

UNIVERSITY ORTHOPAEDIC CLINIC & SPINE CENTER

Today's Date _____

Clinic: T N AX F P

Account # _____

Physician: 1 2 4 5 6 9 10 1001 1002 1003

Reason for Visit

Reason For Visit: _____

Referred By _____

INJURY SYMPTOM If Injury, Place of Accident _____

Date Of Injury or Symptom _____

If Student: FT PT School Name _____

Date First Seen By UOC Physician _____

Will today's visit be covered by Workers Compensation Yes No Case Manager Yes No Name: _____

Name and Telephone Number of Person who can verify W/C Claim. _____

Will there be an attorney involved Yes No Is this for Disability Determination Yes No Is this Related to Auto Accident Yes No

Patient Information

FIRST NAME _____ MI _____ LAST NAME _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

Home Phone _____ Work Phone _____ Cell Phone _____ DOB _____ Age _____

SS# _____ Gender: M F Marital Status: S M D W Language Preference: English Spanish _____

Race _____ Ethnicity: White Black or African American Asian Hispanic or Latino American Indian, Alaskan Native or Pacific Islander

Current Employer _____

Emergency Contact Not Living with Patient _____ Relation _____ Phone # _____

Other Contact _____ Relation _____ Phone # _____

Responsible Party Information (If Different from Patient)

Father's Name _____ SS# _____ Home Phone _____ Cell _____

Address _____ Employer _____ Work Phone _____

Mother's Name _____ SS# _____ Home Phone _____ Cell # _____

Address _____ Employer _____ Work Phone _____

INSURANCE COVERAGE

Primary Insurance Company _____ Policy Number _____

Group # _____ Policyholder _____ DOB _____

Relationship to Patient _____ Employer of Policyholder _____ Effective Date _____
Or Date of Retirement _____

Secondary Insurance Company _____ Policy Number _____

Group # _____ Policyholder _____ DOB _____

Relationship to Patient _____ Employer of Policyholder _____ Effective Date _____

University Orthopaedic Clinic and Spine Center

305/400 Bryant Drive, E.
Tuscaloosa, AL 35401
FAX: (205) 345-7341

Northport Medical Center,
Suite 101
Northport, AL 35476
FAX: (205) 333-9935

Phone (205) 345-0192

Fayette Medical Associates
1716 Temple Ave. N.
Fayette, AL

Pickens County Medical Center
241 Robert K Wilson Drive
Carrollton, AL 35447

NAME _____ Date _____ Chart # _____

DOB _____ Age _____ Height _____ Weight _____ Race _____

PROBLEM (Chief Complaint) _____

Who referred you to our office? _____

Primary Doctor _____ City _____ State _____

Past Medical History:

List all surgeries and hospitalizations including dates

1	5
2	6
3	7
4	8

Do You Smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Quit, when?	Do you Drink Alcohol? <input type="checkbox"/> Y <input type="checkbox"/> N	
# of Years Smoked?	# of packs per day?	Amount Per Day?	Amount Per Week?
Any religious restrictions concerning giving or receiving blood?			

Have you ever had any of the following: Circle if Yes

AIDS	Cancer	Emphysema	Heart Attack	HIV	Seizures
Asthma	Coronary Artery Disease	Epilepsy	Heart Failure	Hypertension	Stroke
Bronchitis	Diabetes Mellitus	Gall Bladder Trouble	Hepatitis	Peptic Ulcers	Tuberculosis

Any medical illnesses that run in your family? _____

ALLERGIES (List Below) No Known Allergies

Allergy	Effect	Allergy	Effect

CURRENT MEDICATIONS: UOC Verification _____

List all current Prescription Medications

Medication	Dosage	Taken How Often	Medication	Dosage	Taken How Often
1			11		
2			12		
3			13		
4			14		
5			15		
6			16		
7			17		
8			18		
9			19		
10			20		

List all current over the counter medications, herbals, vitamin/mineral dietary (nutritional supplements)

Medication	Dosage	Taken How Often	Medication	Dosage	Taken How Often
1			4		
2			5		
3			6		

Please confirm the above medications as being current. If changes are made, please date and initial by changes:

Date _____ Patient Initials _____ Date _____ Patient Initials _____

Date _____ Patient Initials _____ Date _____ Patient Initials _____

REVIEW OF SYSTEMS

The following information is important to your health.
Please check any problems in the areas listed below:

CONSTITUTIONAL SYMPTOMS

- Good General Health lately
- Recent Weight Change
- Fever
- Fatigue
- Headaches
- Chills

EYES

- Eye Disease or Injury
- Wear Glasses/contact Lenses
- Blurred or double vision
- Glaucoma
- Temporary Blindness

RESPIRATORY

- Chronic or frequent coughs
- Spitting up blood
- Shortness of breath
- Asthma or wheezing

PSYCHIATRIC

- Memory Loss or confusion
- Nervousness
- Depression
- Insomnia

ENDOCRINE

- Glandular or hormone problem
- Thyroid disease
- Diabetes
- Excessive thirst or urination
- Heat or cold intolerance
- Skin becoming dryer
- Change in hat or glove size

CARDIOVASCULAR

- Heart trouble
- Chest pain or angina pectoris
- Palpitation
- Shortness of breath with walking,
Or lying flat
- Swelling of feet, ankles or hands

GASTROINTESTINAL

- Loss of appetite
- Change in bowel movements
- Nausea or vomiting
- Frequent Diarrhea
- Painful bowel or movements or
constipation
- Rectal bleeding or blood in stool
- Abdominal pain or heartburn
- Peptic ulcer (stomach or
duodenal)

**INTEGUMENTARY
(SKIN/BREAST)**

- Rash or itching
- Change in skin color
- Change in hair or nails
- Varicose veins
- Breast pain
- Breast lump
- Breast discharge

NEUROLOGICAL

- Frequent or recurring headaches
- Light headed or dizzy
- Convulsions or seizures
- Tremors
- Paralysis
- Stroke
- Head Injury

HEMATOLOGIC/LYMPHATIC

- Slow to heal after cuts
- Bleeding or bruising tendency
- Anemia
- Phlebitis
- Past transfusion
- Enlarged glands
- Sickle Cell Anemia
- Free Bleeding

MUSCULOSKELETAL

- Joint pain
- Joint stiffness or swelling
- Weakness of muscles or joints
- Muscle pain or cramps
- Back pain
- Cold extremities
- Difficulty in walking

EAR/NOSE/MOUTH/THROAT

- Hearing loss or ringing in ears
- Earaches or drainage
- Chronic sinus problem or rhinitis
- Nose bleeds
- Mouth sores
- Bleeding gums
- Bad breath or bad taste
- Sore throat or voice change
- Swollen glands in neck

GENITOURINARY

- Frequent urination
- Burning or painful urination
- Blood in urine
- Change in force of stream when
urinating
- Incontinence or dribbling
- Sexual difficulty
- Urinary Tract Infection
- Male-testicle pain
- Female-pain with periods
- Female-irregular periods
- Female- # of pregnancies _____
- Female- # of miscarriages _____
- Female- Date of last pap smear _____

Patient Signature _____ Date _____

OFFICE USE ONLY: This documents review of the medical history and review of systems:

Date _____	M.D. initials _____	Date _____	M.D. initials _____
Date _____	M.D. initials _____	Date _____	M.D. initials _____
Date _____	M.D. initials _____	Date _____	M.D. initials _____
Date _____	M.D. initials _____	Date _____	M.D. initials _____

**UNIVERSITY ORTHOPAEDIC CLINIC, P.C.
NOTICE OF PRIVACY PRACTICES**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Payment: We may use and disclose medical information about you so that the treatment and services you receive at the practice may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

For Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the practice or the hospital. For example, we may disclose medical information about you to people outside the practice who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.

For Health Care Operations: We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts.

WHO WILL FOLLOW THIS NOTICE: This notice describes our practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION: We create a record of the care and services you receive at the practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the practice, whether made by practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; inmates; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; protective services for the President and others; public health risks; and workers' compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures". This is a list of the disclosures we made of medical information about you. To request this list or account of disclosures, you must submit your request in writing to the Privacy Officer.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances. If you request a copy of the information, we are entitled to charge a fee associated with this request. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer.

Right to a Paper Copy of this Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. *We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.* To request restrictions, you must make your request in writing to the Privacy Officer.

CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the practice's waiting room.

COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, contact Pat Tingle, Privacy Officer for the University Orthopaedic Clinic P.C. at (205) 345-0192. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, any time.

I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights.



Patient Name _____ **Chart #** _____

Authorization For Release Of Medical Information

I (We), the undersigned patient and/or responsible party hereby authorize(s) University Orthopaedic Clinic, P.C., its physicians, agents, employees or contractors to release and disclose all or any part of the patients medical records to the person or persons indicated below:

- _____ NONE Do not release to anyone other than the patient
- _____ Spouse Name _____
- _____ Parents Names _____
- _____ Children Names _____
- _____ Other Name and Relationship _____

_____ Date _____
Patient/Responsible Party Signature

If you are enrolled in the **Medicare PPO Plan in Alabama called Blue Advantage**, your plan requires that providers have information in your medical file regarding whether you have an advance directive or not. Therefore, we ask that you complete the information below so we will have it on file.

- _____ No, I do not have an advance directive.
- _____ Yes, I do have an advance directive.

The person elected to make those decisions for me is _____

Their relationship to me is _____ and they can be reached at _____

Daytime Phone Number

UNIVERSITY ORTHOPAEDIC CLINIC P.C. FINANCIAL POLICY

We are committed to providing our patients with the best possible medical care. If you have special needs with regards to financial obligations, we are here to work with you. This financial policy has been established with these objectives in mind, and to avoid any misunderstandings or disagreements concerning payment for professional services.

1. Our office participates with various insurance plans. It is your responsibility to:
 - Bring an updated insurance card to every visit and inform us of any changes as they occur.
 - Be prepared to pay your co-payment or deductible at every visit. Payment may be made by cash, check or credit card.
 - For medical service not covered by your insurance, *payment in full is due at the time of service.*
2. Referrals: It is your responsibility to bring any required referrals for treatment, *at, or prior to the visit.* If you do not have your referral, your visit may be rescheduled or you may be financially responsible.
3. If you have insurance that we do not participate in, *payment in full is expected at the time of service.*
4. If you are without insurance coverage, *your office visit requires an initial \$150 payment,* payable in cash, check or credit card at the time of service. We are unable to give you the total cost of the services prior to the treatment because we do not know the services the physician will deem necessary. Any remaining balance will be billed to the patient and/or the responsible party. We ask that you pay this as soon as you receive your statement. If you are unable to pay the balance in full, please contact our collection department immediately at 205/345-0192.
5. If the patient is a minor (18 years or younger), the parent or guardian of minor is responsible for any payment due at time of service as well as the insurance information and referrals. For unaccompanied minors, insurance or payment by credit card must be verified with the responsible party.
6. If you have questions about your insurance, our insurance department will be happy to assist you. They may be reached at 205/247-2850. Specific coverage issues, however, should be directed to your insurance company member service department (the number is usually located on the back of the insurance card).
7. Once insurance has paid in full, any patient balance will be billed to the patient and/or responsible party. Our billing policies are as follows:
 - Statements for any amounts owed by the patient are sent out around the 1st of each month. We ask that you send in your payment as soon as you receive your statement. If your payment cannot be made for the full amount, we ask that you contact our collection department at 205/345-0192. They will be happy to assist you in making financial arrangements..
 - If you fail to pay the balance in full after two statements, fail to contact the collection department to make payment arrangements, or fail to pay after making agreed upon financial arrangements, your account may be sent to an outside collection agency. You will be responsible for the fees assessed by the collection agency. This outstanding debt may also be listed with local, regional or national credit-reporting agencies and may have a negative effect on the granting of future credit.

Our practice believes that a good physician/patient relationship is based upon understanding and good communication. Any questions regarding financial arrangements should be directed to the collection department at 205/345-0192. They are here to help you. *Please sign that you have read and agree to the financial policy.*

Signature of Patient or Responsible Party (if minor)

Date

RELEASE AND STATEMENT TO PERMIT PAYMENT OF PRIVATE
INSURANCE BENEFITS TO PROVIDER

I (We), the undersigned Patient and Responsible Party hereby authorize(s) University Orthopaedic Clinic, P.C. (hereafter referred to as "P.C."), its agents, employees, or contractors to release and disclose all or any part of the Patient's medical records to any person, corporation or entity, which is, or may be liable, for all, or part of the provider charges, or to any Professional Review Organization associated therewith, to release and disclose all or any part of my medical records to any health care provider which may be of assistance, in the opinion of the P.C., in providing for, or continuing, the medical care and treatment of the Patient and/or for assisting in any reimbursement or benefits to which I (we) may be entitled.

Confidential patient information may be accessed by employees of the P.C.'s copying service for purposes of photocopying the information in response to properly authorized requests for copies of medical records. Employees of the P.C.'s copying service are bound by the same confidentiality requirements as are employees of University Orthopaedic Clinic, P.C.

I (we) authorize and request that payment of any and all authorized insurance benefits be made on my behalf to P.C. and/or Physicians, for any services furnished to Patient by any of the providers set forth herein. The signatures shall suffice for all insurance forms on a continuing basis.

MEDICAL COST AGREEMENT TO PAY

The Patient and Responsible Party acknowledge that it is difficult to project the full cost of medical services and treatments in advance, since it is impossible to know what services, tests, procedures, and/or treatments will be required in the course of medical care. The Patient and Responsible Party agree to pay in full all charges submitted by P.C., which may include, but shall not be limited to, one of the standard procedure charges set forth below, or on Exhibit "A", or presently on file in the office of the P.C. which has been reviewed by the Patient and/or Responsible Party (attached to this form and by the reference incorporated herein) for any and all services rendered by H. Chester Boston, Jr., M.D., John P. Buckley, M.D., Stephen T. Ikard, M.D., Donald S. Scott, M.D., L. Scott Atkins, Jr., M.D., William C. Standeffer, Jr., M.D., Brian S. Claytor, M.D., William D. Sudduth, M.D., and any other physicians who become associated with the P.C. in the future ("Physicians"), or any other agents, employees or contractors of P.C., during Patient's treatment, including hospitalization, unless P.C., its agents, employees or contractors, are otherwise obligated to accept payment solely from a third party. The Patient and Responsible Party hereby agree to be financially responsible to P.C., even though there may be insurance or other third party, or even though the charges may exceed the amount reimbursed by insurance by insurance, and agree that failure to make payment when due and requested is the basis for legal action, and agree to pay any and all cost of collection, including a reasonable attorney's fee. The Patient and Responsible Party hereby acknowledge their understanding that the payment is due in full upon receipt of services and agree to pay 1.5% per month late charge on all accounts over ninety (90) days past due. The Patient and the Responsible Party agree that their obligations are joint and severable and that the P.C. may pursue either or both parties for payment.

PATIENT: _____ CHART # _____ DATE: _____

RESPONSIBLE PARTY: _____ DATE: _____

H. CHESTER BOSTON, JR. M.D.
 JOHN P. BUCKLEY, M.D.
 STEPHEN T. IKARD, M.D.
 DONALD S. SCOTT, M.D.
 L. SCOTT ATKINS, JR., M.D.

NORTHPORT MEDICAL PLAZA, SUITE 101
 NORTHPORT, ALABAMA 35476



University Orthopaedic Clinic & Spine Center

305 & 400 BRYANT DRIVE EAST P.O. BOX 2447
 TUSCALOOSA, ALABAMA 35403
 TELEPHONE: (205) 345-0192

WILLIAM C. STANDEFFER, JR., M.D.
 BRIAN S. CLAYTOR, M.D.
 WILLIAM D. SUDDUTH, M.D.
 KEVIN J. THOMPSON, M.D.

Fayette Clinic Pickens Clinic

NEW PATIENT, OFFICE VISIT			CASTS/SPLINTS			X-RAY			DIAGNOSIS	
99201	Prob. Focused/Straightfwd	58	29065	Long Arm Cast	219	72020	Cervical (LAT)	83	354.0	Carpal Tunne Syndrome
99202	Exp Problem/Straightfwd	71	29075	Short Arm Cast	149	72040	Cervical (2 or 3 Views)	113	715.15	Osteoarthritis, Localized, Hip
99203	Detailed/Low	105	29105	Long Arm Splint		72050	Cervical (4 Views)	181	715.16	Osteoarthritis, Localized Lower Leg
99204	Comprehensive/Mod	160	29125	Short Arm Splint	94	72070	Thoracic (AP & LAT)	125	717.7	Chondromalacia
99205	Comprehensive/High	215	29355	Long Leg Cast	245	72080	Thoracolumbar, AP & LAT	132	719.06	Effusion of Joint, Lower Leg
ESTABLISHED PATIENT, OFFICE VISIT			29425	Short Leg Cast	205	72090	Spine AP Entire	136	719.41	Pain, Shoulder 719.42 Pain, Elbow
99212	Prob. Focused/Straightfwd	58	29450	Clubfoot Cast Single	130	72100	Lumbar (2 or 3 Views)	125	719.43	Pain, Wrist 719.45 Pain, Hip
99213	Exp. Problem/Low	67	29505	Long Leg Splint	132	72110	Lumbar (AP, LAT, LAT Spot 2 Oblia)	163	719.46	Pain in Joint, Lower Leg 719.47 Pain, Foot
99214	Detailed/Moderate	106	29515	Short Leg Splint	113	72120	Lumbar Bending (4 Views)	144	721.0	Spondylosis, Cervical
99215	Comprehensive/High	146		Q Fiberglass/Plaster		72170	AP Pelvis (1 or 2 Views)	113	721.3	Spondylosis, Lumbosacral
ORTHOPAEDIC SUPPLIES						73510	AP Pelvis & LAT Hips	113	722.4	Deg. Disc disease - cervical
W9214	O.V., Detailed Follow-Up	106	A6443	Ace Bandage, 2 In.		73520	AP Pelvis & Bilateral Hips	132	722.52	Deg. Disc Disease of Lumbar
B9214	O.V., Detailed Follow-Up	106	A6449	Ace Bandage, 3-4 In.	2	73000	Clavicle (AP)	91	723.0	Spinal stenosis - cervical
99024	O.V., Post Op. Follow-Up	0	A6450	Ace Bandage, 6 In.	3	73010	Scapula (AP & Y or outlet)	102	723.1	Cervicalgia
99080	Special Report	80			4	73020	Shoulder (Axil or AP)	83	724.02	Spinal stenosis - lumbar
MOD			L4350	Air Cast Ankle	4	73030	Shoulder (AP & LAT)	102	724.2	Low Back Pain
99243	Consultation, Detail./Low	165	U4572	Alumofaom Splint	66	73030	Shoulder (AP & LAT)	102	724.2	Low Back Pain
99244	Consultation, Moderate	209	L1902	ASO Ankle Brace	4	73050	Acromioclavicular Joint	113	726.10	Disorder, Bursae, Tend. Shdr, Unspec.
99245	Consultation, Comp.	284	L0630	Back Support	61	73060	Humerus (AP & LAT)	106	726.32	Lateral Epicondylitis, Elbow
IME	IME		L0637	Heley Weber LSO	1200	73070	Elbow (AP & LAT)	98	726.5	Enthesopathy of Hip
99455	PPI	204	U0632	California mid profile	582	73080	Elbow (3 Views)	102	727.03	Trigger Finger, Acquired
INJECTIONS / ASPIRATIONS			L4386	Walking Boot	102	73090	Forearm (AP & LAT)	95	727.42	Ganglion of Tendon Sheath
20526	Inj. Carpal Tunnel	110	L3265	Cast Shoe	18	73100	Wrist (AP & LAT)	95	728.71	Plantar Fascial Fibromatosis
20550	Inj. Tendon Sheath or Ligament	110	U3650	Clavicle splint	21	73110	Wrist (3 Views)	102	729.5	Pain In Limb
20551	Inj. Tendon Origin/Insertion	110	A4565	Cradle Sting	14	73120	Hand (AP & LAT)	183	736.81	Leg length discrepancy
20552	Inj. Single/Multiple Trigger Points (1-2 muscles)	110	U4565	Hanging Cast Sting	23	73130	Hand (3 Views)	106	736.89	Tibial torsion
20553	Inj. Single/Multiple Trigger Points (3+ muscles)	110	L1820	Hinged Knee	100	73140	Fingers (AP & LAT)	79	737.30	Scollosis
20600	Inj. Arthrocentesis/Asp. Small Joint or Bursa	90	L1830	Knee Immobilizer	63	73550	Femur (AP & LAT)	106	756.12	Spondylolisthesis
20605	Inj. Arthrocentesis/Asp. Medium Joint or Bursa	94	A4466	Knee Sleeve - open/closed	29	73560	Knee (AP & LAT)	95	813.41	Fx Radius/Ulna, Colles' Fx
20610	Inj. Arthrocentesis/Asp. Major Joint or Bursa	113	A4466	Lateral Patella (Palumbo)	61	73560	Knee R lat or L lat	95	816.01	Fx Mid/Prox Phalanges/Closed
20612	Asp or Inj. ganglion cyst	113	L4396	Night Splint	76	73560	Knee Merchant	95	824.2	Fx Ankle, Lat. Malleolus, Closed
36415	Venipuncture	38	L3260	Post Op Shoe	20	73562	Knee (3 Views)	106	825.25	Fx Metatarsal, Closed
J3301	Kenalogx _____ units	18	L3485	P.Q. Heel Pads	21	73565	Knees AP Standing	140	836.0	Tear Medial Cart./Meniscus/Knee
J7321	Supartz x _____ units	200	U3651	Shoulder Immobilizer	36	73590	Tibia & Fibula (AP & LAT)	95	840.9	Sprain/Strain Shoulder U/E Unspec.
J7322	Synvisc x _____ units	300	U3700	Spider elbow pad	41	73600	Ankle (AP & LAT)	87	844.9	Sprain/Strain Knee/Leg/Unspec.
J7323	Euflexxa x _____ units	200	A4570	Stack Splint	4	73610	Ankle (3 Views)	106	845.03	Sprain/Strain Ankle, Tibio Fibular
	<input type="checkbox"/> ABN Form Inj/Supply/Non-Cov		L3914	Thumb Spica Splint	50	73620	Foot (AP & LAT)	87	847.0	Sprain/Strain Neck, Unspecified
G8427	Meds w/dosage, Ver.		L3649	Toe Straighteners	5	73630	Foot (3 Views)	102	847.2	Sprain/Strain Lumbar
G8430	Meds w/o dosage, not ellg.		L3480	Vicscospot heel cups	90	73650	Os Calcis (Axil & LAT)	87		
G8553	E Rx		L3908	Wrist/Forearm Splint	41	73660	Toes (2 Views)	76		
						77073	Leg Lengths	144		

DIAGNOSTIC/SURGICAL PROCEDURES

"EXHIBIT A"

APPT TIME _____ TIME TO EXAM RM _____		SYMPTOM DATE: _____		Total Charges	
ARRIVAL TIME _____ TIME PT. LEFT _____		ACCIDENT DATE: _____		Coplay \$ _____	
RETURN APPT. _____		DATE FIRST SEEN: _____		Meds \$ _____	
No. 331001		PLACE OF ACCIDENT: _____		Supplies \$ _____	
06/2010		WORK RELATED <input type="checkbox"/> JWR		CC CHECK CASH	
				CC CHECK CASH	

25600	Treatment of closed distal radial fracture	\$734.00
25605	Closed reduction distal radial fracture	\$847.00
26600	Treatment of closed metacarpal fracture	\$400.00
11750	Excision of nail and matrix	\$621.00