General Patient & Insurance Information

Name: _____ **Date of Birth:** _____/_____/_____

Street Address: _____

Apartment #: _____ **City:** _____ **State:** _____ **Zip:** _____

Social Security #: _____ **Home Phone:** _____ **Cell Phone:**_____

Email: _____ **Pharmacy:** _____ **Location:** _____

Primary Care Physician: _____ **Referring Physician:** _____

Emergency Contact: _____ **Phone Number:** _____

Job/Occupation: _____

Sex:	**Marital Status:**	**Ethnicity:** (Please circle)	**Race:** (Please circle)	**Language:** (Please circle)
○ Male ○ Female	○ Married ○ Single ○ Divorced ○ Widowed	American Indian/Alaskan Asian Pacific Islander Black/African American Not Reported White Hispanic Other Race	Hispanic/Latino Not Hispanic No Response	English Spanish Other: _____

Primary Insurance: _____ **ID Number:** _____

Secondary Insurance: _____ **ID Number:** _____

What hurts? _____ **Right, Left, or Both?** _____

What are your symptoms? _____

What doctors have you seen for this problem? _____

What makes the pain better? _____

What makes the pain worse? _____

On a scale of 1-10, rate your pain today: (no/minimal pain) 1 2 3 4 5 6 7 8 9 10 (severe/unbearable pain)

Prior treatments, tests, imaging for this condition: _____

Is your condition the result of an accident or injury? YES _____ NO _____ If yes, date of injury: _____

Did the accident/injury occur at work? YES_____ NO_____ Was the injury reported to your employer? YES _____ NO _____

Is your condition connected to Workman's Comp? YES _____ NO _____

Employer _____ **Claim #:** _____

Employer's phone: _____ **Date of injury:** _____ **Contact name:** _____

How did the accident occur? _____

Are you applying for OR receiving workman's comp for any other condition? YES _____ NO _____

Are you applying for OR receiving disability for this or any other condition? YES _____ NO _____

Health History **Do you have or have you ever had any of the following? (Circle all that apply)**

High Blood Pressure	**Thyroid Dysfunction**	**Cancer _____**	**Heart Disease**	**Heart Attack**
Aneurysm	**Irregular Heartbeat**	**Rheumatic Fever**	**Heart Murmur**	**Chest Pain**
Shortness of Breath	**Lung Disorder**	**Asthma**	**Tuberculosis**	**Chronic Cough**
Pneumonia	**Bronchitis**	**Stroke**	**Head Injury**	**Seizure/Epilepsy**
Weakness/Numbness	**Difficulty Sleeping**	**Fatigue**	**Blackouts/Dizziness**	**Difficulty Hearing**
Hoarseness	**Double/Blurred Vision**	**Excessive Bleeding/Bruising**	**Blood Disorder**	**Anemia**
Blood Transfusion	**Blood in Saliva**	**Diabetes Type 1__Type 2__**	**Liver Disease**	**Jaundice**
Weight gain/loss	**Loss of appetite**	**Heartburn**	**Gastrointestinal ulcers**	**High Cholesterol**
GI Bleed	**Constipation/Diarrhea**	**Abdominal Pain**	**Nausea/Vomiting**	**Black/tarry stool**
Prostate Problems	**Kidney/Bladder Problem**	**Difficult/Frequent Urination**	**Kidney Stones**	**Incontinence**
Gout	**Osteoporosis**	**Rheumatoid Arthritis**	**Osteoarthritis**	**Back Pain**
Joint/Muscle Pain	**Leg Pain with Exercise**	**Neck Pain**	**Skin Disease**	**Eczema**
Unusual/Prolonged Rash	**Prolonged Lesion/Lump**	**Breast Discharge**	**Breast Mass**	**Pregnancy**

Irregular Menstruation **If pre-menopausal, please provide date of last menstrual period: _____**

Please List ALL Medications, Including Over the Counter Meds and Supplements

Medication	Dosage	# Taken Daily	Reason

Allergies: _____

List any hospitalizations/surgeries	**Date**	**Problem/Operation**

Family History

Illness	**Family Member**	**Maternal**	**Paternal**
Arthritis			
Asthma			
Bleeding Disorder			
Cancer			
Diabetes (Type 1 or 2)			
Heart Disease			
High Blood Pressure			
Osteoporosis			
Scoliosis			
Stroke			
Other			

Social History

Do you or have you ever smoked? Y___ N___

For how long? _____ Packs per day? _____

If discontinued, how long ago? _____

Do you drink alcoholic beverage? Y___ N___

What kind? _____

Rare _____ Social _____ Daily _____

Do you use recreational drugs? Y___ N___

If yes, what kind? _____

How often? _____ Last event? _____

Are you currently under the care of:

Pain Management Doctor: _____ Phone number: _____

Cardiologist: _____ Phone number: _____

Pulmonologist: _____ Phone number: _____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, ALSO HOW YOU MAY ACCESS THIS INFORMATIONS.

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by this practice in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPPA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose of your medical records only for each of the following purposes: treatment, payment, and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers, an example of this would include a physical exam.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing, or collection activities, and utilization review. An example of this would be sending your bill for your visit to your insurance company for payment.
- **Health Care Operations** include the business aspect of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorizations. You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified to you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information (our normal copying fee with be required).
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

Patient Acknowledgement

I have received, read and understand your Notice of Privacy Practices containing a complete description of the uses and disclosures of my health information. I understand that this Medical Practice has the right to change its Notice of Privacy Practices from time to time and that I may contact the office at any time at the address noted in this notice to obtain a copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I may elect to have my Protected Health Information (PHI) provided to me by message from the physician's office by signing this form in the space provided below.

****Once your have signed the form, future communication with you concerning your PHI may be left on your voicemail at the number you provide to this office.****

I understand my HIPPA rights and I request that this office may leave messages, including those containing PHI, for me by voicemail at the number below. I understand that it's my responsibility to keep the practice informed of any changes to this information.

- o I consent to having voicemails left on _____
- o I consent to receiving appointments via email _____
- o I consent to receiving appointment updates via text messages _____

I give permission for my Protected Health Information to be disclosed for the purposes of communicating results, findings, and care decisions or releasing forms and/or prescriptions to the family members and others listed below.

Name: _____ Relation: _____Number: _____
Name: _____ Relation: _____Number: _____
Other (MD/Provider): _____Number: _____
Patient Name: _____ Signature: _____ Date: _____

Workers' Compensation Injuries: Written approval/authorization by your employer and/or workers' compensation carrier prior to your initial visit is needed. We will contact your case manager and/or supervisor to confirm your workers' compensation injury. If this claim is denied, for any reason by your employer or your employer's workers' compensation carrier, you will be responsible for payment in full. If denial is made by workers' compensation, health insurance can be filed for these denied services and you will be held responsible for the account. _____(Initials)

Motor Vehicle Accidents (MVA's): Yes, I was involved in a MVA on ____/____/_____. Unless prior agreement has been reached or I am a Medicare recipient, my **health insurance** will be filed for services related to this accident. In the event I do not provide insurance information upon initial visit, I understand insurance denials may occur depending on type of service(s) received or carrier specific filing requirements. I agree, as the patient or patient's guardian, I am ultimately responsible for all balance(s) due to this facility and/or its physician(s) for services rendered regardless of insurance denial(s) or unfavorable case outcomes. If I have chosen an attorney to oversee my case, this financial agreement will serve as a Letter of Protection to my attorney. I further understand my account may be handled by an outside entity that specializes in attorney lien accounts at the facilities discretion. _____(Initials)

Billing Information

Statements: A statement of account will be provided to you if insurance has paid leaving a patient portion, denied, or no response is received. Due to the type of service we provide, you may receive billing from more than one practice, otherwise known as split billing. The balance on your statement is due and payable within 30 days of receipt unless other arrangements are made with our billing department. The statement will be sent to the address provided at the time of service. In the event your mailing address changes after your service date and your account has not been pain in full, you are required to notify our billing office of this change by calling 615.851.6033 ext. 2067. In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child at time of service will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, court documentation is required for any guarantor address changes, otherwise, it is the authorizing/custodial parent's responsibility to collect from the other parent. Any account with a credit balance of less that **$5.00** will not be refunded without specific request from the patient/debtor._____(Initials)

Delinquent Accounts: We review past due accounts frequently and at every statement cycle. Your communication and involvement to ensure your balance is paid timely is important to us. It is imperative that you maintain communications and fulfill your financial agreement and arrangements to keep your account active and in good standing.

If your account becomes **sixty (60) days** past due, further steps to collect this debt may be taken. If we have to refer your account to a collection agency, you agree to pay all of the collection costs, which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer fees which we incur plus all court costs. In case of suit, you agree the venue shall be Davidson County, Tennessee. In addition, we reserve the right to deny future non-emergency treatment for any and all debtor-related unpaid account balances._____(Initials)

Waiver of Confidentiality: You understand if your account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record._____(Initials)

Medical Records: You will be required to request in writing or sign a medical authorization form for the release of your medical records to any organization or physician._____(Initials)

****We charge a thirty-five dollar ($35) flat rate for 1-5 pages for medical records and forty-five dollar ($45) flat rate for completing forms such as FMLA, Time Away, MetLife, etc.****

Medication Usage Agreement

Anyone receiving chronic controlled substances from Pinnacle Surgical Partners, LLC will have to sign a Medication Usage Agreement.

By signing this agreement, I, _____, agree to abide by the following conditions and terms when using any and all medications prescribed to me by the staff at this practice.

1. I will take my mediation(s) **ONLY** as directed. Any change in taking my medication(s) will need to be discussed with the office practitioners prior to the change.
2. I agree to take full responsibility for my medication(s) and understand that:
    - Lost or stolen medications will **NOT** be replaced.
    - I will not share my medication(s) with anyone.
    - Early refills will **NOT** be given if I have accelerated my medication usage and run out before I am due a refill.
3. State law prohibits obtaining medications under false pretenses. If this occurs, we are obligated to report these situations to local law enforcement agencies. Misuse or abuse of these medications is a Class D Felony. If the below occurs we will be required to discharge you from the practice immediately. Such false pretenses include, but are not limited to:
    - "Doctor Shopping" to obtain multiple prescriptions.
    - Multiple emergency room visits to obtain prescriptions and medications.
    - Use of false identification or any other subterfuge in order to obtain medications.
4. It is important that patients receive their medications from only one doctor. This is not only to prevent possible legal penalties, but also to avoid dangerous side effects and interactions that your medication can have with other medicines that we may not be aware that you are taking. Therefore, if you receive any medication(s) from another treating physician, it is imperative that you let us know what these medications are.
5. Please be aware that it is not a medical obligation to prescribe controlled substances to a patient at any time.
6. We strongly encourage all of our patients to refrain from using tobacco and alcohol. We also strongly discourage the use of illicit drugs – either illegal substances or prescriptions medications that are bought from illegal sources.
7. I understand that random urine and/or serum drug testing is done at Pinnacle Surgical Partners. I understand that failing a random drug test can be defined as:
    - The presence of illegal drugs in the sample.
    - The presence of legal drugs that should not be in the sample.
    - The absence of the drugs we prescribe when there should be evidence of that particular medication.
    - Attempting to pass off someone else's sample a my own.
    - Attempting to alter the sample that I leave in order to disguise the results.
8. I understand that refusing or failing a random drug screen may result in one or more of the following occurring:
    - I may be required to repeat the screen.
    - I may be discharged as a patient.
    - I may be referred to a drug rehabilitation program.
9. I understand that requests for medications and/or refills are done as follows:
    - Refills may be requested Monday through Friday from 8:30 a.m. – 4:30 p.m.
    - Refill requests generally take 3 business days to process.
    - No refills will be done on weekends, after normal business hours, or on holidays. There will be **NO** exceptions.
    - All controlled substances received from our office must be written on a prescription. These medications will **NOT** be called in to the pharmacy.
10. I agree to use _____ Pharmacy, located at _____, Phone: _____ for all of my prescription needs. If I change my pharmacy for any reason, I will notify the practitioner at the time I receive my prescriptions.

(If you have any questions or concerns about this policy, please do not hesitate to discuss it with our practitioners.)

I have read the above agreement and agree to abide by the terms set above.

Name of patient: _____ Date: _____

Patient Signature: _____ Date: _____

General Consent for Treatment

As the patient, you have the right to be informed about your conditions and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify appropriate treatment and/or procedure for any identified condition(s).

I request and authorize medical care as my provider, his assistant, or designees (collectively called "the providers") may deem necessary or advisable. This care may include, but is not limited to, routine diagnostics, radiology and laboratory procedures, administration of routine drugs, biological and other therapeutics, and routine medical and nursing car. I authorize my provider(s) to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my (the patient) care is directed by my provider(s) and that other personnel render care and services to me (the patient) according to the provider(s) instructions.

I understand that I have the right and the opportunity to discuss alternative plans of treatment with my provider and to ask and have answered to my satisfaction any questions or concerns.

In the event that a healthcare worker is exposed to my blood or bodily fluid in a way which may transmit HIV (human immunodeficiency virus), hepatitis B virus, or hepatitis C, I consent to the testing of my blood and/or bodily fluids for these infections and the reporting of my test results to the healthcare worker who has been exposed _____(Initial here).

I HAVE READ OR HAD READ TO ME AND FULLY UNDERSTAND THIS CONSENT; I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS AND HAVE HAD THESE QUESTIONS ADDRESSED.

Name of Patient (Printed): _____

Signature of Patient: _____ Date: _____

☐ Consent of Legal Guardian, Patient Advocate or Nearest Relative (If patient is unable to sign)

☐ Consent of Caregiver (If patient is unable to sign)

Name of Legal Guardian, Patient Advocate, or Nearest Relative or Other (Print):

_____

Relationship: _____ Phone Number: _____

Address: _____

Signature of the above: _____ Date: _____

Signature of Witness: _____ Date: _____

Patient Financial Policy

This is an agreement between AdvancedHEALTH, as creditor, and the Patient/Debtor named on this form and indicated by the Patient/Debtor signature below.

In this agreement the words "you", "your", and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us", and "our" refer to AdvancedHEALTH. By executing this agreement, you are agreeing to pay for all services that are rendered.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect. A copy of your signed financial agreement will be provided to you.

HEALTH INSURANCE – IT IS YOUR RESPONSIBILITY TO:

- Ensure we have been provided with the most current insurance information relative to filing your claim including insurance care, ID number, employer, birth date, and patient address. This information will be located on our patient registration form.
- Ensure we are contracted with your insurance carrier to receive maximum benefits.
- Pay your co-payment or patient portion at the time of service.
- Inform us of any insurance changes made after this signed agreement/date of service. Insurance carriers have specific timely filing guidelines and pre-authorization requirements for certain services. If revised insurance information is not provided to us within your insurances' timely filing limits, you will be required to pay for services in full. If prior authorization was required for services already received and your claim is denied for lack of authorization, you will be required to pay for services in full.
- Contact your insurance company if no correspondence is received by you within 45 days of the date of service.

IT IS OUR RESPONIBILITY TO:

- Submit a claim to your health insurance carrier based on the information provided by the patient/debtor at the time of service or as updated information is provided.
- Provide your health insurance carrier with information necessary to determine benefits. This may include medical records and/or a copy of your insurance card.
- Provide MVA patients a courtesy health insurance claim form for their records upon request.

Payment Options: Per our contracted agreement with your insurance carrier, we are required to collect your copayment on the day of service. If you do not have insurance, you are required to pay for treatment at the time of service unless other arrangements have been formally made. A separate self-pay financial agreement will be provided to you. Our office collects all copays plus estimated coinsurance and deductibles at the time of service.

We accept the following: CASH, CHECK, CREDIT CARD (Visa, Mastercard, Discover, American Express**)**
****A twenty-five dollar ($25.00) returned check fee will be assessed to the patient account PER incident.****

For convenience, payments may be made online at **www.ePayItOnline.com.** To utilize this service you will need your account number, access code, and Code ID. This information can be found on the patient statement you will receive reflecting your balance. **Patients who No-Show may be subject to a no-show fee of twenty-five dollars ($25.00).**

Pending Approvals For Services: In the event we are unable to obtain approval for services and you wish to proceed, we will not bill your insurance. Services will be rendered to the in-network insurance allowable amount and will apply to the patient's responsibility.

_____ Initials Patient/Debtor Signature: _____

Date: _____