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

Employer:_____ Phone:_____

Address:_____ City:_____ State:___ Zip:_____

Emergency Contact_____ Relationship:_____ Phone:_____

Insured's Full Name _____ Date of Birth: _____

Address: _____ City:_____ State: __ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Insured's ID: _____ Relationship to Patient: _____

Employer Name:_____

Insurance Company Name: _____ Group Number: _____

Insurance Company Phone Number _____

Insurance Company Address: _____

Is this visit Workers Compensation? Yes No Is this visit Auto Accident? 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, Brain & 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, interest or added expense for my failure to pay any balance due.

Patient/Insured Signature: _____ Date: _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT INFORMATION

Last name:	First name:	SSN:	Date of birth:

AUTHORIZATION INFORMATION

I request and authorize Southeastern Spine, Brain & Joint as noted below from my medical records to: ☐ request ☐ release the information

☐ Medical Provider ☐ Parent/Guardian ☐ Myself ☐ Other_____

Entity:	Address: _____

Phone:	Fax:	Email:

☐ Fax to number above ☐ Mail to address above ☐ Email to address above ☐ Picked up by patient

INFORMATION TO BE RELEASED (select one)

☐ All medical records to include all chart entries, diagnostics, test results and reports

☐ All records related to visits on the following date(s)_____

☐ All records related to the following diagnosis/symptoms_____

☐ All medical records **EXCEPT**_____

☐ Test results only from the following date(s)_____

☐ Other _____

I authorize and request for my sole benefit the release of medical information which is part of my file at Southeastern Spine, Brain & Joint. This does not constitute blanket permissions for release of such information for an infinite period of time, but is limited to this instance only.

I agree that a copy of this release, electronic or faxed submission of this release shall be valid as this original release. I understand that if I authorized Southeastern Spine, Brain & Joint to fax or email the information, that there are inherent privacy risks with these methods.

_____ _____

Patient signature Date

FOR OFFICE USE ONLY

Copied: Initial _____ Date:_____ SENT: Mailed Picked-up Faxed Emailed

Initial:_____ Date:_____

Disclosure of Protected Health Information

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, Brain & 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, Brain, & 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, Brain, & 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, Brain, 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, Brain & Joint, PLLC 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, Brain & Joint, PLLC 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, Brain & 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, Brain & 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_____

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, Brain & 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

Oswestry Disability Index (ODI) version 2.1a

This questionnaire is designed to give us information as to how your back (or leg) trouble affects your ability to manage in everyday life.

Please answer every section. Mark one box only in each section that most closely describes you today.

Section 1 - Pain intensity

- (0) I have no pain at the moment.
- (1) The pain is very mild at the moment.
- (2) The pain is moderate at the moment.
- (3) The pain is fairly severe at the moment.
- (4) The pain is very severe at the moment.
- (5) The pain is the worst imaginable at the moment.

Section 2 - Personal care (washing, dressing, etc.)

- (0) I can look after myself normally without causing extra pain.
- (1) I can look after myself normally but it is very painful.
- (2) It is painful to look after myself and I am slow and careful.
- (3) I need some help but manage most of my personal care.
- (4) I need help every day in most aspects of self-care.
- (5) I do not get dressed, wash with difficulty and stay in bed.

Section 3 - Lifting

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

Section 4 - Walking

- (0) Pain does not prevent me walking any distance.
- (1) Pain prevents me walking more than one mile.
- (2) Pain prevents me walking more than a quarter of a mile.
- (3) Pain prevents me walking more than 100 yards.
- (4) I can only walk using a stick or crutches.
- (5) I am in bed most of the time and have to crawl to the toilet.

Section 5 - Sitting

- (0) I can sit in any chair as long as I like.
- (1) I can sit in my favorite chair as long as I like.
- (2) Pain prevents me from sitting for more than 1 hour.
- (3) Pain prevents me from sitting for more than half an hour.
- (4) Pain prevents me from sitting for more than 10 minutes.
- (5) Pain prevents me from sitting at all.

Section 6 - Standing

- (0) I can stand as long as I want without extra pain.
- (1) I can stand as long as I want but it gives me extra pain.
- (2) Pain prevents me from standing for more than 1 hour.
- (3) Pain prevents me from standing for more than half an hour.
- (4) Pain prevents me from standing for more than 10 minutes.
- (5) Pain prevents me from standing at all.

Section 7 - Sleeping

- (0) My sleep is never disturbed by pain.
- (1) My sleep is occasionally disturbed by pain.
- (2) Because of pain I have less than 6 hours sleep.
- (3) Because of pain I have less than 4 hours sleep.
- (4) Because of pain I have less than 2 hours sleep.
- (5) Pain prevents me from sleeping at all.

Section 8 - Sex life (if applicable)

- (0) My sex life is normal and causes no extra pain.
- (1) My sex life is normal but causes some extra pain.
- (2) My sex life is nearly normal but is very painful.
- (3) My sex life is severely restricted by pain.
- (4) My sex life is nearly absent because of pain.
- (5) Pain prevents any sex life at all.

Section 9 - Social life

- (0) My social life is normal and causes me no extra pain.
- (1) My social life is normal but increases the degree of pain.
- (2) Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. sport, etc.
- (3) Pain has restricted my social life and I do not go out as often.
- (4) Pain has restricted social life to my home.
- (5) I have no social life because of pain.

Section 10 - Travelling

- (0) I can travel anywhere without pain.
- (1) I can travel anywhere but it gives extra pain.
- (2) Pain is bad but I manage journeys over two hours.
- (3) Pain restricts me to journeys of less than one hour.
- (4) Pain restricts me to short necessary journeys under 30 minutes.
- (5) Pain prevents me from travelling except to receive treatment

Total Score=

Your ODI = %

ODI % = Total score/5 x Number of questions answered x 100

HOOS, JR. HIP SURVEY

INSTRUCTIONS: This survey asks for your view about your hip. This information will help us keep track of how you feel about your hip and how well you are able to do your usual activities.
Answer every question by ticking the appropriate box, only one box for each question. If you are unsure about how to answer a question, please give the best answer you can.

Pain
What amount of hip pain have you experienced the **last week** during the following activities?

1. Going up or down stairs

None	Mild	Moderate	Severe	Extreme
☐	☐	☐	☐	☐

2. Walking on an uneven surface

None	Mild	Moderate	Severe	Extreme
☐	☐	☐	☐	☐

Function, daily living
The following questions concern your physical function. By this we mean your ability to move around and to look after yourself. For each of the following activities please indicate the degree of difficulty you have experienced in the **last week** due to your hip.

3. Rising from sitting

None	Mild	Moderate	Severe	Extreme
☐	☐	☐	☐	☐

4. Bending to floor/pick up an object

None	Mild	Moderate	Severe	Extreme
☐	☐	☐	☐	☐

5. Lying in bed (turning over, maintaining hip position)

None	Mild	Moderate	Severe	Extreme
☐	☐	☐	☐	☐

6. Sitting

None	Mild	Moderate	Severe	Extreme
☐	☐	☐	☐	☐

KOOS, JR. KNEE SURVEY

INSTRUCTIONS: This survey asks for your view about your knee. This information will help us keep track of how you feel about your knee and how well you are able to do your usual activities.
Answer every question by ticking the appropriate box, only one box for each question. If you are unsure about how to answer a question, please give the best answer you can.

Stiffness
The following question concerns the amount of joint stiffness you have experienced during the **last week** in your knee. Stiffness is a sensation of restriction or slowness in the ease with which you move your knee joint.

1. How severe is your knee stiffness after first wakening in the morning?

None	Mild	Moderate	Severe	Extreme
☐	☐	☐	☐	☐

Pain
What amount of knee pain have you experienced the **last week** during the following activities?

2. Twisting/pivoting on your knee

None	Mild	Moderate	Severe	Extreme
☐	☐	☐	☐	☐

3. Straightening knee fully

None	Mild	Moderate	Severe	Extreme
☐	☐	☐	☐	☐

4. Going up or down stairs

None	Mild	Moderate	Severe	Extreme
☐	☐	☐	☐	☐

5. Standing upright

None	Mild	Moderate	Severe	Extreme
☐	☐	☐	☐	☐

Function, daily living
The following questions concern your physical function. By this we mean your ability to move around and to look after yourself. For each of the following activities please indicate the degree of difficulty you have experienced in the **last week** due to your knee.

6. Rising from sitting

None	Mild	Moderate	Severe	Extreme
☐	☐	☐	☐	☐

7. Bending to floor/pick up an object

None	Mild	Moderate	Severe	Extreme
☐	☐	☐	☐	☐

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 Brain 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 Brain 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 our Front Office Manager at 423-693-2175.

_____

Patient Signature