTIONNAIRE

MIDLANDS
orthopaedics, p.a.
(803) 256-4107
1910 Blanding St.
Columbia,SC 29201
1013 Lake Murray Blvd.
Irmo,SC 29063

Hip X-ray Request Letter

FOR: ______________________________ DATE: ______________

℞ ADDRESS: ______________________________________

Please select/circle ONE section (either 1, 2, or 3) to ensure the appropriate xrays are obtained from the patient's radiology facility.

1. LEFT
   a. Diagnoses:
      i. Osteoarthritis (OA) of the hip – **M16.12**
      ii. Hip pain – **M25.552**
2. RIGHT
   a. Diagnoses:
      i. Osteoarthritis (OA) of the hip – **M16.11**
      ii. Hip pain – **M25.551**
3. BILATERAL
   a. Diagnoses:
      i. Osteoarthritis (OA) of the hip – **M16.10**
      ii. Hip pain – **M25.559**

Views (please include all of the following):

1. AP Pelvis Standing (Please label as "STANDING")
2. AP Pelvis Supine (Please label as "SUPINE")
3. Johnson Lateral

Please provide the patient with a CD digital copy of these x-rays for my review and mail to:
Midlands Orthopaedics & Neurosurgery
ATTN: Gross follow-up
1910 Blanding Street
Columbia, SC 29201