-Local patients: The following materials are available in our office upon your initial visit.

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

Thomas P. Gross M.D.
ATTN: New patient package
1910 Blanding Street
Columbia, SC 29201

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 knee questionnaire (page 11-14)
6. Recent x-rays (prescription on page 15)

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

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:_____

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

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

Patient/Guardian Signature Date

Printed Name of Patient/Guardian Date

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:	**Family Physician Information**
Name: Address: Phone:	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	

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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 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:	**ALL daily medication/vitamins/supplements:**
Please List:	Please list:

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	Heartburn/GERD	Pneumonia
Blood Clots in Legs or lungs	Hepatitis B or C	Poor Circulation
Bronchitis	Hernia	Pregnancy (Current or recent)
Cancer	Irritable Bowel Syndrome	Pulmonary Embolism
Cardiac Stents	High Blood Pressure	Restless Legs
Chronic Bronchitis	High Cholesterol	Rheumatoid Arthritis
Congenital Heart Defect	Sickle Cell Anemia/Trait	Seizure Disorder
Depression	Enlarge Prostate	Emphysema
Diabetes	Epilepsy	Kidney Disease
Eating Disorder	Migraines	Kidney Stones
Insomnia	Mitral Valve Prolapse	Liver Disease
Stomach Ulcers	MRSA or VRE	Lupus
Stroke	Multiple Sclerosis	Tuberculosis
Thyroid Disorder		
Fibromyalgia		

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:

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 KNEE
X-RAY ORDER

MIDLANDS orthopaedics & NEUROSURGERY

***Patient - Please fill your NAME and DATE OF BIRTH before visiting the office.**

Rx

FOR (NAME)_____ DOB:_____

ADDRESS_____ DATE_____

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

1. LEFT
    a. Diagnoses:
        i. Osteoarthritis (OA) of the knee – **M17.12**
        ii. Knee pain – **M25.562**
2. RIGHT
    a. Diagnoses:
        i. Osteoarthritis (OA) of the knee – **M17.11**
        ii. Knee pain – **M25.561**
3. BILATERAL
    a. Diagnoses:
        i. Osteoarthritis (OA) of the knee – **M17.0**
        ii. Knee pain – **M25.569**

Views (please include each of the following)

1. AP
2. Lateral
3. Sunrise
4. 45° flexion

Please send these x-ray images to us via Nuance PowerShare. **Our facility lookup information is**:

Midlands Orthopaedics & Neurosurgery, 1910 Blanding Street, Columbia, SC 29201

If you are not in the PowerShare network, please mail a CD with digital .DICOM copies of these images to us at:

Midlands Orthopaedics & Neurosurgery
ATTN: Gross MD New Knee Patient
1910 Blanding Street
Columbia, SC 29201

Thomas P. Gross MD

Digitally signed by Thomas P. Gross MD
Date: 2025.06.17 09:45:35 -04'00'

NEW KNEE
QUESTIONNAIRE

First name: _____

Last name: _____

SECTION I. INTRODUCTION

1. **This questionnaire is for the evaluation of my (side) knee.**
   ☐ Left ☐ Right

2. I have had problems with my (side) knee(s).
☐ Left ☐ Right ☐ Both

3a. The most pain is in my (side) knee.
☐ Left ☐ Right

3b. When does this joint hurt?
☐ 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 may have affected this joint?
☐ Yes; please explain: _____ | ☐ No

7. Please indicate location of pain. (Check all that apply)
☐ No knee pain ☐ Inside Knee ☐ Back of Knee ☐ General/all-over knee ☐ Outside Knee
☐ Above Knee ☐ Knee Cap ☐ Other Knee Pain: _____

8. List all PREVIOUS medications used to treat your pain:
a. Over-the-counter: _____
b. Prescription: _____

9. List all CURRENT medications used to treat your pain:
a. Over-the-counter: _____
b. Prescription: _____

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

11. Have you had knee injections to treat your pain?
☐ Yes; how long did it help? _____
☐ No

12. List any previous surgeries you've had on your problematic joint:

13. List other treatments you've tried. How successful was it?

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

15. What activities are now difficult due to knee pain/

16. Is your pain worse with certain movements? Explain.

17. Please list two daily activities that cause pain:

18. Has any orthopedic surgeon recommended surgery?

19. What prompted you to contact us for evaluation?

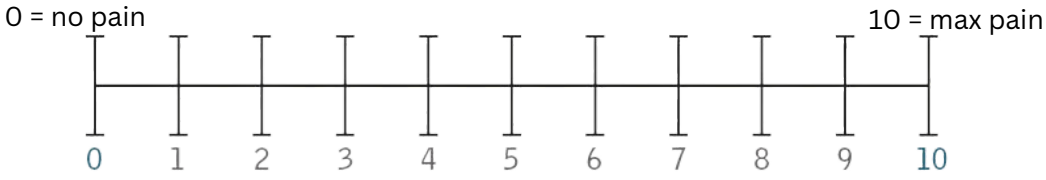
20. Please list any additional notes here:

SECTION II. CLINICAL FUNCTION SCORE

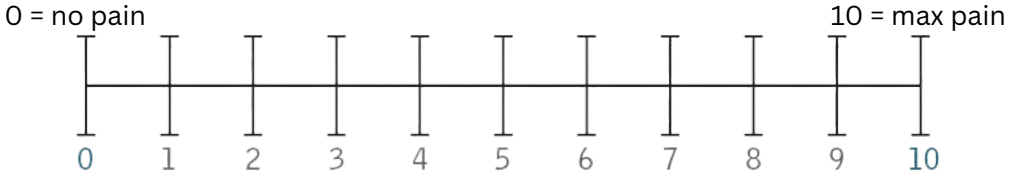
1. What category most closely represents your pain level?

- None, or so insignificant that I ignore it
- Regularly slight
- Mild
- Moderate
- Severe
- Disabled

2a. Please circle your regular pain level on the following scale.



2b. Please circle your highest hip pain level on the following scale.



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

- None required
- Use of a cane
- Use of two canes
- Use of two crutches or a walker

4. I am able to walk _____ without a break:

- Over one mile/Unlimited
- 10 blocks or roughly 45 minutes
- 5-10 blocks or roughly 30 minutes
- <5 block, 10-20 min
- <1 block
- Bed and chair only

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

- Normally foot-over-foot without NEEDING the railing
- Normal up, require railing going down
- Require railing going up or down
- Up with rail; need person's assistance going down
- Unable to take stairs even with assistance

SECTION III. ACTIVITY SCORE

1. Choose your current level of activity:

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