



PATIENT INFORMATION

Form with fields for Patient Information, Information About Illness or Injury, and Guarantor Name (Responsible for Payment).

PATIENT/GUARDIAN SIGNATURE

DATE

Form with sections for Primary Insurance, Secondary Insurance, Referral Information, and Method of Payment.

Updated _____ Emp Int Updated _____ Emp Int Updated _____ Emp Int



TENNESSEE ORTHOPAEDIC CLINICS

ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the release of any medical information necessary for the processing of insurance claims. I hereby assign all medical benefits to include major medical benefits to which I am entitled to Tennessee Orthopaedic Clinics, P.C. this will remain in effect until revoked by me in writing. A photocopy is to be considered as valid as the original. I further agree to be solely responsible for any balances that my insurance does not pay.

Signature: _____

Date: _____

REFERRAL INFORMATION:

I understand that if a referral is required by my primary physician, I am responsible for obtaining this referral and following the rules/regulations of my insurance provider. I understand that failure to obtain my referral could result in my responsibility for payment of services rendered.

Signature: _____

Date: _____

In the event this account is turned over for collection, patient (or responsible party) agrees to pay for all costs of collections, including court costs and attorney's fees.

Signature: _____

Date: _____

Until my accounts are finally settled, I give my direct consent to receive communications regarding my accounts from any servicers and any collectors of my accounts, through various means such as 1) any cell, landline, or text number that I provide, 2) any email address that I provide, 3) auto dialer systems, 4) voicemail messages and other forms of communications.

Signature: _____

Date: _____



TENNESSEE ORTHOPAEDIC CLINICS



I, _____, give TOC permission to disclose my health information and account information to: Please list all parties we may discuss this information with (spouse, other family members, etc), including yourself if the patient is a minor. **Please give full names.**

Where and how may we contact you?

	Yes	No	
Home	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please give phone number

Work	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please give phone number

Email	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please give us your email address

Other/Cell	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please give us another contact number

May we leave a message on your answering machine or voicemail?

At Home?	Yes <input type="checkbox"/>	<input type="checkbox"/>	At Work?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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May we leave a message if there is no answering machine?

At Home?	Yes <input type="checkbox"/>	<input type="checkbox"/>	At Work?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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Signature of patient or responsible party Date



TENNESSEE ORTHOPAEDIC CLINICS

PROOF NOTICE OF PRIVACY POLICIES RECEIVED

Your Rights Regarding Your Protected Health Information

We are required by law to maintain the privacy of your health information and to provide you with this Privacy Notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of the Notice currently in effect. We reserve the right to change the terms of this Notice and to make any new provisions effective for all protected health information that we maintain. If we change the Notice, we will provide a copy to the revised notice through in-person contact.

Your Rights Regarding Your Protected Health Information

You have the right to express complaints to us and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated.

If you wish to complain to us, please do so in writing, and direct your complaint to the Privacy Officer.

You will not be penalized for filing a complaint

Contact Information

PLEASE CONTACT THE PRIVACY OFFICER AT THE SITE YOUR SERVICE WERE GIVEN

Effective Date

This Notice is effective April 14, 2003

Please print name

Account#

Signature of patient or responsible party

Date

Your First Visit and Medical History

Today's Date _____

First Name: _____ Last Name: _____ Age: _____ Sex: M / F
 Occupation: _____ Dominant Hand: _____ Referring Dr. _____

List all current medications you are taking (dose and frequency)

List all over-the-counter medications and oral steroids you have taken for these symptoms: _____

List all ALLERGIES you have to food, medications, including Steroids, IVP Dye / Iodine, etc: _____

 Patient Signature Date

FOR OFFICE USE:

HT: _____ WT: _____

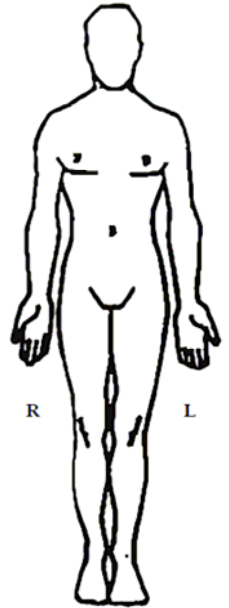
TEMP: _____ BP: _____

PULSE: _____ RESP: _____

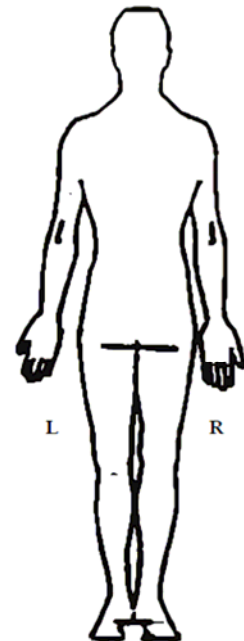
Front:

Draw your pain on the diagrams.
 Use the corresponding symbols to show the type of pain you feel.

- Stabbing pain ///
- Burning pain 000
- Aching pain xxx
- Pins & Needles vvv
- Numbness -----



Back:



Circle your pain level. 1=No pain 10=Unbearable
 1 2 3 4 5 6 7 8 9 10