



CAROLINA ORTHOPAEDIC CENTER

MICHAEL J. O'BOYLE, M.D.
Acute Trauma • Post-Traumatic Reconstruction
Foot & Ankle Surgery

THOMAS B. PACE, M.D.
Arthritic Hip & Knee Surgery

ALAN G. POSTA, JR., M.D.
Sports Medicine • Shoulder, Elbow & Knee
Reconstructive Surgery

H. STANLEY REID, M.D.
Spine Surgery

Attention All New Patients:

Please bring your insurance cards, photo id, and all previous X-ray/MRI films and reports with you to your appointment. Please bring all medical records (office notes, surgery reports, etc...) related to your injury to your appointment, or forward them to our office.

Please complete the appropriate new patient paperwork in full.

Please call 864.234.9900 with any questions.

Thank you for your cooperation. We look forward to providing your medical care.

New Patient Information Sheet

Please help us serve you better by taking a few minutes to provide the following information.

PATIENT INFORMATION

SOCIAL SECURITY NUMBER		TITLE	LAST NAME		FIRST NAME	MI
STREET ADDRESS (ROAD OR STREET)			(APARTMENT # OR SECOND ADDRESS LINE)			
ZIP CODE		CITY			STATE	
HOME PHONE					COUNTY	
BIRTHDAY		SEX (M,F)			RACE	
MARITAL	EMPLOYMENT		STUDENT		REL. TO INSURED	
EMPLOYER/SCHOOL NAME						
STREET ADDRESS (ROAD OR STREET)			(APARTMENT # OR SECOND ADDRESS LINE)			
ZIP CODE		CITY		STATE	BUSINESS PHONE	

POLICYHOLDER INSURANCE INFORMATION

SOCIAL SECURITY NUMBER		TITLE	LAST NAME		FIRST NAME	MI
STREET ADDRESS (ROAD OR STREET)			(APARTMENT # OR SECOND ADDRESS LINE)			
ZIP CODE		CITY			STATE	
HOME PHONE					COUNTY	
BIRTHDAY		SEX (M,F)			RACE	
MARITAL	EMPLOYMENT		STUDENT		REL. TO INSURED	
EMPLOYER/SCHOOL NAME						
STREET ADDRESS (ROAD OR STREET)			(APARTMENT # OR SECOND ADDRESS LINE)			
ZIP CODE		CITY		STATE	BUSINESS PHONE	
PRIMARY INSURANCE COMPANY NAME			MAILING ADDRESS			
TELEPHONE #			POLICY #		GROUP #	
SECONDARY INSURANCE COMPANY NAME			MAILING ADDRESS			
TELEPHONE #			POLICY #		GROUP #	

Financial Policy

Dear Patient,

Thank you for choosing us as your health care provider. The following is our Financial Policy. Our main concern is that you receive the proper and optimal treatment needed to restore your health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to ask.

We ask that all patients read and sign our Financial Policy as well as complete our Patient Information Form prior to seeing the doctor.

Payment for services is due at the time services are rendered. We accept cash, checks, MasterCard and Visa. We are participating providers with most insurance carriers. Please contact your insurance company to verify that we are participating providers.

WE DO NOT FILE ANY THIRD PARTY CLAIMS.

1. Your insurance policy is a contract between you, your employer and the insurance company. We are not a party to that contract. Our relationship is with you, not your insurance company.
2. All charges are your responsibility whether your insurance company pays or not. Not all services are a covered benefit in all contract. Some insurance companies arbitrarily select certain services they will not cover.
3. Fees for services are due at the time of service. We are under contract with most insurance companies and require deductibles and co-payments to be paid at the time of service.
4. Balances older than 60 days will be considered delinquent and will be subject to interest charges of 1.5 % per month. Patient will be responsible for all collection charges (including but not limited to: collection agency fees, legal expenses, filing fees, etc.).
5. Workmen's Compensation claims will be verified at the time of service.
6. **Disability Claim Forms will be completed for a \$5.00 charge.**

I hereby authorize Carolina Orthopaedic Center to obtain any and all medical records needed for my treatment. I understand that I am responsible for all medical expenses regardless of insurance coverage and whether or not there is an accident with another person at fault. I hereby authorize Carolina Orthopaedic Center to release any information acquired in the course of my examination or treatment. I also authorize Carolina Orthopaedic Center to release any information to assist in the collection of any delinquent account. I hereby authorize payment directly to the Carolina Orthopaedic Center of all my rights, title and interest to my reimbursement benefits under the insurance policy applicable to my medical care. I request that payment of authorized Medicare benefits be made to Carolina Orthopaedic Center for any services furnished me by that physician. I understand that you may be transmitting my records electronically and authorize you to do so. If they are received by another party, in error, I absolve the physicians of the Carolina Orthopaedic Center of any and all liability relating to such submission of records.

Patient Signature _____ Date _____