Date: ___________ Name: (First) __________________ (Middle) _____________ (Last) ______________

Date of Birth:_________ Sex:____ Marital Status: ___________ Social Security Number: _____________

Home Phone:___________ Work Phone: _____________ Cell Phone: _____________

Address:____ City: _______________ State: __ Zip:_______

Email:___________________________________

How would you like to be contacted? Home Work Cell Email Appointment reminders by text? Yes No

Patient's Employer:____________________________________ Phone:_______________

Address:_____________________________________ City:__________________ State:___ Zip:________

Emergency Contact______________________ Relationship:________________ Phone:_______________

Insured's Full Name __________________ Date of Birth: _________ Relation to Patient______________

Address: ___________________________ City:___________________ State: __ Zip: _______

Home Phone: ________ Work Phone: ________ Cell Phone: _____________

Employer Name:____

Insurance Company Name: ____

Primary Care Physician ____

Referring Physician or source____

Is this visit Workers Compensation? Yes No Is this visit Auto Accident or Personal Injury? Yes No

State of MVA, Accident or Injury:____________ Date of injury or accident:_______

Carrier Name: _______________________________

Case Manager/Adjuster: _______________________

Claims Address: ______________________________

____

Phone: ___________________

Claim #:__________________________________

Attorney Name: ___________________________

Attorney Address: _________________________

____

Phone: _________________

Employer at time of injury: _________________

Authorization: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or the party who accepts assignment. I authorize payment of medical benefits to Southeastern Spine and Joint for medical services rendered to me. I understand that by signing this, I am taking full responsibility for any unpaid medical expenses that are not covered by my insurance company including copays, deductible or my failure to obtain a referral from my primary care physician. I will be responsible for any collection charges, bounced check fees, interest or added expense for my failure to pay any balance due.

Patient/Insured Signature: Date:

____

Financial Responsibility Policy

All co-pays, deductible, or co-insurance amounts are due at the time the service is rendered. Southeastern Spine and Joint accepts cash, check, Visa, Mastercard, American Express, Discover, and Care Credit. There is a $25 fee for all returned checks.

Although Southeastern Spine and Joint gladly files a claim to your medical insurance on your behalf, medical insurance is ultimately a contract between the patient and their insurance company. It is the patient's responsibility to monitor the processing and payment of claims. After payment is received from the insurance carrier, any patient responsibility amounts that remain will be transferred to a patient balance. A statement will be sent to the patient. The balance due amount showing on the statement should be paid in full when the first statement is received. You must notify us of any errors or objections to the billing statement within (30) days or they will be deemed accurate, and the fees and expenses shall be deemed reasonable and necessary for the services incurred.

You are responsible for knowing your insurance policy and for giving us the correct information. For example, you will be responsible for any charges if any of the following apply: (i) your health plan requires prior authorization or referral before receiving services at Southeastern Spine and Joint, and you have not obtained such an authorization or referral, (ii) you receive services in excess of such authorization or referral; (iii) your health plan determines that the services you received at Southeastern Spine and Joint are not medically necessary and/or not covered by your insurance plan; (iv) your health plan coverage has lapsed or expired at the time you receive services at Southeastern Spine and Joint; (v) we are not in-network with your insurance carrier; or (vi) you have chosen not to use your health plan coverage. If you are not familiar with your plan coverage, we recommend you contact your carrier or plan provider directly.

Should collection proceedings or other legal action become necessary to collect an overdue account or missed appointments/late cancellations result in associated charges, the Patient or the Patient's Responsible Party understands that the practice has the right to disclose to an outside agency all relevant personal and account information necessary to collect payment for services rendered. They also understand that they are responsible for all cost of collection.

By signing below, you agree to accept full financial responsibility as a Patient who is receiving medical services, or as the Responsible Party. Your signature verifies that you have read this Patient Financial Responsibility statement, understand your responsibilities, and agree to these terms.

______________________________________ ________________

Signature or Patient/Responsible Party Date

According to our policy, test results or the release of medical information will be provided to the patient only. Please specify below whom information may be released to other than you. Please complete the information and sign below to verify your permission. Please circle all that apply and fill in the blanks:

Do we have permission to leave messages on your voicemail? Yes No

Do we have permission to text you appointment reminders, patient instructions, and updates on surgeries, procedures, and imaging? Yes No

Do we have permission to email you appointment reminders, patient instructions, and updates on surgeries, procedures, and imaging? Yes No *If yes - e-mail address________________________________

Do we have permission to discuss medical information with a family member? Yes No *If yes, please list below.

Emergency contact name: Relationship:

Phone: Alternate Phone:

Alternate contact name: Relationship:

Phone: Alternate Phone:

Advanced Directives

It is the right of every adult citizen in Tennessee (18 years and over) to sign a living will, as well as a Durable Power of Attorney for Healthcare that empowers an individual of your choosing to see that your wishes are carried out. It is important to decide whether or not you wish to sign a Living Will now when you are fully competent to make your own decision. The choices that you make in your Living Will will be binding on doctors, hospitals, and other healthcare providers in the event you become incapable of telling them your wishes. If you have signed either document, please make sure that your provider has a copy for your file.

Authorization

I authorize Southeastern Spine & Joint to release any insurance company, managed care organization, state or federal agencies, centers for Medicare and Medicaid services. Third Party Administrators, and/or Workers' Compensation (or its' agents) any information needed to process my claim and/or determine benefits payable for related services. I also authorize Southeastern Spine & Joint to utilize a fax machine to transmit any/all of the above medical records pertaining to my medical care or insurance reimbursement. I acknowledge that faxing my medical records may increase the risk of accidental disclosure of my medical records. I grant permission to Southeastern Spine & Joint to release all or part of my medical record to any consulting entity that may be involved in my medical care. This includes, but is not limited to, testing facilities, consulting physicians, and outpatient facilities. I request that payment of Medicare, MediGap, Medicaid, Managed Care Organization, Third Party Administrators, Commercial insurance, Worker's Compensation, Liability, and/or any other benefits made on my behalf to Southeastern Spine And Joint. I permit a copy of this authorization to be used in place of the original. Regulations pertaining to medical assignment benefits apply.

Patient or Guarantor Signature___________________________________ Date____

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

By signing below, I hereby acknowledge receipt of Southeastern Spine & Joint Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how DPS may use and disclose my protected health information.

By signing below, I acknowledge that I understand that Southeastern Spine & Joint has reserved the right to change its privacy practices that are described in the Notice of Privacy Practices. By signing below, I acknowledge that I also understand that any revisions to the Notice of Privacy Practices will be provided to me or made available to me.

____
Signature

____
Print Name

____
Date

If you are not the patient, please specify your relationship to the patient: ____________________________

Southeastern Spine & Joint Medication Agreement

1. I understand that I need to give 24 hours notice when requesting a refill on any medication. Walk-in requests for medication or appointments will not be accepted.
2. I agree to take all medication exactly as instructed. I am not allowed to change the dosage or time schedule without speaking to my provider first.
3. I understand that no medication will be changed or called in after hours or on weekends.
4. I understand that a follow up visit may be required from my provider in order to obtain a refill and I must keep all recommended appointments.
5. I understand that urine drug screens will be required at my provider's discretion as long as I am receiving opioid medication. I understand that my medication may be stopped or changed at the provider's discretion, based upon the results of the drug screen or the TN prescription monitoring data base.
6. Southeastern Spine & Joint will not refill lost or stolen medication. These are your responsibility once you leave our office.
7. I will not trade, sell or give away the medications that are prescribed for me. I will also not take any medication that is prescribed to someone else.
8. I am aware that while I am on medications that treat my pain, I am prohibited from driving or using heavy machinery. I understand that driving while taking opioid medication could result in a DUI charge.
9. I understand that verbal abuse and/or argumentative behavior towards the staff will not be tolerated and could result in dismissal from the practice.
10. I will not use multiple pharmacies when filling my prescriptions.
11. I understand that prescriptions from Nurse Practitioners or Physician Assistants must be filled in the state of Tennessee.
12. The following are conditions for immediate discharge from the practice:
    a. Obtaining opioid prescriptions from other physicians while receiving medications from our providers
    b. Altering or forging a prescription in any way. This is a felony and will be reported.
    c. Non-compliance with any of the above statements.

I have read, understand and agree with the above policies, and I understand that if I do not sign, my physician may refuse to prescribe pain medications to me.

Printed Name_______________________________ **Date**______________

Patient Signature____

Cancellation/ Late Arrival/ No Show Policy

Our goal is to provide quality medical care in a timely manner. To do so we have implemented an appointment/cancellation policy. The policy enables us to better utilize available appointments for our patients in need of medical care.

Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours before your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our appointment Cancellation/No Show Policy below.

- Any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24 hours notice will be considered a No Show and may be charged a $50 No Show fee.
- If a third No Show or cancellation/reschedule with no 24-hour notice should occur the patient may be dismissed from Southeastern Spine and Joint.
- Any new patient who fails to show for their initial visit will not be rescheduled until they get a new referral to Southeastern Spine and Joint.
- If you are over 15 minutes late for your appointment the clinic will be asked if they are able to work you back into that day's schedule. If they are able to you will have to wait for the clinic to have an opening to see you.
- If you are late by 30 minutes or more you will be considered a No Show.

We understand there may be times when an unforeseen emergency occurs and you may not be able to cancel 24 hours in advance. If you should experience extenuating circumstances please contact management at 423-693-2175.

____

Patient Signature

Opioid Risk Tool

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management.

Sex (circle one): Female Male

Mark appropriate box beside each question	**Yes**	**No**
Do you have a *family history* of any of the following?		
Alcohol Abuse		
Illegal Drug Abuse		
Prescription Drug Abuse		
Do you have a *personal history* of any of the following?		
Alcohol Abuse		
Illegal Drug Abuse		
Prescription Drug Abuse		
Are you between 16—45 years old?		
Do you have a history of preadolescent sexual abuse?		
Do you have a personal history of ADD, OCD, bipolar, schizophrenia		
Do you have a personal history of depression?		
Scoring totals		

**A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse.

Questionnaire developed by Lynn R. Webster, MD to asses risk of opioid addiction. Adapted for use by Southeastern Spine & Joint.

Webster LR, Webster R. Predicting aberrant behaviors in Opioid-treated patients: preliminary validation of the Opioid risk too. Pain Med. 2005; 6 (6) : 432

Patient Name: ______________________________ Date:______________________

Patient Name:____ DOB:____________________

Oswestry Disability Index v1.4

Directions: *This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. Please answer every section, and mark in each section only one statement which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the one which most closely describes your problem.*

01. Pain Intensity *(Mark only one)*

- ◯ I can tolerate the pain I have without having to use pain medication.
- ◯ The pain is bad, but I can manage without having to take pain medication.
- ◯ Pain medication provides me with complete relief from pain.
- ◯ Pain medication provides me with moderate relief from pain.
- ◯ Pain medication provides me with little relief from pain.
- ◯ Pain medication has no effect on my pain.

02. Personal Care (e.g., Washing, Dressing) *(Mark only one)*

- ◯ I can take care of myself normally without causing increased pain.
- ◯ I can take care of myself normally, but it increases my pain.
- ◯ It is painful to take care of myself, and I am slow and careful.
- ◯ I need help, but I am able to manage most of my personal care.
- ◯ I need help every day in most aspects of my care.
- ◯ I do not get dressed, wash with difficulty, and stay in bed.

03. Lifting *(Mark only one)*

- ◯ I can lift heavy weights without increased pain.
- ◯ I can lift heavy weights, but it causes increased pain.
- ◯ Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (e.g., on a table).
- ◯ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ◯ I can lift only very light weights.
- ◯ I cannot lift or carry anything at all.

04. Walking *(Mark only one)*

- ◯ Pain does not prevent me from walking any distance.
- ◯ Pain prevents me from walking more than 1 mile. (1 mile = 1.6 km)
- ◯ Pain prevents me from walking more than 1/2 mile.
- ◯ Pain prevents me from walking more than 1/4 mile.
- I can only walk with crutches or a cane.
- ◯ I am in bed most of the time and have to crawl to the toilet.

05. Sitting *(Mark only one)*

- ◯ I can sit in any chair as long as I like.
- ◯ I can only sit in my favorite chair as long as I like.
- ◯ Pain prevents me from sitting for more than 1 hour.
- ◯ Pain prevents me from sitting for more than 1/2 hour.
- ◯ Pain prevents me from sitting for more than 10 minutes.
- ◯ Pain prevents me from sitting at all.

06. Standing *(Mark only one)*

- ◯ I can stand as long as I want without increased pain.
- ◯ I can stand as long as I want, but it increases my pain.
- ◯ Pain prevents me from standing more than 1 hour.
- ◯ Pain prevents me from standing more than 1/2 hour.
- ◯ Pain prevents me from standing more than 10 minutes.
- ◯ Pain prevents me from standing at all.

Please continue on next page

07. Sleeping *(Mark only one)*

◯Pain does not prevent me from sleeping well. ◯

I can sleep well only by using pain medication.

◯Even when I take pain medication, I sleep less than 6 hours.

◯Even when I take pain medication, I sleep less than 4 hours.

◯Even when I take pain medication, I sleep less than 2 hours.

◯Pain prevents me from sleeping at all.

08. Social Life *(Mark only one)*

◯My social life is normal and does not increase my pain.

◯My social life is normal, but increases my level of pain.

◯Pain prevents me from participating in more energetic activities (e.g., sports, dancing).

◯Pain prevents me from going out very often.

◯Pain has restricted my social life to my home.

◯I have hardly any social life because of my pain.

09. Traveling (*Mark only one)*

◯I can travel anywhere without increased pain.

◯I can travel anywhere, but it increases my pain.

◯My pain restricts my travel over 2 hours.

◯My pain restricts my travel over 1 hour.

◯My pain restricts my travel to short necessary journeys under 1/2 hour.

◯My pain prevents all travel except for visits to the physician/therapist or hospital.

10. Employment/Homemaking *(Mark only one)*

◯My normal homemaking/job activities do not cause pain.

◯My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.

◯I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (e.g., lifting, vacuuming).

◯Pain prevents me from doing anything but light duties.

◯Pain prevents me from doing even light duties.

◯Pain prevents me from performing any job or homemaking chores.

VAS Pain Scales

11. On a scale from 0 to 10, mark the intensity of your <u>back pain</u> during the past week, with 0 being 'None' and 10 being 'Unbearable pain'. *(Mark only one)*

0 1 2 3 4 5 6 7 8 9 10

None ◯-◯-◯-◯-◯-◯-◯-◯-◯-◯-◯ Unbearable

12. On a scale from 0 to 10, mark the intensity of your <u>left leg pain</u> during the past week, with 0 being 'None' and 10 being 'Unbearable pain'. *(Mark only one)*

0 1 2 3 4 5 6 7 8 9 10

None ◯-◯-◯-◯-◯-◯-◯-◯-◯-◯-◯ Unbearable

13. On a scale from 0 to 10, mark the intensity of your <u>right leg pain</u> during the past week, with 0 being 'None' and 10 being 'Unbearable pain'. *(Mark only one)*

0 1 2 3 4 5 6 7 8 9 10

None ◯-◯-◯-◯-◯-◯-◯-◯-◯-◯-◯ Unbearable