PATIENT REGISTRATION FORMS

P: (731) 885-8484 F: (731) 884-1609

Michael D. Calfee, M.D. www.aosm-tn.com Stephanie Wilder, P.A.-C

Patient First Name: _____ MI: ____ Last Name: _____ Sex: M or F Please Circle

Address: _____ City: _____ State: _____ Zip: _____ Date of Birth: _____

Social Security: _____ Home Phone: _____ Cell Phone: _____ Marital Status: _____

Employer: _____ Ph: _____ Occupation: _____ Email: _____

Spouse's Name: _____ Employer: _____ Address: _____

Social Security: _____ Date of Birth: _____ Phone: _____ Cell Phone: _____

EMERGENCY CONTACT INFORMATION-(Other Than Above Address)

Name: _____ Phone: _____ Relationship: _____

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

GUARANTOR INFORMATION (Person Responsible For Account if Other Than Patient)

Name: _____ Phone: _____ Relationship: _____

Address: _____ City: _____State: _____ Zip: _____ Date of Birth:_____

Social Security: _____ Relationship to Patient: _____ Does patient live with guarantor? Yes or No

Employer: _____ Address: _____ Work Phone: _____ Cell Phone: _____

COMPLETE FOR MINOR CHILDREN IF (UNDER THE AGE OF 18)

Mother's Name: _____ Address: _____ City: _____ State: _____ Zip: _____

Phone: _____Date of Birth: _____ Social Security: _____ Whom the child resides with? _____

Father's Name: _____ Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Date of Birth: _____ Social Security: _____

Patient's Race: _____ Patient's Ethnicity: _____ Patient's Preferred Language: _____

PATIENT AGREEMENT

Insurance Claims Filing

In all cases, the patient is responsible for payment of their account. As a courtesy, AOSM will file a claim to the patient's insurance coverage however, it is the patient's responsibility to bring current and updated insurance card.

Assignment and Release

Patient hereby authorizes and assigns applicable insurance benefits to be paid directly to the physician; Patient is financially responsible for non-covered services. Patient authorizes release of information necessary to process insurance claims. Patient authorizes photographs to be restricted for medical, education or insurance purposes and information released to other practitioners in good faith effort for my medical care.

Medicare

Patient requests that payment of authorized Medicare benefits be made either to the patient or on the patient's behalf to AOSM for any services furnished to the patient by that physician. Patient authorizes any holder of medical information about the patient to release AOSM for Medicare and Medicaid Services (CMS) or its agents any information needed to determine these benefits payable for related services. This form is not to be used by the patient for Medicare reimbursement.

Managed Care Plans and Referrals

Managed care plans (e.g.HMO's) require specialist and sub-specialists to obtain a referral number prior to service will result in reduced benefits by the managed care plan. Therefore, the patient is responsible for any balance not paid by the coverage plan.

Co-Payments

In all cases, the patient is responsible for making co-payments and deductible payments at the time of the patient visit in the form of cash, check or credit card. If surgery is scheduled, you may be asked to pay a percentage down prior to your surgery. In the alternative, the patient must make acceptable payment arrangements by contacting AOSM directly at 731-885-8484.

PATIENT BILLING INFO

Advanced Orthopedics & Sports Medicine, PLLC

GENERAL FINANCIAL INFORMATION

AOSM is committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

SEPARATE CHARGES

There are separate charges for the facility, the physician/surgeon and anesthesia. As part of AOSM's patient rights and responsibility guidelines, we feel that you have a right to know how we file for reimbursement and what your financial responsibility is to us prior to your surgery.

PARTICIPATION

Participation means we follow the carrier's guidelines of the amount determined payable on a given procedure, minus any deductibles, co-pays or co-insurance due from the patient if during the verification process, it is discovered that an out-of-pocket expense is due, it will need to be paid prior to receiving services. To assist you in making a deposit, we accept Visa and MasterCard. If we have scheduled surgery for you, a down payment may be required for you to pay prior to your procedure or this could potentially postpone or even cancel your procedure.

PRE-APPROVAL PROCESS

Your insurance coverage will be verified prior to the date of your procedure. A patient account representative will contact your insurance carrier to:

- **Verify approval for the medical necessity of the treatment**
- **Confirm that a valid referral is on file**
- **Determine co-pay/co-insurance or deductible liability**
- **Verify your eligibility and benefits**
- **Pre-Cert any procedures or DME products prior to appointment**

PATIENTS WITHOUT INSURANCE

If you are not covered by an insurance carrier, we ask that you speak with the Billing Manager prior to treatment to discuss your financial situation. It is the policy of AOSM to request $250.00 prior to or on the date of service. If special arrangements need to be made, a payment contract can be arranged for you with our Billing Manager. If it becomes necessary, past due accounts will be turned over to a collection agency.

PAST DUE ACCOUNTS

Please remember that when you receive our statements, you have already received quality healthcare and your insurance has been initiated by us. We would then ask that you pay promptly upon receiving your statement.

IF YOU HAVE QUESTIONS

AOSM is committed to providing the highest quality care to patients who require a procedure or surgery. We will take all the necessary steps to ensure appropriate reimbursement for all procedures performed at our facility. If at any time, you have specific questions regarding our reimbursement policy, do not hesitate to contact our patient account representative at (731) 885-8484.

HEALTH HISTORY INTAKE FORM

Patient Name: _____

Referred by : _____ **Reason for Medical Attention:** _____

What would you rate your pain today? 1-10 _____ **Are you currently in pain management?** _____

Date of injury or duration of symptoms? _____ **Height:**_____**Weight:** _____

Have you had any diagnostic studies for this condition? Please circle: X-Rays MRI Bone Scan CT Scan

Past Medical History: (please circle all that apply)

AIDS/HIV
Allergies
Anemia
Asthma
Bleeding Disorder
Cancer
Chronic Back Pain
COPD
Congestive Heart Failure
Coronary Artery Disease
Depression
Diabetes
Emphysema
Gout
Heart Attack
Heart Problems
Hepatitis
Hernia
High Blood Pressure
High Cholesterol
Hypothyroidism
Irritable Bowel Syndrome
Kidney Disease
Liver Disease
Lung Disease
Lupus
Migraine Headaches
Muscle Joint or Bone Problems
Neck Injury
Neurologic Disorder
Neuropathy
Osteoporosis
Peripheral Vascular Disease
Pulmonary Embolism
Reflux/GERD
Rheumatoid Arthritis
Seizures
Stomach Ulcers
Stroke
Thyroid Disease
Tuberculosis

Past Surgical History: (please circle all that apply)

Ankle/Foot Surgery
Appendectomy
Arm Surgery
Back Surgery
Breast Mastectomy
Carpal Tunnel Surgery
Cataract Surgery
Cesearian Section
Cholecystectomy
Elbow Surgery
ENT Surgery
Eye Surgery
Gallbladder Surgery
Gastrointestinal Surgery
General Surgery
Hand Surgery
Head or Neck Surgery
Heart Stents/CABG Surgery
Hernia Repair
Hip Replacement
Hysterectomy
Knee Scope
Knee Replacement
Lumpectomy
Neck Surgery
Pacemaker/Defibrillator
Plastic Surgery
Shoulder Surgery
Spine Surgery
Stent Surgery
Thyroid Surgery
Tonsillectomy/Adenoidectomy
Vascular Surgery
Wisdom Teeth Extraction
Wrist Surgery

Other: _____

Family Medical History:

_____

_____

_____

_____

Social History: (Please circle all that apply)

Cigarette Smoking:	Alcohol Use:
Never Smoked	None
Quit: Former Smoker	1-2 drinks a day
Smokes daily	3 or more a day

What pharmacy do you prefer? _____

List all your medications currently taking, dosage instructions, and reason for taking this medicine.

Medicine	mg	Frequency	Medicine	mg	Frequency

Allergies: (Please enter all allergies)

_____ _____

_____ _____

REVIEW OF SYSTEMS: (Please circle all that apply)

Head, Ears, and Eyes: Corrective Lenses, glasses, blurred vision, Cataracts, Glaucoma, Hearing Aids

Nose, Sinuses, Throat, and Mouth: Wearing Dentures, Nose problems, Sleep Apnea, Sore Throat

Integumentary: Herpes Simplex, psoriasis, skin color changes, rashes, sores, or infections, erythema, edema, bruising

Cardiovascular: Chest pain, palpations or arrhythmias, light headedness, murmur, high blood pressure, or myocardial infarction

Respiratory: Asthma, bronchitis, emphysema/COPD, shortness of breath, a productive cough

Gastrointestinal: crohn's disease, diverticulitis, hepatitis, hernia, pancreatitis, reflux, nausea/vomitting, ulcers, constipation, diarrhea, blood/tarry stools

Musculoskeletal: Bone cancer, osteoporosis, lupus, rheumatoid arthritis, degenerative joint disease, joint pain, joint stiffness, unsteady gait

Neurological/Psychiatric: Alzheimers, epilepsy, depression, anxiety, multiple sclerosis, parkinson's, polio, seizures, history of stroke

Hematolgic/Lymphatic/Vascular: Bruising, bleeding gums, adenopathy, blood transfusion, blood clot, varicose veins

Genitourinary: Frequent urination, difficult/painful urination, incontinence, blood in urine

Endocrine: Thyroid disease, diabetes, hypercalcemia, polyuria, abnormal hair growth/loss

Allergic/Immunologic: Allergic conditions

I certify that all information provided on this form is complete and accurate. I understand that providing information can be dangerous to my health. It is my responsibility to inform the doctor's office of any in my medical status. I authorize the healthcare staff to perform the necessary services I may need. By this I am acknowledging that I have read the entire document and am in agreement with the policies of AOSM.

Signature: _____ **Date:** _____

Patient/Guardian's Signature(If Minor): _____ **Date:** _____

AOSM

HIPAA

Advanced Orthopedics & Sports Medicine, PLLC

Health Insurance Portability & Accountability Act

YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in a reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

A copy of your health record will be available through the patient portal, and you will be given a log in at your visit for access and instructions.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to amend, change or eliminate provisions of the Notice. If our information practices change and we amend our Notice, you are entitled to receive a revised copy by calling and requesting a copy or by visiting our office and picking up a copy. You then have the right to object or withdraw as provided in this notice.

OUR RESPONSIBILITIES

Advanced Orthopedics & Sports Medicine, PLLC is required to:

- **Maintain the privacy of your health information as required by law**
- **Provide you with a notice as to our duties and privacy practices as to the practices as to the information we collect and maintain about you**
- **Abide by the terms of this notice**
- **Notify you if we cannot accommodate a requested restriction or request**
- **Accommodate your reasonable requests regarding methods to communicate health information with you**
- **Accommodate your request for an accounting of disclosures**

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at (731) 885-8484.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

PRINT NAME:

X_____

SIGNATURE: X _____ **DATE:** _____

Michael D. Calfee, M.D.
Board Certified Orthopedic Surgeon

Stephanie Wilder, P.A.-C
Board Certified Physician Assistant

Advanced Orthopedics & Sports Medicine, PLLC

1720 E. Reelfoot Ave. Suite 104
Union City, TN. 38261
P: (731) 885-8484
F: (731) 884-1609

AUTHORIZATION FOR RELEASE OF INFORMATION

For information about how your medical information may be used or disclosed, please see the Patient Notice. You have the right to review the Notice before you decide to sign this form. The Notice is subject to change. You may request a copy of the Notice from the Privacy Officer of AOSM.

•YOU HAVE THE RIGHT TO INSPECT, COPY AND/OR AMEND INFORMATION TO BE USED OR DISCLOSED.
•YOU MAY REFUSE TO SIGN THIS FORM, HOWEVER IT MAY PREVENT US FROM COMPLETING A TASK YOU HAVE REQUESTED (such as enrollment in research study or examining you to create a report for your attorney).
•WE WILL NOT CONDITION YOUR TREATMENT ON AN AUTHORIZATION, EXCEPT FOR AN AUTHORIZATION FOR RESEARCH-RELATED TREATMENT.
•WE MUST PROVIDE YOU WITH A COPY OF THIS AUTHORIZATION FORM UPON REQUEST.

THIS AUTHORIZATION IS VOLUNTARY

TO BE COMPLETED BY PATIENT OR PATIENT REPRESENTATIVE

I, _____ Date of Birth _____, SS# _____
(Print Patient's Name)

Address _____ Phone# _____ do hereby authorize AOSM to obtain, use, disclose or receive my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization to whom I authorize disclosure of my personal data and/or individually identifiable health information is not a health plan, health care provider, or clearinghouse that the released information may no longer be protected by federal privacy regulations.

PATIENT OR PATIENT REPRESENTATIVE PLEASE CHOOSE AND INITIAL

Please forward the following items that are indicated:

☐ **Complete medical record** that may contain treatment notes regarding radiology, pathology *(including HIV test results and genetic testing information)*, immunization, procedure, *alcohol and drug abuse records protected by Federal Confidentiality Rules 42 CFR Part 2*, and other common medical record documentation made by the physician, nurse or other ancillary personnel for the entire time I was treated by the practice.

☐ **Operative Reports** ☐ **MRI or X-Ray Discs** ☐ **X-Ray Reports** ☐ **Other** _____

TO BE COMPLETED BY PATIENT OR PATIENT REPRESENTATIVE

Release my records to the following:
Name: _____ Fax# _____

Address: _____ Phone# _____

For the purpose of: _____

I understand that I may withdraw my authorization in writing to the Privacy Officer of AOSM at any time, except to the extent that action has been taken in reliance on this statement. I understand that even if I do not withdraw authorization that this statement will expire **one (1) year from this date.** I have carefully read and understand the above, and do herein expressly and voluntarily authorize the disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

X_____ _____

Signature of patient or patient's representative Date
Name of patient's representative_____
Relationship to the patient _____