



Patient Name _____ Account Number _____

Patient Financial Responsibility

I acknowledge full financial responsibility for services rendered by Tennessee Orthopaedic Alliance. I understand that I am responsible for prompt payment of any amounts due including, but not limited to: co-pays, deductibles, and coinsurance amounts. I understand that payment of co-pays, deductibles and coinsurance amounts are expected at time of service, as well as any prior balances I may owe. I also consent that payment of authorized Medicare and any other insurance benefits may be made on my behalf directly to TOA for any medical and/or therapy, imaging, and/or surgical services furnished. I agree to be responsible for all reasonable attorney fees and collection costs in the event of default of payment of my charges, as outlined in office and financial policy guidelines.

Signed _____ Date _____

Consent for Purposes of Treatment, Payment, and Healthcare Operations

I authorize Tennessee Orthopaedic Alliance physicians and staff to render medical treatment and evaluation needed. I further authorize order of x-rays, injections, casting or other diagnostic tests and treatment that may be necessary to diagnose and treat my illness or injuries. I hereby give my consent to TOA to use or disclose, for the purpose of carrying out treatment, payment or healthcare operations, all protected health information contained in the patient record of:

_____.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice. I also understand that I will not be able to revoke this consent in cases where my provider has referred to it for purposes of disclosing my health information. Written revocation of consent must be sent to the physician's office, Attn: Administration.

Signed _____ Date _____

Printed Name _____

Acknowledgment - Notice of Privacy Practices

I hereby acknowledge receipt of TOA's Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential protected health information. I have reviewed TOA's Notice of Privacy Practices. I understand that TOA reserves the right to change its privacy practices that are described in that Notice. I also understand that any Revised Notice will be posted on TOAs website, available at each office, or mailed upon request.

Signed _____ Date _____

Printed Name _____

If you are not the patient, please specify your relationship to the patient _____



MRN: _____

MEDICATION NOTICE TO ALL PATIENTS

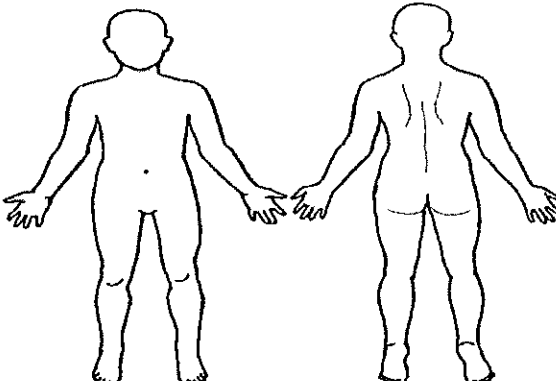
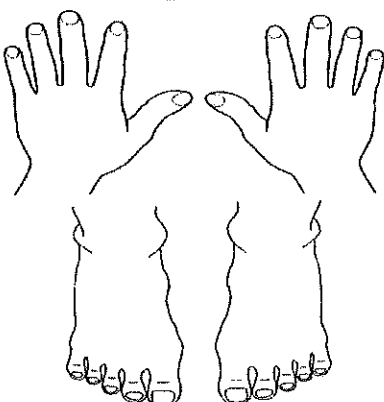
In compliance with Tennessee State law, our physicians do not routinely prescribe narcotic pain medications in their practice. Narcotics are only used rarely, such as post-operative pain or acute fracture/injury. Our physicians do not prescribe long term pain medications. If you are on chronic pain medication or feel you need these types of medications we recommend that the topic be discussed and reviewed with your primary care physician. Non-narcotic medications are only called in during office hours from 8:00am – 4:30pm, Monday through Friday. For any after hours medication please call your primary care physician or pain management specialist, or go to your local Emergency Room.

Patient/Guardian Signature

Date

Print Patient Name

Guardian Name

Patient Name: _____						Age: _____					
What are we seeing you for today? <input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Bilateral (Both) Body Part: _____											
What symptom(s) are you having? <input type="radio"/> Pain <input type="radio"/> Swelling <input type="radio"/> Weakness <input type="radio"/> Numbness <input type="radio"/> Tingling											
<input type="radio"/> Other (please specify) _____											
Is this an injury? <input type="radio"/> Yes <input type="radio"/> No						Is your problem work related? <input type="radio"/> Yes <input type="radio"/> No					
When did your problem/injury begin? _____											
Where did the injury occur? <input type="radio"/> Home <input type="radio"/> School <input type="radio"/> During Sports (please list) _____											
<input type="radio"/> Work <input type="radio"/> MVA (In what state did this occur?) _____ <input type="radio"/> Other (specify) _____											
Is an attorney involved? <input type="radio"/> Yes <input type="radio"/> No											
How did the problem/injury occur? _____											
<p>Using the symbols below, mark on the body, hands, or feet where you feel the following: Numbness ===== Pins and Needles 00000 Burning xxxxx Stabbing ///// Aching +++++</p> <div style="display: flex; align-items: center; justify-content: space-around;">   <div style="text-align: right;"> <p>Which are you?</p> <p><input type="radio"/> Right Handed</p> <p><input type="radio"/> Left Handed</p> <p><input type="radio"/> Ambidextrous</p> </div> </div>											
How severe is your pain?		None 0 1 2 3 4 5 6 7 8 9 10 Severe									
What makes your symptoms worse?		<input type="radio"/> Daily activity <input type="radio"/> Exercise <input type="radio"/> Walking <input type="radio"/> Standing <input type="radio"/> Stairs <input type="radio"/> Repetitive activities <input type="radio"/> Driving <input type="radio"/> Other (specify) _____									
What makes your symptoms better?		<input type="radio"/> Nothing <input type="radio"/> Heat <input type="radio"/> Ice <input type="radio"/> Rest <input type="radio"/> Splinting <input type="radio"/> Medication <input type="radio"/> Other (specify) _____									
Have you received any treatment?		<input type="radio"/> Yes <input type="radio"/> No If yes, by whom? _____									
Please indicate all treatment received prior to today's visit		<input type="radio"/> X-ray <input type="radio"/> MRI <input type="radio"/> EMG <input type="radio"/> Myelogram/CT <input type="radio"/> Surgery <input type="radio"/> Physical Therapy <input type="radio"/> Injection <input type="radio"/> Medication <input type="radio"/> Pain Management									
Provider's Notes (office use only): _____ _____ _____											

Patient Name: _____		Office Use Only: MRN _____		
Vitals	Height: _____	Have you had a flu shot this season? <input type="radio"/> Yes <input type="radio"/> No		
		If yes, what month and year? _____		
		If you are 65 years or older, have you ever had a pneumonia vaccine? <input type="radio"/> Yes <input type="radio"/> No		
	Weight: _____	If yes, what year? _____		
		If you are 65 years or older, have you fallen in the last year? <input type="radio"/> Yes <input type="radio"/> No		
		If yes, number of falls _____ Did an injury occur? <input type="radio"/> Yes <input type="radio"/> No		
Review of Systems <input type="radio"/> I have NO other symptoms or complaints. (please check all that apply)				
Constitutional:	<input type="radio"/> Chills <input type="radio"/> Fatigue <input type="radio"/> Fever <input type="radio"/> Night Sweats <input type="radio"/> Weakness			
HEENT:	<input type="radio"/> Blurred Vision <input type="radio"/> Headache <input type="radio"/> Hearing Loss <input type="radio"/> Ringing in Ears <input type="radio"/> Vertigo			
Respiratory:	<input type="radio"/> Cough <input type="radio"/> Recent Infection <input type="radio"/> Known TB Exposure			
Cardiovascular:	<input type="radio"/> Chest Pain <input type="radio"/> Heart Murmur <input type="radio"/> Leg Swelling <input type="radio"/> Syncope/Fainting <input type="radio"/> Irregular Heartbeat			
GI:	<input type="radio"/> Abdominal Pain <input type="radio"/> Constipation <input type="radio"/> Black Tarry Stools <input type="radio"/> Diarrhea <input type="radio"/> Nausea <input type="radio"/> Vomiting			
Genitourinary:	<input type="radio"/> Blood in Urine <input type="radio"/> Incontinence <input type="radio"/> Painful Urination <input type="radio"/> Frequent Urination			
Endocrine:	<input type="radio"/> Cold Intolerance <input type="radio"/> Heat Intolerance			
Neurological:	<input type="radio"/> Difficulty Walking <input type="radio"/> Dizziness <input type="radio"/> Poor Coordination <input type="radio"/> Memory Loss <input type="radio"/> Muscle Weakness			
Emotional:	<input type="radio"/> Depression <input type="radio"/> Insomnia			
Hematologic:	<input type="radio"/> Bleeding Tendency <input type="radio"/> Bruising Tendency			
Medical History: <input type="radio"/> I have NO medical history. * Special Orthopaedic Alerts				
Please check all that apply	<input type="radio"/> *AIDS/HIV <input type="radio"/> Congestive Heart Failure <input type="radio"/> Fibromyalgia <input type="radio"/> MI/Heart Attack <input type="radio"/> *Previous MRSA			
	<input type="radio"/> Alzheimer's <input type="radio"/> COPD/Emphysema <input type="radio"/> *Hepatitis <input type="radio"/> Obesity <input type="radio"/> Psoriasis			
	<input type="radio"/> Anemia <input type="radio"/> Coronary Artery Disease <input type="radio"/> High Blood Pressure <input type="radio"/> Osteoporosis <input type="radio"/> Scoliosis			
	<input type="radio"/> Arthritis <input type="radio"/> Depression <input type="radio"/> Inflammatory Bowel <input type="radio"/> Parkinson's <input type="radio"/> Seizures			
	<input type="radio"/> Asthma <input type="radio"/> *Diabetes <input type="radio"/> *Kidney Disease <input type="radio"/> Pulmonary Embolism <input type="radio"/> *Sleep Apnea			
	<input type="radio"/> *Blood Clot <input type="radio"/> Excessive Bleeding <input type="radio"/> *Liver Disease <input type="radio"/> *Peptic Ulcers <input type="radio"/> Stroke			
	<input type="radio"/> Cancer, Type: _____ <input type="radio"/> Lyme Disease <input type="radio"/> *Pregnant (currently) <input type="radio"/> Thyroid Disease			
	Are you on blood thinners, (circle) such as Aspirin, Coumadin, Eliquis, Pradaxa, Warafin, Xarelto, or any others?			
	Other: _____			

Surgical History: <input type="radio"/> I have NO surgical history.				
Have you ever had any problems with anesthesia? <input type="radio"/> Yes <input type="radio"/> No				
Do you have a(n) <input type="radio"/> *Pacemaker <input type="radio"/> Implanted nerve or bladder stimulator <input type="radio"/> Defibrillator				
Please list all surgeries	Name of Surgery:	Side:	Name of Surgery:	Side:
	_____	<input type="radio"/> R <input type="radio"/> L <input type="radio"/> Both	_____	<input type="radio"/> R <input type="radio"/> L <input type="radio"/> Both
	_____	<input type="radio"/> R <input type="radio"/> L <input type="radio"/> Both	_____	<input type="radio"/> R <input type="radio"/> L <input type="radio"/> Both
	_____	<input type="radio"/> R <input type="radio"/> L <input type="radio"/> Both	_____	<input type="radio"/> R <input type="radio"/> L <input type="radio"/> Both
	_____	<input type="radio"/> R <input type="radio"/> L <input type="radio"/> Both	_____	<input type="radio"/> R <input type="radio"/> L <input type="radio"/> Both

Physician Signature: _____ Date: _____

Patient Name: _____

DOB: ____/____/____ Acct#: _____



Patient's Preferences

Regarding their PHI

Telephone Communication Preferences

<u>Location</u>	<u>May we call you here?</u>		<u>May we leave a message?</u>	
Home	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Work	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mobile Phone	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Mail Communication Preferences

May we send mail to your home address? *(If no, please provide an alternate mailing address below.)* ☐ Yes ☐ No

Other than you, your insurance company, and health care providers involved in your care, whom can we talk with about your health care information? (Check all that apply)

	<u>Name</u>	<u>Telephone</u>
<input type="checkbox"/> Spouse	_____	_____
<input type="checkbox"/> Caretaker	_____	_____
<input type="checkbox"/> Child	_____	_____
<input type="checkbox"/> Parent	_____	_____
<input type="checkbox"/> Other	_____	_____

Do you have any health information that you would like to be kept confidential from any person or persons? If so, please specifically describe the information and person or persons below:

- ☐ Yes
☐ No

Consent to Receive Text Messages

I authorize Tennessee Orthopaedic Alliance (TOA) to contact me by SMS text message for health related notifications and/or appointment reminders. I understand that message/data rates may apply. I know that I am under no obligation to authorize TOA to send text messages. I may opt-out of receiving these communications at any time.

- ☐ Yes, sign me up for SMS text messages
- ☐ No thanks, I choose not to participate in SMS text messages

Patient or Personal Representative Signature

Date