Date: _____ Name: (First) _____ (Middle) _____ (Last) _____

Date of Birth:_____ Sex:____ Marital Status: _____ Social Security Number: _____

Home Phone:_____ Work Phone: _____ Cell Phone: _____

Address:_____ City: _____ State: __ Zip:_____

Email:_____

How would you like to be contacted? Home Work Cell Email Appointment reminders by text? Yes No

Patient's Employer:_____ Phone:_____

Address:_____ City:_____ State:___ Zip:_____

Emergency Contact_____ Relationship:_____ Phone:_____

Insured's Full Name _____ Date of Birth: _____ Relation to Patient_____

Address: _____ City:_____ State: __ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer Name:_____

Insurance Company Name: _____

Primary Care Physician _____

Referring Physician or source_____

Is this visit Workers Compensation? Yes No Is this visit Auto Accident or Personal Injury? Yes No

State of MVA, Accident or Injury:_____ Date of injury or accident:_____

Carrier Name: _____

Case Manager/Adjuster: _____

Claims Address: _____

_____

Phone: _____

Claim #:_____

Attorney Name: _____

Attorney Address: _____

_____

Phone: _____

Employer at time of injury: _____

Authorization: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or the party who accepts assignment. I authorize payment of medical benefits to Southeastern Spine and Joint for medical services rendered to me. I understand that by signing this, I am taking full responsibility for any unpaid medical expenses that are not covered by my insurance company including copays, deductible or my failure to obtain a referral from my primary care physician. I will be responsible for any collection charges, bounced check fees, interest or added expense for my failure to pay any balance due.

Patient/Insured Signature: Date:

Financial Responsibility Policy

All co-pays, deductible, or co-insurance amounts are due at the time the service is rendered. Southeastern Spine and Joint accepts cash, check, Visa, Mastercard, American Express, Discover, and Care Credit. There is a $25 fee for all returned checks.

Although Southeastern Spine and Joint gladly files a claim to your medical insurance on your behalf, medical insurance is ultimately a contract between the patient and their insurance company. It is the patient's responsibility to monitor the processing and payment of claims. After payment is received from the insurance carrier, any patient responsibility amounts that remain will be transferred to a patient balance. A statement will be sent to the patient. The balance due amount showing on the statement should be paid in full when the first statement is received. You must notify us of any errors or objections to the billing statement within (30) days or they will be deemed accurate, and the fees and expenses shall be deemed reasonable and necessary for the services incurred.

You are responsible for knowing your insurance policy and for giving us the correct information. For example, you will be responsible for any charges if any of the following apply: (i) your health plan requires prior authorization or referral before receiving services at Southeastern Spine and Joint, and you have not obtained such an authorization or referral, (ii) you receive services in excess of such authorization or referral; (iii) your health plan determines that the services you received at Southeastern Spine and Joint are not medically necessary and/or not covered by your insurance plan; (iv) your health plan coverage has lapsed or expired at the time you receive services at Southeastern Spine and Joint; (v) we are not in-network with your insurance carrier; or (vi) you have chosen not to use your health plan coverage. If you are not familiar with your plan coverage, we recommend you contact your carrier or plan provider directly.

Should collection proceedings or other legal action become necessary to collect an overdue account or missed appointments/late cancellations result in associated charges, the Patient or the Patient's Responsible Party understands that the practice has the right to disclose to an outside agency all relevant personal and account information necessary to collect payment for services rendered. They also understand that they are responsible for all cost of collection.

By signing below, you agree to accept full financial responsibility as a Patient who is receiving medical services, or as the Responsible Party. Your signature verifies that you have read this Patient Financial Responsibility statement, understand your responsibilities, and agree to these terms.

_____ _____

Signature or Patient/Responsible Party Date

According to our policy, test results or the release of medical information will be provided to the patient only. Please specify below whom information may be released to other than you. Please complete the information and sign below to verify your permission. Please circle all that apply and fill in the blanks:

Do we have permission to leave messages on your voicemail? Yes No

Do we have permission to text you appointment reminders, patient instructions, and updates on surgeries, procedures, and imaging? Yes No

Do we have permission to email you appointment reminders, patient instructions, and updates on surgeries, procedures, and imaging? Yes No *If yes - e-mail address_____

Do we have permission to discuss medical information with a family member? Yes No *If yes, please list below.

Emergency contact name: Relationship:

Phone: Alternate Phone:

Alternate contact name: Relationship:

Phone: Alternate Phone:

Advanced Directives

It is the right of every adult citizen in Tennessee (18 years and over) to sign a living will, as well as a Durable Power of Attorney for Healthcare that empowers an individual of your choosing to see that your wishes are carried out. It is important to decide whether or not you wish to sign a Living Will now when you are fully competent to make your own decision. The choices that you make in your Living Will will be binding on doctors, hospitals, and other healthcare providers in the event you become incapable of telling them your wishes. If you have signed either document, please make sure that your provider has a copy for your file.

Authorization

I authorize Southeastern Spine & Joint to release any insurance company, managed care organization, state or federal agencies, centers for Medicare and Medicaid services. Third Party Administrators, and/or Workers' Compensation (or its' agents) any information needed to process my claim and/or determine benefits payable for related services. I also authorize Southeastern Spine & Joint to utilize a fax machine to transmit any/all of the above medical records pertaining to my medical care or insurance reimbursement. I acknowledge that faxing my medical records may increase the risk of accidental disclosure of my medical records. I grant permission to Southeastern Spine & Joint to release all or part of my medical record to any consulting entity that may be involved in my medical care. This includes, but is not limited to, testing facilities, consulting physicians, and outpatient facilities. I request that payment of Medicare, MediGap, Medicaid, Managed Care Organization, Third Party Administrators, Commercial insurance, Worker's Compensation, Liability, and/or any other benefits made on my behalf to Southeastern Spine And Joint. I permit a copy of this authorization to be used in place of the original. Regulations pertaining to medical assignment benefits apply.

Patient or Guarantor Signature_____ Date_____

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

By signing below, I hereby acknowledge receipt of Southeastern Spine & Joint Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how DPS may use and disclose my protected health information.

By signing below, I acknowledge that I understand that Southeastern Spine & Joint has reserved the right to change its privacy practices that are described in the Notice of Privacy Practices. By signing below, I acknowledge that I also understand that any revisions to the Notice of Privacy Practices will be provided to me or made available to me.

_____
Signature

_____
Print Name

_____
Date

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

Cancellation/ Late Arrival/ No Show Policy

Our goal is to provide quality medical care in a timely manner. To do so we have implemented an appointment/cancellation policy. The policy enables us to better utilize available appointments for our patients in need of medical care.

Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours before your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our appointment Cancellation/No Show Policy below.

- Any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24 hours notice will be considered a No Show and may be charged a $50 No Show fee.
- If a third No Show or cancellation/reschedule with no 24-hour notice should occur the patient may be dismissed from Southeastern Spine and Joint.
- Any new patient who fails to show for their initial visit will not be rescheduled until they get a new referral to Southeastern Spine and Joint.
- If you are over 15 minutes late for your appointment the clinic will be asked if they are able to work you back into that day's schedule. If they are able to you will have to wait for the clinic to have an opening to see you.
- If you are late by 30 minutes or more you will be considered a No Show.

We understand there may be times when an unforeseen emergency occurs and you may not be able to cancel 24 hours in advance. If you should experience extenuating circumstances please contact management at 423-693-2175.

_____

Patient Signature

Southeastern Spine & Joint Medication Agreement

1. I understand that I need to give 24 hours notice when requesting a refill on any medication. Walk-in requests for medication or appointments will not be accepted.
2. I agree to take all medication exactly as instructed. I am not allowed to change the dosage or time schedule without speaking to my provider first.
3. I understand that no medication will be changed or called in after hours or on weekends.
4. I understand that a follow up visit may be required from my provider in order to obtain a refill and I must keep all recommended appointments.
5. I understand that urine drug screens will be required at my provider's discretion as long as I am receiving opioid medication. I understand that my medication may be stopped or changed at the provider's discretion, based upon the results of the drug screen or the TN prescription monitoring data base.
6. Southeastern Spine & Joint will not refill lost or stolen medication. These are your responsibility once you leave our office.
7. I will not trade, sell or give away the medications that are prescribed for me. I will also not take any medication that is prescribed to someone else.
8. I am aware that while I am on medications that treat my pain, I am prohibited from driving or using heavy machinery. I understand that driving while taking opioid medication could result in a DUI charge.
9. I understand that verbal abuse and/or argumentative behavior towards the staff will not be tolerated and could result in dismissal from the practice.
10. I will not use multiple pharmacies when filling my prescriptions.
11. I understand that prescriptions from Nurse Practitioners or Physician Assistants must be filled in the state of Tennessee.
12. The following are conditions for immediate discharge from the practice:
    a. Obtaining opioid prescriptions from other physicians while receiving medications from our providers
    b. Altering or forging a prescription in any way. This is a felony and will be reported.
    c. Non-compliance with any of the above statements.

I have read, understand and agree with the above policies, and I understand that if I do not sign, my physician may refuse to prescribe pain medications to me.

Printed Name_____ Date_____

Patient Signature_____

Opioid Risk Tool

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management.

Sex (circle one): Female Male

Mark appropriate box beside each question	Yes	No
Do you have a *family history* of any of the following?		
Alcohol Abuse		
Illegal Drug Abuse		
Prescription Drug Abuse		
Do you have a *personal history* of any of the following?		
Alcohol Abuse		
Illegal Drug Abuse		
Prescription Drug Abuse		
Are you between 16—45 years old?		
Do you have a history of preadolescent sexual abuse?		
Do you have a personal history of ADD, OCD, bipolar, schizophrenia		
Do you have a personal history of depression?		
Scoring totals		

**A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse.

Questionnaire developed by Lynn R. Webster, MD to asses risk of opioid addiction. Adapted for use by Southeastern Spine & Joint.

Webster LR, Webster R. Predicting aberrant behaviors in Opioid-treated patients: preliminary validation of the Opioid risk too. Pain Med. 2005; 6 (6) : 432

Patient Name: _____ Date:_____

KOOS, JR. KNEE SURVEY

Patient Name:_____ DOB:_____

INSTRUCTIONS: This survey asks for your view about your knee. This information will help us keep track of how you feel about your knee and how well you are able to do your usual activities.
Answer every question by ticking the appropriate box, only one box for each question. If you are unsure about how to answer a question, please give the best answer you can. **Stiffness**
The following question concerns the amount of joint stiffness you have experienced during the **last week** in your knee. Stiffness is a sensation of restriction or slowness in the ease with which you move your knee joint.

1. How severe is your knee stiffness after first wakening in the morning?

None	Mild	Moderate	Severe	Extreme
☐	☐	☐	☐	☐

Pain
What amount of knee pain have you experienced the **last week** during the following activities?

2. Twisting/pivoting on your knee

None	Mild	Moderate	Severe	Extreme
☐	☐	☐	☐	☐

3. Straightening knee fully

None	Mild	Moderate	Severe	Extreme
☐	☐	☐	☐	☐

4. Going up or down stairs

None	Mild	Moderate	Severe	Extreme
☐	☐	☐	☐	☐

5. Standing upright

None	Mild	Moderate	Severe	Extreme
☐	☐	☐	☐	☐

Function, daily living
The following questions concern your physical function. By this we mean your ability to move around and to look after yourself. For each of the following activities please indicate the degree of difficulty you have experienced in the **last week** due to your knee.

6. Rising from sitting

None	Mild	Moderate	Severe	Extreme
☐	☐	☐	☐	☐

7. Bending to floor/pick up an object

None	Mild	Moderate	Severe	Extreme
☐	☐	☐	☐	☐

Patient Name: _____ DOB:_____

HOOS, JR. HIP SURVEY

INSTRUCTIONS: This survey asks for your view about your hip. This information will help us keep track of how you feel about your hip and how well you are able to do your usual activities.
Answer every question by ticking the appropriate box, only one box for each question. If you are unsure about how to answer a question, please give the best answer you can.

Pain
What amount of hip pain have you experienced the **last week** during the following activities?

1. Going up or down stairs

None	Mild	Moderate	Severe	Extreme
☐	☐	☐	☐	☐

2. Walking on an uneven surface

None	Mild	Moderate	Severe	Extreme
☐	☐	☐	☐	☐

Function, daily living
The following questions concern your physical function. By this we mean your ability to move around and to look after yourself. For each of the following activities please indicate the degree of difficulty you have experienced in the **last week** due to your hip.

3. Rising from sitting

None	Mild	Moderate	Severe	Extreme
☐	☐	☐	☐	☐

4. Bending to floor/pick up an object

None	Mild	Moderate	Severe	Extreme
☐	☐	☐	☐	☐

5. Lying in bed (turning over, maintaining hip position)

None	Mild	Moderate	Severe	Extreme
☐	☐	☐	☐	☐

6. Sitting

None	Mild	Moderate	Severe	Extreme
☐	☐	☐	☐	☐