Boyette Orthopedics
& Sports Medicine, PA

Our Team: Working Together, Keeping You Active

2573 Stantonsburg Rd., Suite B • Greenville, NC 27834
Phone (252) 215-5200 • Fax (252) 215-5201
www.boyetteorthopedics.com

Please complete this New Patient Packet and bring it with you at the time of your visit.

Patient Information

Patient Name: _____ Today's Date: _____

Social Security #: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Mobile: _____

Email: _____

Sex: ◯ Female ◯ Male Marital Status: _____

Occupation: _____

Employer Name: _____ Employer Phone: _____

Employer Address: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact: _____

Phone: _____ Relationship to You: _____

Patient No Show / Cancellation Policy

It is important that you keep your scheduled appointments. If you are unable to do this, please call our office at least 24 hours in advance so that another patient can be accommodated in that time slot. If you do not show for a scheduled appointment, or cancel less than 24 hours in advance, you will be charged $50.00.

Patient Incident / Accident / Illness Form

Patient Name: _____ Acct #: _____

Date of Incident / Illness: _____

If accidental injury, state type of accident:

On the Job?	◯ Yes ◯ No	
At Home?	◯ Yes ◯ No	
Auto?	◯ Yes ◯ No	
Retail Store?	◯ Yes ◯ No	
Commercial Parking Lot?	◯ Yes ◯ No	
Any other type than listed above?	◯ Yes ◯ No	If Yes, what type? _____

If reason for visit is chronic pain / illness, when did first symptoms occur? (need date) _____

Where is your pain located?

Arm / Shoulder?	◯ Yes ◯ No	◯ Right ◯ Left
Knee / Leg?	◯ Yes ◯ No	◯ Right ◯ Left
Ankle / Foot?	◯ Yes ◯ No	◯ Right ◯ Left
Other than listed above:	◯ Yes ◯ No	If Yes, where? _____

Do you have an attorney representing you for any issues stated above? ◯ Yes ◯ No

If Yes, please provide:

Attorney Name: _____

Address: _____

Phone Number: _____

Please notify attorney that you are being treated by Boyette Orthopedics & Sports Medicine, PA as they will need to send a letter of representation!

Patient or Legal Guardian Signature: _____ Date: _____

Safety Questionnaire

Please fill out this form. We will use this information if any future testing/imaging is needed.

If you do not provide us with a specific location of where you would like your testing to be done, we will schedule you at our desired location and the test will not be able to be rescheduled.*

Patient Name: _____

1. * What facility or city would you like your test scheduled? _____

   _____

2. Weight: _____

3. Are you claustrophobic? ◯ Yes ◯ No

4. Have you had an aneurism clip in the brain or body? ◯ Yes ◯ No

5. Internal pacemaker/defibrillator/neuro-stimulator/heart valve? ◯ Yes ◯ No

6. History of metal fragments in the eyes? ◯ Yes ◯ No

7. Have you been around any welding in the past month? ◯ Yes ◯ No

8. Any surgery with in the past 6 weeks? ◯ Yes ◯ No

   If Yes, where? _____

9. Any metal in the body (clips, screws, pins or plates)? ◯ Yes ◯ No

10. Do you have Diabetes? ◯ Yes ◯ No

11. Do you have Renal Disease? ◯ Yes ◯ No

12. Do you have allergies to dye or contrast material? ◯ Yes ◯ No

We will contact your insurance company and acquire any pre-authorization prior to scheduling your test. Please allow up to 72 business hours for your test to be scheduled.

Prescription Pain Medicine Policy for Scheduled / Narcotic Pharmaceuticals

STOP Act 2017: No authorized prescriber can issue an initial prescription for a scheduled substance in a quantity exceeding a 7-day supply for postoperative pain.

Scheduled/Narcotic pain medicine will only be prescribed by our practice as a means of postoperative pain control following surgical intervention and fracture/dislocation reduction.

Scheduled/Narcotic prescription pain medicine for inpatient/outpatient surgery and fracture care will be prescribed in appropriate decreasing dosages. Inpatient surgery will receive up to 6 weeks supply, outpatient will receive a 2-week supply. (Maximum of 3 prescriptions after inpatient surgery).

Scheduled/Narcotic prescription pain medicine refill requests are only considered during normal office hours. No requests for refills will be considered when the office is closed, including holidays. No request will be considered through the on-call answering service. The refill Rx must be picked up at our office by the patient and/or patient representative during normal business hours or it can be mailed to the patient's address. By law, most scheduled/narcotic prescription pain medicine cannot be called or faxed in to the pharmacy.

No lost (including in the mail), misplaced and/or reportedly stolen prescriptions will be rewritten or refilled.

Requests for refills must come directly from the patient or legal guardian/power of attorney.

Patients who are receiving scheduled/narcotic pain medication from another provider and/or pain clinic must discuss their upcoming orthopedic surgical intervention with them as we will not prescribe any additional pain medication.

Patients who were seen at the hospital by another provider/service will not receive pain medication from our office. You must contact the discharge provider. Patients who were seen at the emergency department and have not been seen in our office will not receive any prescription pain medicine from out office.

Please sign below indicating you have read and understand our pain medication policy.

Patient or Legal Guardian Signature: _____ Date: _____

Witness: _____

Financial Agreement

I understand that all applicable copayments and deductibles are due at the time of service. I agree to be financially responsible and make full payment for all charges not covered by my insurance company. I authorize my insurance benefits to be paid directly to Boyette Orthopedics & Sports Medicine for services rendered. I authorize representatives of Boyette Orthopedics & Sports Medicine to release pertinent medical information to my insurance company when requested or to facilitate payment of claim.

Notice of Privacy Practices

I acknowledge that I was provided with a copy of the Notice of Privacy Practices for Boyette Orthopedics & Sports Medicine, PA. *Please refer to our website at www.boyetteorthopedics to read our full Financial Policy and Notice of Privacy Practices.*

I have read and agree to the above Financial Agreement and acknowledge receipt of the Notice of Privacy Practices.

Patient or Legal Guardian Signature: _____ Date: _____

Insurance Authorization

Medicare One-Time Authorization (Medicare Patients Only)

I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services (CMS) or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of this original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 11288 of the Social Security Act and U.S.C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

Patient or Legal Guardian Signature: _____ Date: _____

Insurance other than Medicare

The insurance information furnished here represents full disclosure of the insurance/third party benefits to which I am entitled. I understand that failure to disclose precertification/second opinion requirements for any and all plans to which I subscribe may cause me to incur full liability for professional charges as a result of non-payment by and carrier. I authorize payment of medical and surgical benefits to Boyette Orthopedics & Sports Medicine, PA. I acknowledge that I am responsible for all fees, regardless of insurance coverage or attorney representation.

Patient or Legal Guardian Signature: _____ Date: _____

METHOD OF PAYMENT FOR TODAY'S VISIT: CASH, CHECK, MASTERCARD/VISA OR VISA CHECKCARD