TENNESSEE VALLEY BONE and JOINT
2350 North Ocoee St. ▫ Cleveland, TN 37311
office 423.476.5554 ▫ toll-free 877.676.5554 ▫ fax 423.614.6116

PATIENT INFORMATION

Date: ____________ Male Female

Patient Name: ______________________ Address: ______________________

City: ______________ State: ________ Zip: __________ County: ______________

Social Security: ______________ Date of Birth: ______________ Age: ______________

Marital Status: Single Divorced Widowed Married/Spouse's Name: ______________________

Phone #: ______________ Secondary Phone #: ______________ Work Phone#: ______________

Employer: ______________________ Occupation: ______________________

Referring Physician/Provider: ______________ Family Physician/Provider: ______________

RESPONSIBLE PARTY OR SPOUSE INFORMATION

Name: ______________________ Relationship: ____________ Date of Birth: ____________

Social Security Number: ______________ Address: ______________________

City: ______________ State: ________ Zip: __________ Employer: ______________

INSURANCE INFORMATION

Primary Insurance Name: ______________ Policy #: ____________ Group #: __________

Insured SS#: __________ Insured/Subscriber Name: ______________ Date of Birth: __________

Secondary Insurance Name: ______________ Policy #: ____________ Group #: __________

Insured SS#: __________ Insured/Subscriber Name: ______________ Date of Birth: __________

EMERGENCY CONTACTS

Name: ______________________ Relationship: ______________ Phone: ____________

Name (Not living with you): ______________________ Relationship: __________ Phone: __________

ACCIDENT INFORMATION

My visit today is not due to an injury:

Date of Injury: ___/___/_____ Has an attorney been contacted? Yes No If so, who: ______________

Work Related? Yes No What state did the injury occur in? __________

Automobile Accident? Yes No What state did the injury occur in? __________

Sports Activity Injury? Yes No What state did the injury occur in? ________ School/Institution: __________

Were you treated in the Emergency Room for an injury? Yes No If yes, which ER? __________ Date: ________

(Form continues on back) Revised: 12/20/2010

HIPPA QUESTIONAIRE

Tennessee Valley Bone *and* Joint has always protected your medical information and your privacy is important to us. New federal guidelines now mandate that we ask you the following questions before we can discuss your medical information for purposes other than treatment:

Please list any/all family members/friends/caregivers to which we may speak with regarding your medical information (i.e., spouse, sibling, caregivers, children, etc.)

Name: ______________________________ Relationship __________________Phone ___________________

Name: ______________________________ Relationship __________________Phone _________________

Our office may have to phone your home regarding appointment reminders or changes. If you are not at home, we will leave a message.

I, ________________________________, hereby acknowledge receipt of the Notice of Privacy Practices given to me by **Tennessee Valley Bone *and* Joint.**

Signature: ____ Date: ____________________________

AUTHORIZATION AND FINANCIAL AGGREEMENT

AUTHORIZATION AND RELEASE OF INFORMATION: I hereby authorize Tennessee Valley Bone *and* Joint to perform medical services as needed for my care. I also authorize TN Valley Bone *and* Joint to release any medical information to my referring physician, my family physician, and my insurance company with whom I have medical benefits for the purpose of filing a medical claim. I acknowledge that this authorization is valid until such time as it is revoked in writing. I further understand that I can withdraw this consent for release of information at any time except to the extent that action has been taken in reliance hereon.

ASSIGNMENT OF BENEFITS: I authorize my health insurance benefit plan to pay directly to Tennessee Valley Bone *and* Joint the surgical and/or medical benefits, if any, otherwise payable to me. In the event this account is turned over for collection, I agree to pay the cost of collection and reasonable attorney's fees. I understand I am responsible for obtaining authorization for treatment as required by my insurance company. If authorization is not received, as required by my insurance company, I will be responsible for payment of total charges.

MEDICARE AND MEDIGAP, CLAIM AUTHORIZATION AND PAYMENT REQUEST: I authorize any holder of medical or other information about me to release to the social security administration and health care financing administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulation pertaining to Medicare assignment of benefits apply.

COST OF SUPPLIES: Insurance Companies may consider supplies such as cast boots, post-op shoes, wrist braces, exer-tubing, sprain walkers, finger splints, fracture braces, shoe inserts, metatarsal pads, etc. as luxury items and not cover them.
I understand that I am responsible for payment in full at the time I am given any supplies that I decide to accept in treatment of my condition from Tennessee Valley Bone *and* Joint. Just as I would pay for any supply or brace I purchased at a drug store or retail store. My insurance may not be billed for these supplies by Tennessee Valley Bone *and* Joint and they may not accept assignment or payment from my insurance company for any supplies. Patients are always welcome to check other places and compare prices before purchasing any recommended supply from out office.

I hereby warrant all information contained herein to be true and accurate to the best of my knowledge and I understand that I am financially responsible for all charges whether or not they are covered by insurance. It is the patient's responsibility to verify coverage prior to treatment by Tennessee Valley Bone *and* Joint and to provide accurate insurance information. Failure of either by patient may render patient responsible for ALL expenses associated with any visit. ANY CHECK OR BANK DRAFT NOT HONORED BY YOUR BANKING INSTITUTION FOR ANY REASON WILL RESULT IN THE PATIENT (OR RESPONSIBLE PARTY) BEING ASSESSED A FEE OF $30.00 (Thirty Dollars & 00/100) IN ADDITION TO THE FACE AMOUNT OF THE DISHONORED CHECK OR BANK DRAFT. In the event I do not pay my account in full and my account is turned over to collections, I agree to be responsible for all collection costs incurred in the collection of any delinquent account balances, including any attorney fees, Interest at 2% monthly, and previously adjusted or allowed discounts.

Signature: ____ Date: ____________________________

(Form continues on back)

Tennessee Valley Bone and Joint

MEDICATION POLICY

_______________________________ Patient's Name

_____/_____/_____ Date of Birth

In an effort to assure all your medication needs are addressed at the time of your office visit, please discuss medication refills or changes with your provider before leaving the room.

Medication verification: Please bring all medications which you are currently taking to each visit. Your medications will be verified before refills can be issued.

Medication refills: Medication should only be taken as prescribed. Early refills will not be authorized. Medications will only be refilled or changed at the time of your scheduled visit. Refill prescriptions will only be filled at the same pharmacy. **Medications will not be refilled by phone.**

_________________________	____________________	___________________
Pharmacy Name	Street Name	Phone
_________________________	____________________	___________________
Alternative Pharmacy *(Must be open 24 hours)*	Street Name	Phone

Medication replacement: Lost or stolen medications will not be replaced.

You will not request or accept controlled substance medication (pain medication) from any other physician/ health care provider or individual while you are receiving such medication from Tennessee Valley Bone and Joint. **Non-compliance with the above condition may result in re-evaluation of your treatment plan and discontinuation of controlled medication and/or discharge from our practice.**

I have read the above information and agree to the Medication Policy of Tennessee Valley Bone and Joint.

Patient's Signature: ___________________________ Date: _______________

Witness's Signature: ___________________________ Date: _______________

Revised: 01/09

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PATIENT FORMS POLICY

There will be a 7 – 10 day turn-around time for all forms to be filled out and returned to the patient. We will make an effort to return these forms in a timely manner. These include disability, FMLA, insurance forms, etc.

The charge for this service is $15.00 minimum per form to be paid at the time the form is given to the office.

Patient Signature: _________________________ Date: ____________