



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

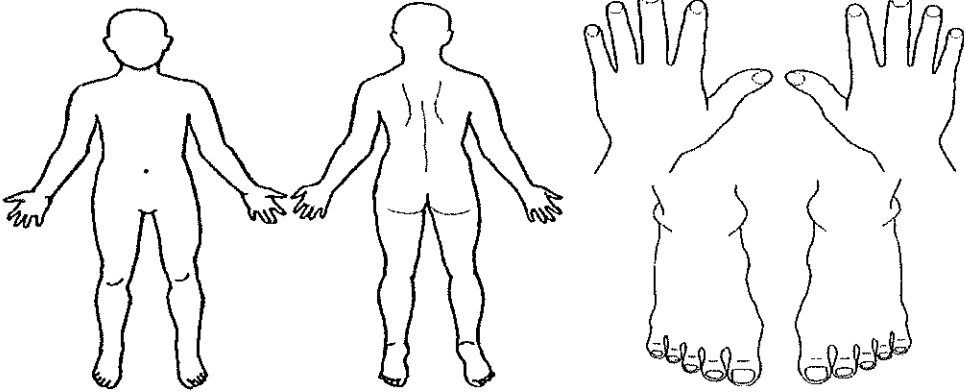
In compliance with Tennessee State law, our physicians do not routinely prescribe narcotic pain medications in their practice. Narcotics are only used rarely, such as post-operative pain or acute fracture/injury. Our physicians do not prescribe long term pain medications. If you are on chronic pain medication 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>	
	
<p>Which are you? <input type="radio"/> Right Handed <input type="radio"/> Left Handed <input type="radio"/> Ambidextrous</p>	
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	
	Weight: _____	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	
		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
HEENT:	<input type="radio"/> Blurred Vision	<input type="radio"/> Headache	<input type="radio"/> Hearing Loss
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
GI:	<input type="radio"/> Abdominal Pain	<input type="radio"/> Constipation	<input type="radio"/> Black Tarry Stools
Genitourinary:	<input type="radio"/> Blood in Urine	<input type="radio"/> Incontinence	<input type="radio"/> Painful Urination
Endocrine:	<input type="radio"/> Cold Intolerance	<input type="radio"/> Heat Intolerance	<input type="radio"/> Night Sweats
Neurological:	<input type="radio"/> Difficulty Walking	<input type="radio"/> Dizziness	<input type="radio"/> Poor Coordination
Emotional:	<input type="radio"/> Depression	<input type="radio"/> Insomnia	<input type="radio"/> Memory Loss
Hematologic:	<input type="radio"/> Bleeding Tendency	<input type="radio"/> Bruising Tendency	<input type="radio"/> Weakness
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"/> Alzheimer's	<input type="radio"/> COPD/Emphysema	<input type="radio"/> *Hepatitis
	<input type="radio"/> Anemia	<input type="radio"/> Coronary Artery Disease	<input type="radio"/> High Blood Pressure
	<input type="radio"/> Arthritis	<input type="radio"/> Depression	<input type="radio"/> Inflammatory Bowel
	<input type="radio"/> Asthma	<input type="radio"/> *Diabetes	<input type="radio"/> *Kidney Disease
	<input type="radio"/> *Blood Clot	<input type="radio"/> Excessive Bleeding	<input type="radio"/> *Liver Disease
	<input type="radio"/> Cancer, Type: _____	<input type="radio"/> Lyme Disease	<input type="radio"/> *Pregnant (currently)
			<input type="radio"/> *Previous MRSA
			<input type="radio"/> Obesity
			<input type="radio"/> Osteoporosis
			<input type="radio"/> Parkinson's
			<input type="radio"/> Pulmonary Embolism
			<input type="radio"/> *Sleep Apnea
			<input type="radio"/> Stroke
			<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: <input type="radio"/> R <input type="radio"/> L <input type="radio"/> Both	Name of Surgery: _____
	_____	<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	_____

Patient Name: _____		Office Use Only: MRN _____	
Family History	<input type="radio"/> I have NO family history.		
	Arthritis <input type="radio"/>	Liver Disease <input type="radio"/> Other: _____	
	Blood Disorder <input type="radio"/>	Mental Illness <input type="radio"/> _____	
	Cancer <input type="radio"/>	Muscle Disease <input type="radio"/> _____	
	Heart Disease <input type="radio"/>	Peripheral Vascular <input type="radio"/> _____	
	Diabetes <input type="radio"/>	Kidney Disease <input type="radio"/> _____	
	Genetic Disease <input type="radio"/>	Stroke <input type="radio"/> _____	
Hypertension <input type="radio"/>	Thyroid Disorder <input type="radio"/> _____		
Social History	Have you ever used tobacco? <input type="radio"/> Never <input type="radio"/> Former <input type="radio"/> Decline to Answer		
	<input type="radio"/> Current Every Day <input type="radio"/> Current Some Days Type: _____		
	Alcohol Use: <input type="radio"/> None <input type="radio"/> Rarely <input type="radio"/> Socially <input type="radio"/> Daily <input type="radio"/> Alcoholism		
	Recreational drug use: <input type="radio"/> None <input type="radio"/> Rarely <input type="radio"/> Socially <input type="radio"/> Daily <input type="radio"/> Drug Addiction		
	Employment/Student Status: <input type="radio"/> Student <input type="radio"/> Employed <input type="radio"/> Retired <input type="radio"/> Unemployed		
Employer/Occupation: _____		School: _____	
Pharmacy Information	Name of Pharmacy: _____		
	Address or Street Name: _____		
Phone #: () _____		City: _____	
Current Medication List <small>Please list all prescriptions, over-the-counter medications, supplements, and vitamins, or provide a list to the front desk staff.</small>	<input type="radio"/> I do NOT take any medications.		
	Medication Name:	Dosage:	Times per Day:
Allergies	<input type="radio"/> I have NO medication/food allergies.		
	List all medication/food allergies:		Reaction:

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
