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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: _____ **Gender:** ☐ Male ☐ Female **Race:** ☐ White ☐ African American\Black ☐ Other
Ethnicity ☐ Hispanic ☐ Non-Hispanic **Language**: ☐ English ☐ Spanish ☐ Other

Patient Name: _____ Address: _____

City: _____ State: _____ Zip: _____ County: _____

Social Security: _____ Date of Birth: _____ Age: _____

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

Phone #: _____ Phone #: _____ E-Mail _____

Employer: _____ Work Phone#: _____ Ext _____

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: _____

ACCIDENT INFORMATION

My visit today is due to an injury: YES / NO

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 Page #1)

HIPAA CONSENT/EMERGENCY CONTACTS

Tennessee Valley Bone and Joint has always protected your medical information and your privacy is important to us. Federal guidelines now mandate that we ask you the following questions before we can discuss your medical information for purposes other than treatment. Our office may have to phone your home regarding appointment reminders or changes. If you are not at home, we will leave a message.
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: _____ **Relation** _____ **Phone** _____ **Emergency Contact?** _____

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Name: _____ **Relation** _____ **Phone** _____ **Emergency Contact?** _____

Because of the recent changes to patient rights we are required by the Omnibus HIPAA final ruling to provide all new patients access to our revised notice, also posted in waiting room and available on practice website.
I hereby acknowledge receipt of Tennessee Valley Bone and Joint's HIPAA Notice of Privacy Practices.

Signature: _____ ***Date:*** _____

AUTHORIZATION AND FINANCIAL AGREEMENT

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, off site facility for continued care, 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.
AUTHORIZATION TO RETRIEVE RX HISTORY FROM OTHER HEALTHCARE PROVIDERS AND 3RD PARTY PHARMACIES: I agree that TN Valley Bone and Joint may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.
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. Regulations pertaining to Medicare assignment of benefits apply.
COST OF SUPPLIES: Insurance Companies may consider supplies such as cast boots, post-op shoes, braces, exer-tubing, walkers, finger splints, shoe inserts, slings, 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 becomes collection pending, written off to bad debt, and/or turned over to collections....I agree to be responsible for a 2% monthly interest charge, all collection costs incurred in the collection of any delinquent account balances including any attorney fees and previously adjusted or allowed discounts for private pay.

****Signature:*** _____ ***Date:*** _____