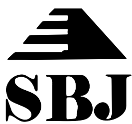

SUMMIT BONE & JOINT, PLLC

PATIENT REGISTRATION

PATIENT INFORMATION

NAME ______________ SSN ______________ Drivers Lic # ______________ STATE ______
STREET ______________ CITY ______________ ST ______ ZIP ______
HOME # ______________ WORK # ______________ CELL # ______________
DOB ______________ AGE ______ SEX: M F Married Single Divorced Widowed STUDENT? ☐ YES ☐ NO
E-MAIL ______________ EMPLOYER ______________ OCCUPATION ______________
ADDRESS ______________ PHONE # ______________

RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

NAME ______________ SSN ______________ IS THIS: ☐Spouse ☐Mother ☐Father ☐Other
STREET ______________ CITY ______________ ST ______ ZIP ______
E-MAIL ______________
HOME # ______________ WORK # ______________ CELL # ______________ DOB ______________ AGE ____
EMPLOYER ______________ OCCUPATION ______________ FAX # ______________
ADDRESS ______________ PHONE # ______________

REASON FOR VISIT

WORK RELATED ☐ YES ☐ NO CLAIM # ______________ AUTO ACCIDENT ☐ YES ☐ NO CLAIM # ______________
DATE OF INCIDENT/ONSET ________ INJURY: ☐YES ☐ NO WORK-RELATED OR AUTO INSURANCE RESPONSIBLE:
NAME ______________ ADDRESS ______________
CASE MGR/ATTORNEY ______________ PHONE # ______________ FAX # ______________
STREET ______________ CITY ______________ ST ______ ZIP ______

INSURANCE INFORMATION (PRIMARY)

INSURANCE ______________ ID# ______________ GROUP# ______________ DOB ______________
POLICY HOLDER ______________ ADDRESS ______________
SSN ______________ HOME PHONE ______________ IS THIS: ☐Spouse ☐Mother ☐Father ☐Other SEX: M F

INSURANCE INFORMATION (SECONDARY)

INSURANCE ______________ ID# ______________ GROUP# ______________ DOB ______________
POLICY HOLDER ______________ ADDRESS ______________
SSN ______________ HOME PHONE ______________ IS THIS: ☐Spouse ☐Mother ☐Father ☐Other SEX: M F

EMERGENCY CONTACT (NOT LIVING WITH YOU)

NAME ______________ ADDRESS ______________
PHONE # ______________ LIVING WILL/POWER OF ATTORNEY? ☐ YES ☐ NO

PRESENT INSURANCE CARD AND PHOTO ID TO RECEPTIONIST AT TIME OF APPOINTMENT

I consent to release, by the physician, of any use of my health care information regarding treatment, payment and health care operations. I further authorize payments of medical benefits to the doctor in the event insurance is filed on my behalf. I agree to pay for any items that are not covered by my insurance company, if applicable. I understand that these items will be itemized by date of service and I will be billed after insurance is filed, if applicable.

If the patient is a minor (under 18), I certify that I am the legal guardian and I authorize treatment by the Doctors/Staff of Summit Bone and Joint, PLLC ("SBJ").

I understand that if Workers' Compensation or another carrier is liable for my bills, my group insurance is not responsible for payment. I understand that all insurance information must be given to Summit Bone & Joint, PLLC before or at the time of appointment in order to verify insurance coverage and liability.

I understand that all referrals are my responsibility. I am ultimately responsible for any balance incurred at Summit Bone & Joint, PLLC. In the event that my balance is transferred to a collection agency or attempts are made to collect the balance using an outside source, I will be responsible for collection costs, attorney fees, and/or court costs up to and beyond the existing balance incurred at Summit Bone & Joint, PLLC.

______________________________	______________________________
PATIENT/RESPONSIBLE PARTY SIGNATURE	**DATE**

HIPAA CONSENT/PATIENT MEDICAL RELEASE

I consent for treatment or diagnosis by a provider of SBJ. I consent to the use or disclosure of my medical information (Protected Health Information "PHI") by SBJ for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of SBJ.

My PHI is any information, including my demographics, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This PHI relates to my past, present or future physical or mental health or condition. There is a reasonable belief that the PHI may identify me.

I understand I have the right to request in writing a restriction as to how my PHI is used or disclosed to carry out treatment, payment or healthcare operations of the practice. SBJ is not required to agree to the restrictions that I may request. However, if SBJ agrees to a restriction that I request, the restriction is binding on SBJ. I have the right to revoke this consent in writing at any time, except to the extent that SBJ has taken action in reliance on this consent.

I authorize SBJ to use the phone numbers, email and/or fax numbers I have supplied to contact me. I authorize the use of any messaging person or system, voice mail and/or an answering machine to convey information regarding my care. I understand that every effort is made to protect my privacy; however, no absolute privacy guarantee is given when faxing or email is used. We may disclose to a family member, relative, close friend or any other person about your PHI that directly relates to that person's involvement in your health care unless otherwise named in writing: ______________________________.

I acknowledge I have received a copy of the SBJ Notice of Privacy Practices. This Notice describes how SBJ may use and disclose my PHI, certain restrictions on the use and disclosure of my health care information, and rights I may have regarding my PHI. SBJ reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised copy by request.

I authorize the release of all medical or diagnostic records to Summit Bone & Joint, PLLC, 5653 Frist Blvd, Ste 731, Hermitage, TN 37076 Phone: (615) 232-3838 Fax: (615) 232-3833 unless restricted in writing:

____

______________________	______________________	______________________
Signature of Patient or Personal Representative	**If guardian, PRINT patient name**	**Relationship to patient**
______________________	______________________	______________________
Name of Patient or Personal Representative	**Patient Date of Birth**	**Date**

Rev 05/2009

NEW PATIENT FORM

Welcome to our office. Please ask for staff assistance if you need any help in completing these forms. Thank you.

NAME: ________________________ **DOB**: ___________ **Occupation**: _________________ **Date**: ________________

Primary Care Doctor: ________________________ **Referring Doctor**: ______________________________________

Age: ___________ ☐**Right** ☐**Left (handed)** **Race**: __________________ ☐**Male** ☐**Female**

1. List all medications: ____

____

____

____

Do you have any drug/latex allergies? ______ **If "yes", list:** ____

2. List all surgeries you have had: ____

____

____

____

____

Location of pain or injury: ___________________________________ **Date of injury/problem:** _________________

3. Past Medical History: Please circle any illnesses that you have been treated for. (Items not circled are understood to be negative)

Bleeding Tendencies	Heart Murmur	Pacemaker	Poor Circulation	Intestine/Bowel Issues
Ulcer	Pneumonia	Cancer	Diabetes	Heart Disease
Arthritis/Rheumatoid	Hepatitis	Hypertension	Kidney Disease	Anemia
Depression/Anxiety	Osteoporosis	Liver disease	Asthma	Gout
Stroke	Emphysema	Phlebitis	Tuberculosis	Polio
Rheumatic Fever	Blood Clot	Back/Neck Injury	AIDS/HIV Positive	Sexually trans. disease
Thyroid disorder	Epilepsy/Seizure	Multiple Sclerosis	Psych disorders	Other: _______________

Last Menstrual Cycle: ____________________ Age of First Menstrual Cycle: ______________

Height: ________ **Weight:** _________ **Age:** _________ **Marital Status:** **Single** **Married** **Widowed** **Divorced**

Do you smoke tobacco? ☐ **Yes** ☐ **No** **How many packs a day?** _______ **How many years?** ___________________

Do you drink alcohol? ☐ **Yes** ☐ **No** **Frequency?** __________ **Exercise Program** _______________________

Have you ever used recreational drugs? ☐ **Yes** ☐ **No** **Type?** ____________________________________

4. Family History: Please circle any conditions your family members have. (Items not circled are understood to be negative)

Bleeding Tendencies	Pneumonia	Cancer	Diabetes	Heart Disease
Ulcer	Hepatitis	Hypertension	Kidney disease	Anemia
Arthritis/Rheumatoid	Osteoporosis	Liver disease	Asthma	Gout
Depression/Anxiety	Emphysema	Phlebitis	Stroke	Tuberculosis
Polio	Rheumatic Fever	Blood Clot	Back/Neck injury	AIDS/HIV Positive
Thyroid Disorder	Epilepsy/Seizure	Other: ____________		

PATIENT SIGNATURE: ____ **DATE:** ________________________

REVIEWED: ________________________

SUMMIT BONE & JOINT, PLLC

Michael S. LaDouceur, M.D.
Diplomate, American Board of Orthopaedic Surgeons
Christopher M. Cook, M.D.
Board Eligible
Todd Warren, N.P., A.T.C.

Summit Medical Center
5653 Frist Blvd., Suite 731
Hermitage, TN 37076
Phone 615.232.3838
Fax 615.232.3833

Shoulder and Elbow
Sports Medicine
Adult Reconstruction
General Orthopaedics

MANAGED CARE AND THIS OFFICE

Dear Patient:

To avoid confusion with our patients and our office regarding your health insurance carrier, the following information is provided as a guide to our office referral system including, but not limited to: X-ray, C-T, MRI, surgery and physician referrals (both to and from this office). Preauthorization is often required before we can see patients.

While we promise to make every effort to refer patients to properly credentialed providers, we simply cannot take sole responsibility for 100% accuracy for all our referrals. There needs to be joint responsibility between us (the office) and you (our patients) to be certain that everything is done within the limits of your insurance policy.

In addition to assistance with referrals, please review the following office policies:

- **Office Hours-** Our office hours are Monday and Wednesday 7:30-5:00, Tuesday and Thursday, 8:00-5:00 and Friday 7:30-4:00.
- **Medication Guidelines-** If you experience adverse affects of any medication, STOP taking it immediately. If you are rapidly becoming ill, report to the nearest emergency room or call emergency services (911).
  Please call the office one full business day BEFORE your prescription needs refilling. If the call is received late Friday, it may be the first of the following week before the refill is authorized. Provide us with the phone and fax numbers of the pharmacy you desire. Refills are called in between 4 and 5 p.m., so check with the pharmacy after those times to pick up the prescription. The amount given and the strength of medication prescribed will be reduced during the recovery process. Narcotics will not be prescribed on a long-term basis.
- **Medical Records/Form Completion-** Request for records needs to be in writing. Records request and completion of forms incurs a $20 fee, payable in advance by cash or credit card.
- **Non-Sufficient Funds-** Checks returned for non-sufficient funds will incur a $20 fee in addition to the amount of the original check. Only cash or credit cards may be used to clear the returned check. If two NSF checks are incurred, no further personal checks will be accepted by our office.
- **Co-payments-** Your insurance requires your co-payment be collected at the time of service. If not paid at that time, a $5 fee will be added to the original co-payment or the visit will need to be rescheduled.
- **CoInsurance/Deductibles-** A maximum payment of $150 for office visits will be collected at time of service until your deductible has been fully paid for the current year. This payment represents partial payment for services rendered until we receive an EOB from your insurance carrier to enable us to calculate the balance due.
- **X-rays-** We request 24 hour notice for x-rays to be copied/burned to a CD-R.

We want to thank you for choosing Summit Bone and Joint, PLLC, for treatment and thank you in advance for your help regarding referrals and reviewing our office policies. Please call our staff with any comments or questions.

________________________________ ____________________
Patient Signature Date

Rev 05/09