

Sean Kaminsky, MD
Shoulder & Sports Medicine



Paul Abbey, MD
Hand & Upper Extremity Recons. Microsurg

Patient Information:

PATIENT AND INSURANCE INFORMATION

Name: _____ Birth Date: _____
Street Address: _____ Social Security #: _____
City/State/Zip: _____ Home Phone #: _____
Email Address: _____ Other Phone #: _____
Primary Physician: _____ Referring Physician: _____

Sex:
 Male
 Female

Marital Status:
 Married
 Single
 Widowed
Other _____

Race:
 American Indian/Alaskan
 Asian
 Black/African American
 White
 Hispanic
Other _____

Ethnicity:
 Hispanic or Latin
 Not Hispanic or Latin

Language:
 English
 Spanish
Other _____

Emergency Contact:

Name: _____
Relationship: _____
Street Address: _____
City/State/Zip: _____
Phone #: _____
Pharmacy _____

Patient Employer:

Employer: _____
Street Address: _____
City/State/Zip: _____
Work Phone #: _____
Position: _____
 Unemployed Retired Student Other

Office Policy for Service Fees

- \$10 prepay for each X-ray production to a CD
- \$20 prepay for Form Completion or Copy Fee such as FMLA, Disability, etc.
- \$25 returned check fee
- \$25 missed or cancelled appointments the same day as your appointment



Tennessee Bureau of Workers' Compensation
220 French Landing Drive, I-B
Nashville, TN 37243-1002
800-332-2667

FORM C-31

MEDICAL WAIVER AND CONSENT

This form is not required for injuries occurring on or after July 1, 2014

THIS MEDICAL AUTHORIZATION FORM ONLY PERMITS THE EMPLOYER OR THE BUREAU OF WORKERS' COMPENSATION TO OBTAIN MEDICAL INFORMATION THROUGH ORAL OR WRITTEN COMMUNICATION, INCLUDING, BUT NOT LIMITED TO, CHARTS, FILES, RECORDS, AND REPORTS IN THE POSSESSION OF A MEDICAL PROVIDER AUTHORIZED BY THE EMPLOYER PURSUANT TO T.C.A. § 50-6-204 AND A MEDICAL PROVIDER THAT IS REIMBURSED BY THE EMPLOYER FOR THE EMPLOYEE'S TREATMENT.

I, _____, having filed a claim for workers' compensation benefits, do hereby authorize
(Printed Patient Name)

_____ to furnish to my employer or my employer's
(Name of Medical Provider)

representative, and/or the Bureau of Workers' Compensation any information or written material reasonably related to my
work-related injury of _____ for which I am claiming compensation. I further authorize the release of
(Date of Injury)

the same information to me or my attorney. The authorization includes, but is not restricted to, a right to review and obtain copies of all records, x-rays, x-ray reports, medical charts, prescriptions, diagnoses, opinions and courses of treatment.

A photocopy of the authorization may be accepted in lieu of the original.

Patient Signature

Date

Date of Birth

Pinnacle Surgical Orthopedics

Today's Date: _____

PATIENT INFORMATION

Name: _____

Date of Birth: _____ Age: _____

Height: _____ Weight: _____

Referring Physician: _____

What are you being seen for today? (include right or left body part)

Injury Date: _____

Work Related: Yes No

Reported to Employer: Yes No

Rank Today's Pain:

(Minimal) 1 2 3 4 5 6 7 8 9 10 (Severe)

SYMPTOMS: Describe your symptoms:

Symptoms Are:

Mild Moderate Severe

Symptoms Are:

Constant or Intermittent

Additional Symptoms with this injury are:

None Fever Chills Weight Loss

Tingling Numbness Swelling

Locking Giving Way

When did these symptoms begin?

What occurred for these symptoms to begin?

What makes you feel better?

What makes you feel worse?

PRIOR TESTING: Date: _____

Check all tests you have had regarding this injury: X-rays MRI CT Scan

Bone Density Bone Scan EMG

Facility/Hospital: _____

MEDICAL HISTORY: Check all that apply

Diabetes Heart Disease High Blood Pressure Stroke Lung Disorder

Sleep Apnea Hepatitis Depression

HIV Asthma Cancer

Headache Anemia Chest Pain

Shortness of Breath Weight Gain

Neurological Disorder Weight Loss

Bleeding Problems Osteoporosis

Bladder/Bowel Problems High Cholesterol

****MEDICAL HISTORY FORM****

Check all surgeries You have had:

Joint Surgery Spine Heart

Hysterectomy C-Section Tonsils

Appendix Gallbladder

Other: _____

FAMILY HISTORY

Check all health problems blood members of your family have had & list that relative:

Arthritis Osteoporosis

Cancer Diabetes

Scoliosis Heart Disease

Stroke Bleeding Disorder

Blood Clots Hypertention

Other: _____

Date of your last Flu Shot: _____

Date of last Pneumonia Shot: _____

Do You smoke? Yes No

Number of Packs per Day: _____

Do You Drink Alcohol? Yes No

Number of Drinks per Day: _____

Have you been treated for, or do you currently have a problem with alcohol, illegal drug use, or prescription drug abuse?

Yes No

MEDICATIONS

List the name, dosage and frequency of all medications you are currently taking:

Medicine	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES

List the name of any drugs you are allergic to and what it does to you when taken:

LATEX ALLERGY

Internal Use Only:

Physician Review: _____ name _____ date

Release Of Medical Information

NAME (Please print): _____

By Signing Below, I Authorize AdvancedHEALTH To Release My Medical And Billing Information To:

RELATIONSHIP			NAME OF DESIGNATED PERSON
SPOUSE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
CHILDREN	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
IN-LAWS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
CAREGIVERS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
PARENTS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
OTHERS			_____

PATIENT SIGNATURE _____ DATE _____

PARENT SIGNATURE _____ DATE _____

We ask that if you have any change in this request, that you please inform the receptionist.

AdvancedHEALTH may leave appointment information on my voicemail:

HOME	<input type="checkbox"/> YES	<input type="checkbox"/> NO
WORK	<input type="checkbox"/> YES	<input type="checkbox"/> NO
RELATIVE	<input type="checkbox"/> YES	<input type="checkbox"/> NO

PATIENT SIGNATURE _____ DATE _____

I authorize the following to pick up prescriptions, X-rays, etc.

RELATIONSHIP			
SPOUSE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
RELATIVE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
CAREGIVER	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____

PATIENT SIGNATURE _____ DATE _____

We charge a \$20 flat rate for 1-5 pages plus .50 per additional page and postage.

I understand that AdvancedHEALTH will ask for identification of the person picking up patient medical information or products.



AdvancedHEALTH

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 care. 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)

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

Name of Patient: _____

Signature of Patient: _____ Date: _____

Consent of Legal Guardian, Patient Advocate or Nearest Relative if patient is unable to sign

Consent Caregiver if patient is unable to sign

Name of Legal Guardian, Patient Advocate, Nearest Relative or Other: _____

Relationship: _____ Telephone: _____

Address: _____

Signature of the above: _____ Date: _____ Time: _____

Signature of Witness: _____ Date: _____



AdvancedHEALTH

Patient Financial Policy

This is an agreement between AdvancedHEALTH, as creditor, and the Patient/Debtor named on this form and indicated by 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 card, 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 responsibility 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 co-payment 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.**

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 reduced to the in-network insurance allowable amount and will apply to the patient's responsibility.

_____ Initials

Patient and/or Debtor Signature: _____ Date ____/____/____

Additional financial explanations are continued on the back side of this page



AdvancedHEALTH

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.

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.

____ Yes, I have chosen to retain an attorney. Signed: _____ Date: ____/____/____

Attorney Name: _____ Phone: _____

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 paid 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 than <\$5.00> will not be refunded without specific request from the patient/debtor.

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.

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.

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. We charge a \$20 flat rate for 1-5 pages plus .50 per additional page and postage.



AdvancedHEALTH

Notice Of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

Patient Name or Legal Guardian: _____

Signature: _____

Date: _____

PRACTICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date: _____ Initials: _____

Reason: _____



AdvancedHEALTH