*WELCOME TO OUR OFFICE*

WE FIND THAT COMMUNICATION WITH OUR PATIENTS REGARDING OUR BUSINESS OFFICE POLICIES ASSISTS US IN PROVIDING YOU THE BEST SERVICE. THEREFORE WE HAVE PROVIDED A HIGHLIGHT OF SOME IMPORTANT POINTS.

• Please advise us if you change your address, phone number, place of employment, or insurance.

• We do not accept responsibility for charges denied as a result of changes in your insurance coverage during the course of your treatment. Denials due to changes in your insurer and/or managed care organization are your financial responsibility.

• If we participate with your insurance plan, we will file an insurance claim for you. At the time of your visit, we expect payment for your percentage or portion that is not covered by insurance.

• Patients without insurance or patients with insurance plans in which we do not participate are expected to pay for charges at the time of service.

• It is your responsibility to obtain a referral from your primary care physician for services rendered in our office. Charges which are denied due to lack of a referral are your responsibility.

• Some insurers normally do not pay for supplies provided by our office. If we inform you that a supply prescribed by your physician will not be covered, we expect payment when you receive the supply. In the event that your insurance company is billed and does not remit payment, you will be billed for the supplies which are not paid.

• If you need to cancel or reschedule your appointment, you must do so at least 24 hours before you scheduled office appointment and 48 hours before your scheduled procedure. This notification is necessary so that we may schedule other patients needing immediate appointments.

• There is a $40.00 administrative fee for any forms (FMLA, Disability forms, etc) that are needed to be filled out.

• A fee of $35.00 will be added to your account for any check dishonored by your bank.

I have read the above business office policy statements. As a patient of Dominion Orthopaedic Clinic, LLC I understand my responsibilities.

PATIENT/GUARDIAN SIGNATURE*___________________________________________________

SIGNATURE*_____________________________________________________________________

DATE OF SIGNATURE*____________________________________________________________
PATIENT INFORMATION

NAME* ________________________________________________________________
DATE OF BIRTH* _______________________________________________________
ADDRESS*
  Street Address__________________________________________________________
  City_______________________________________________________________
  State / Province / Region______________________________________________
  ZIP / Postal Code____________________________________________________
HOME PHONE____________________________________________________________
WORK PHONE____________________________________________________________
CELL PHONE* __________________________
SOCIAL SECURITY NUMBER* __________________________
SEX*     ___MALE     ___FEMALE
EMPLOYER* ____________________________________________________________
EMERGENCY CONTACT*____________________________________________________
EMERGENCY PHONE*______________________________________________________
EMERGENCY RELATIONSHIP* ______________________________________________

GUARANTOR INFORMATION

NAME* ________________________________________________________________
DATE OF BIRTH* _______________________________________________________
ADDRESS*
  Street Address__________________________________________________________
  City_______________________________________________________________
  State / Province / Region______________________________________________
  ZIP / Postal Code____________________________________________________
HOME PHONE____________________________________________________________
WORK PHONE____________________________________________________________
CELL PHONE*__________________________________________________________

SOCIAL SECURITY NUMBER*________________________________________________

EMPLOYER*______________________________________________________________

Address*
  Street Address___________________________________________________________
  Address Line 2___________________________________________________________
  City___________________________________________________________
  State / Province / Region______________________________________________
  ZIP / Postal Code_______________________________________________________

INSURANCE INFORMATION

Primary Insurance*_______________________________________________________
  Certificate #*___________________________________________________________
  Group Number*___________________________________________________________
  Group Name*____________________________________________________________
  Copay*_______________________________________________________________
  Subscriber Name*_______________________________________________________

Secondary Insurance*____________________________________________________
  Certificate #*___________________________________________________________
  Group Number*___________________________________________________________
  Group Name*____________________________________________________________
  Copay*_______________________________________________________________
  Subscriber Name*_______________________________________________________

ADDITIONAL INFORMATION

Primary Care Physician*__________________________________________________
Physician Phone Number*_____________________________________________________
Physician Fax*_______________________________________________________________
Physician Address*
  Street Address____________________________________________________________
  Address Line 2___________________________________________________________
  City____________________________________________________________________
  State / Province / Region___________________________________________________
  ZIP / Postal Code_________________________________________________________

Pharmacy Name*___________________________________________________________
Pharmacy Phone Number*___________________________________________________
Pharmacy Fax*______________________________________________________________
Pharmacy Address*
  Street Address____________________________________________________________
  Address Line 2___________________________________________________________
  City____________________________________________________________________
  State / Province / Region___________________________________________________
  ZIP / Postal Code_________________________________________________________

COMPLETE INFORMATION BELOW IF APPLICABLE
Attorney Name*__________________________
Attorney Phone*____________________________________________________________
Attorney Address
  Street Address____________________________________________________________
  Address Line 2___________________________________________________________
  City____________________________________________________________________
  State / Province / Region___________________________________________________
  ZIP / Postal Code_________________________________________________________
Adjuster Name*_____________________________________________________________
Adjuster Phone*_____________________________________________________________
Adjuster Fax*_______________________________________________________________

Date Of Injury*______________________________________________________________

Authorization To Pay Benefits To Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or Dominion Orthopedic Clinic when they accept assignment.

Authorization To Release Medical Information. I hereby authorize Dominion Orthopedic Clinic to release any information necessary for my course of treatment.

Signature*_______________________________________________________________
Date*_______________________________________________________________
Patient Health Information-Release Authorization

Your health and medical information is considered sensitive and private and is afforded protection under the law. However, there are circumstances when you may want someone other than yourself to pick up documents, x-rays or other items on your behalf.

Please list the names of any individuals that you would like to access or retrieve personal health information, documents, or other items on your behalf:

I understand that authorizing disclosure of this health information is voluntary and I can refuse to sign this authorization. Any other use of this information without my written consent is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it.

Name 1* ____________________________________________________________________________
Relationship 1* _______________________________________________________________________

Name 2______________________________________________________________________________
Relationship 2________________________________________________________________________

Name 3_____________________________________________________________________________
Relationship 3________________________________________________________________________

I decline to have anyone pick-up patient information on my behalf.

I understand that authorizing disclosure of this health information is voluntary and I can refuse to sign this authorization. Any other use of this information without my written consent is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it.

Signature of Patient or Legal Representative* ______________________________________________
Date* ______________________________________________________________________________
PATIENT CONSENT FORM

PLEASE READ AND SIGN I, the undersigned, hereby consent to the following treatment:

• Administration and performance of all treatments.
• Administration of any needed anesthetics.
• Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient.
• Use of prescribed medication.
• Performance of diagnostic procedures/tests and cultures.
• Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees.

I fully understand that this given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that John I. Foster, III, M.D., FACS, William G. Sutlive, III, M.D., Nicole E. Forsythe, M.D., will include consent at satellite offices under common ownership.

I, the undersigned, authorize John I. Foster, III, M.D., FACS, William G. Sutlive, III, M.D., Nicole E. Forsythe, M.D. to use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

MEDICARE PATIENTS: I authorize the release of medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to John I. Foster, III, M.D., FACS, William G. Sutlive, III, M.D., Nicole E. Forsythe, M.D..

I acknowledge that I have been given the Notice of Privacy Practices of Dominion Orthopaedic Clinic, LLC. I understand that if I have questions or complaints that I should contact the Privacy Official.

PATIENT INITIAL:_____ 

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient (or Responsible Party) Signature*________________________________________________________

Date*_________________________________________________________________________________
PATIENT PAIN MANAGEMENT

It is our goal to manage our patient’s pain in the healthiest manner. Dominion Orthopaedic Clinic, LLC’s policy regarding pain medicine is as follows:

• Nonsurgical patients will be given narcotics for 2 to 3 weeks after the onset of the acute phase of their injury or illness. Then non-narcotic measures will be implemented for pain control.

• Patients will be given strong pain medication when scheduling their surgery. This prescription will be for their use of immediately following their surgery. This allows patients the convenience of having their pain medication filled, and readily available to them when returning home after surgery. It will be the patient’s responsibility not to lose or use this prescription before surgery. No exceptions will be made if this prescription is lost or used, for writing any additional prescriptions.

• If pain continues, a lesser strength pain medication will be prescribed. These types of pain medications will be given for 2 to 6 weeks depending on the severity of the surgery.

• Following these 6 weeks, no other narcotic pain medication will be given. Measures used to decrease pain will include: Physical therapy, icing, rest, NSAIDs, and muscle relaxants.

• If pain persists following the above, patients will be referred to pain management specialist.

• If we determine our patient is obtaining narcotics elsewhere, the patient will not receive any future pain prescriptions.

• No narcotics will be called in by this practice. NARCOTIC PRESCRIPTIONS MUST BE OBTAINED AT THE TIME YOU ARE SEEING DR. FOSTER, DR. SUTLIVE OR DR FORSYTHE.

DOMINION ORTHOPAEDIC CLINIC, LLC believes the above policy is only in the best interest of all our patients. Each patient’s request will be evaluated individually and professionally. It is our wish that patients do not become addicted to narcotic pain medication.

I acknowledge the above policy and understand it in full.

Patient Signature* ____________________________________________________________

Date* ____________________________________________________________
NEW PATIENT QUESTIONNAIRE

Patient Name* _______________________________________________________________________

Date of Birth______________________________________________________________________

Age* ______________________________________________________________________________

Date* ______________________________________________________________________________

Primary Care Physician* ________________________________________________________________

Referred By* ________________________________________________________________________

Have you been treated by another physician in our practice? (Please mark with an X)

___ Dr. John Foster

___ Dr. Eric Steenlage

___ Dr. William Sutlive III

___ Dr. Pinecca Patel

___ Dr. Nicole Forsythe

Have any family members been treated by Dominion Orthopedic Clinic LLC?*

___ Yes

___ No

Please identify the area(s) in which you are experiencing pain.

Back

___ Right  ___ Left  ___ Both

Neck

___ Right  ___ Left  ___ Both

Shoulder

___ Right  ___ Left  ___ Both
<table>
<thead>
<tr>
<th>Location</th>
<th>Right</th>
<th>Left</th>
<th>Both</th>
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<tbody>
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<td>Elbow</td>
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<td>Foot</td>
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</tbody>
</table>
Toe
___Right ___Left ___Both

Other
___Right ___Left ___Both

Date of Injury* __________________________________________________________________________

Is your injury work related?*
___Yes ___No

How did your injury occur?* __________________________________________________________________________________________________________

Which is your dominant hand?*
___Left ___Right

How severe is your pain?*
___Mild ___Moderate ___Severe

Describe the onset of your pain.*
___Gradual
___Gradual following an incident at work
___Sudden
___Sudden following an incident at work
___Sudden following a motor vehicle accident

How long have you had your pain?*
___Hours ___Days ___Weeks ___Months ___Years
Describe the course of your pain?*
___ Increasing
___ Decreasing
___ Constant

Describe the pattern of your pain?*
___ Intermittent
___ Persistent

What diagnostic tests have you had for this problem?*
___ MRI
___ CT
___ X-RAY

What treatments have you had for this problem?*
___ None
___ Injection
___ Occupational Therapy
___ Physical Therapy
___ Chiropractic Care

Allergies*
___ None
___ Penicillin
___ Sulfa Codeine
___ Iodine IVP Dye
___ Ibuprofen
___ Latex Erythromycin
___ Levaquin
___Demerol
Other Allergies?*

Type Of Reaction

FAMILY HISTORY - Please place a check box in all areas where there is family medical history.

___Heart Disease  ___Diabetes  ___Stroke  ___Bleeding Problems  ___Hypertension
___Kidney Problems  ___High Cholesterol  ___Osteoporosis

Please notify us of which family members are associated with the medical problem outlined above.

PAST MEDICAL HISTORY - Please place a check box in all areas where you have a medical history.

___Asthma  ___Diabetes  ___Stroke  ___Anemic  ___Hypertension  ___HIV  ___High Cholesterol
___Blood Clots  ___Kidney Disease  ___Ulcers  ___Hepatitis A B C  ___Ulcer (stomach)  ___Depression
___Cancer  ___Rheumatoid Arthritis  ___Pacemaker  ___Gout  ___Renal Insufficiency

Surgery______________________________________________________
Date____________________________________________________________________________
Hospital__________________________________________________________________________

Additional Surgery_______________________________________________________________
Date____________________________________________________________________________
Hospital__________________________________________________________________________

Additional Surgery_______________________________________________________________
SOCIAL HISTORY

Tobacco Use*
__Yes __No ___Occasional
How often is tobacco used?_________________________________________________________

Alcohol Use*
__Yes __No ___Occasional
How often is alcohol used?_________________________________________________________

Drug Use*
__Yes __No ___Occasional
How often are drugs used?_________________________________________________________

Please List All Current Medications
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Are you currently pregnant?*
__Yes __No ___Unknown

Vitals*______________________________________________________________________________

Height*____________________________________________________________________________

Weight____________________________________________________________________________

Patient Signature*____________________________________________________________________
Medical Release Authorization

You are authorized and directed to furnish any and all information requested pertaining to my medical care and treatment to:

Dominion Orthopaedic Clinic, LLC
John I. Foster, III, M.D., FACS
William G. Sutlive, III, M.D.
Nicole E. Forsythe, M.D.
5555 Peachtree Dunwoody Road
Suite 215
Atlanta, GA 30342
Phone: (770)455-4009
Fax: (770)455-4065

This authorization includes furnishing of the originals or copies of all charts, summaries, test results and all other written memoranda or data including x-rays and photographs.

Date Of Birth* _________________________________________________________________
Signature* _________________________________________________________________
Todays Date* _________________________________________________________________
Cancellation & No Show Policy

As our goal is to meet the needs of our patients, we will make every effort to schedule your appointments as efficiently as possible. In return, it is your responsibility to make every effort to keep your scheduled appointments and to arrive promptly at the time instructed.

However, we realize that unanticipated events can occur and may prevent you from keeping your appointment. In fairness and consideration to the other patients that need to be seen as soon as possible, we hereby request that you notify our office immediately when you realize you will not be keeping your appointment.

If you need to cancel or reschedule your appointment, you must do so at least 24 hours before your scheduled office appointment and 48 hours before your scheduled procedure to avoid paying a $50.00 fee. This fee is not covered by your medical insurance or Worker's Compensation benefits. In an effort to see patients promptly at the scheduled time, therefore, this notification of 24 or 48 hours is necessary so that we may schedule other patients needing immediate appointments.

The cancellation/rescheduling fee must be paid on or before your next scheduled appointment. Thank you for your attention to this matter.

Worker’s Compensation patients, please note that we will need to notify your adjustor and/or Nurse Case Manager in the event that you cancel within 48 hours of your scheduled procedure.

I hereby acknowledge that I have read and understand the above cancellation and no show policy and that I agree to abide by these guidelines.

Patient Signature* ______________________________________________________________________

Date* _____________________________________________________________________________