Patient Registration Form PLEASE PRINT

PATIENT INFORMATION

Last Name: _____ First Name: _____ M. Initial:

DOB: _____ Sex: ☐ Female ☐ Male Social Security Number: _____ - _____ - _____

Marital Status: S M D W email: _____

Address: _____ City: _____ State: Zip: _____

Race: _____ Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Refused to Report English Speaking: Y N

Home Phone: _____ Cell Phone: _____

EMPLOYER: _____ **WORK RELATED INJURY (circle): YES / NO**

PHARMACY NAME & PHONE NUMBER: _____

Who referred you to the office: _____ **Primary Care Physician:** _____

PARENT OR GUARDIAN INFORMATION *(Only fill out if the patient is under the age of 18)*

Last Name: _____ First Name: _____ M. Initial:

Address: _____

City: _____ State: _____ Zip: _____

DOB: _____ Social Security Number: _____ - _____ - _____

Home Phone: _____ Cell Phone: _____

EMERGENCY CONTACT INFORMATION (may also release medical information)

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

PRIMARY & SECONDARY INSURANCE INFORMATION *(ALL insurance)*

Insurance Plan Name: _____

POLICY HOLDER NAME *(if other than patient)*: _____

DOB: _____ Sex: ☐ Female ☐ Male Relationship to Patient: _____

HOW MAY WE CONTACT YOU REGARDING YOUR PROTECTED HEALTH INFORMATION (PHI)?

☐ No ☐ Yes: I may be contacted by e-mail at: _____

☐ No ☐ Yes: I may be contacted by phone at: _____

☐ No ☐ Yes: May we leave a message with your PHI at the number you have provided? ***(MUST BE ANSWERED)***

Would you like to receive text messages regarding your appointment, lab results, etc.?

☐ No ☐ Yes: What number? _____

DO YOU WANT ANYONE TO HAVE ACCESS TO YOUR PHI? IF SO, WHO? NAME:

_____

_____

In order to maintain an accurate and up-to date medical record, we request permission to query outside resources for a list of your medications. ☐ Yes ☐ No

Signature: _____ **Date:** _____

Relationship to Patient (if minor): _____

DUBE Orthopedics Physical Therapy
AdvancedHEALTH

PATIENT MEDICAL HISTORY FORM

Date:_____

Name: _____ DOB: _____ Age: _____ Height: _____ Weight: _____

Date of Injury or onset of problem: _____If an injury, where did it take place? (circle) Home / School / Work / Other

Are you in Pain Management? ☐ Yes ☐ No If YES, where? _____ Phone

CURRENT or CHIEF PROBLEM

Area of body to be examined:_____ Which side? Left Right

What is your pain level today (circle one): 1 2 3 4 5 6 7 8 9 10 Did this injury occur during a fall? Y N

How does it affect you, i.e. Swelling Bruising Numbness Weakness ECT? _____

When does it affect you most and how long does it last? _____

Type of pain: SHARP_____ DULL_____ THROBBING_____ STABBING_____ BURNING_____ RADIATING_____

INFECTION HISTORY

*Circle if you currently have or have had:

Hepatitis	HIV/AIDS	MRSA	Bone/Joint Infection	Surgical Site Infection
Yes No	Yes No	Yes No	Yes No	Yes No

Have you had the following vaccinations?: Tetanus/T-Dap ____ Flu ____ Hepatitis B ____ Pneumonia ____

CHRONIC ILLNESSES

*Circle if you currently have or have had:

Diabetes	CABG/Heart Bypass	Pulmonary Embolus	Blood Transfusion
Hypertension/HBP	Pacemaker/Defibrillator	Blood Clots/DVT	Cancer
Heart Disease/MI/Cardiac	Emphysema/COPD	Sleep Apnea (CPAP)	Reflux/Ulcer
Stents	Asthma/Bronchitis	Anemia	Seizures
Heart Arrhythmia			
	Other:		

REVIEW OF SYSTEMS

* Please circle all symptoms which are significantly affecting you today:

MUSCULOSKELETAL	**RESPIRATORY**	**EARS, NOSE & THROAT**	**RENAL**
Joint Pain	Shortness of Breath	Corrective Lenses	Difficult/Painful Urination
Joint Swelling	Wheezing	Blurred/Double Vision	Frequency
Joint Stiffness	Cough	Eye Pain	Urgency
Muscle Pain		Headache	Incontinence
Instability	**GASTROINTESTINAL**	Difficulty Swallowing	
	Heartburn	Nose Bleeds	**GENERAL**
NEUROLOGIC	Nausea	Earaches	Unexpected Weight Loss
Numbness/ Tingling	Vomiting		Unexpected Weight Gain
Dizziness	Constipation	**HEMATOLOGIC**	Fever
Nervousness	Diarrhea	Easy Bleeding	Chills
Anxiety		Easy Bruising	Fatigue
Seizures	**SKIN**		
Tremors	Skin Changes	**ENDOCRINE**	**CARDIOVASCULAR**
Balance Disturbances	Poor Healing	Excessive Thirst	Chest Pain
	Rash	Excessive Urination	Palpitations
	Itching	Heat or Cold Intolerance	Fainting

NOTES: _____

PREVIOUS OPERATIONS *Please list:

Type	Year	Reason
1.		
2.		
3.		
4.		

Have you ever had anesthesia complications? No Yes
Please describe if answered Yes:

Do you have a pain management contract? No Yes With which doctor or hospital?_____

I authorize the following people to pick up my prescription:_

Are you taking any Blood Thinning medications. i.e. Coumadin_____Warfarin_____Plavix_____Xarelto_____Effient_____ Pradaxa____Eliquis____Aspirin____Other:_____

CURRENT MEDICATIONS *if you are providing your own list, circle here: MY MED LIST

Medication / Vitamin / Herbal Supplement		Dose	How often?	What condition is the prescription
1.				
2.				
3.				
4.				

ALLERGIES: Medications, Solutions or Metal

Medication, Solution or Metal Name	Allergic Reaction
1.	
2.	
3.	
4.	

FAMILY HISTORY

PLEASE INDICATE WITH RELATIONSHIP (i.e. father): Do you know of any blood relatives who have or have had any of the following?

Cancer	Diabetes	Epilepsy
Heart Disease	High Blood Pressure	Psoriasis
Congenital Problems	Obesity	Asthma
Alcoholism	TB	Thyroid Problems
Rheumatic Fever	Rheumatoid Arthritis	Stroke
Other:		

SOCIAL HISTORY

Tobacco Use?
Snuff No_____ Yes
E-Cigarettes No____ Yes
Cigarettes: _____packs a day

Drug Use?
No_ No Yes
Meth No_ No Yes
Cocaine Yes
Marijuana Yes

Alcohol Use?
Do you drink No____ Yes____
Drinks per week_____

Do you have an Advance "Directive"?
No____ Yes____

Employment
Employer: _____ Occupation: _____ Unemployed Disabled Retired

General Consent For Treatment/ Medical Records Release

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/Legal Guardian:_____Date: _____

I, _____, DOB:_____, also authorize the release of my medical records to covered
(NAME) (BIRTHDATE)
entities and work place upon my written or verbal requests, and I hold ADI dba DUBE Orthopedics & PT harmless for any such release.

I hereby request and authorize:

ADI dba DUBE Orthopedics & PT
302 Old Lebanon Dirt Rd
Hermitage, Tennessee 37076

____To Disclose Information to: ____To Receive Information from:

Provider:_____
Adress:_____
City:_____
Phone Number: _____ Fax:_____

Information to be disclosed may include copies of: (please check all that apply)
____Clinical Records
____Hospital records
____X-ray reports
____Other

Patient or Legal Guardian Signature: _____ Date: _____
Witness Signature: _____ Date: _____

DUBE Orthopedics Physical Therapy
AdvancedHEALTH

Patient Financial Policy

This is an agreement between AdvancedHEALTH dba DUBE Orthopedics & PT, 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.

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. 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.

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.

_____Initials

Patient and/or Debtor Signature: _____Date _____/_____/_____

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

MOTOR VEHICLE ACCIDENTS (MVA's) – Yes, I was involved in a MVA on _____/ _____/ _____. In the event I do not provide insurance information before the 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: _____

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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.

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.

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: / /