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: _______________________________________

Home Phone #: ______________________ Cell Phone #: _______________________ E-Mail __________________________

Employer: ____ Work Phone#: ________________________ Ext _________

Family Physician/Provider: _________________________________ Phone# ____________________________________

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: _____________

HIPAA CONSENT/EMERGENCY CONTACTS

We have a policy to always protect 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.) This list will be used for HIPAA and Emergency Contacts.

Name: _______________________________________ **Relation** _______________________ **Phone** ____________________________

Name: _______________________________________ **Relation** _______________________ **Phone** ____________________________

Name: _______________________________________ **Relation** _______________________ **Phone** ____________________________

We are required by the Omnibus HIPAA final ruling to provide all new patients access to our 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 and certify all above information is correct.**

Signature: ____ ***Date:*** ________________________________

PATIENT NAME: ____ **DOB:**______________________________

AUTHORIZATION AND FINANCIAL AGREEMENT

AUTHORIZATION AND RELEASE OF INFORMATION: I hereby authorize TN 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, data collection CSMD, 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, exercise tubing, walkers, finger splints, shoe inserts, slings, etc. as luxury items or non-covered services. 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 TN 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.

COLLECTIONS: In the event I do not pay my account in full all previously adjusted or allowed discounts for private pay will be added back and account will be turned over to collections. To the extent permitted by law, you agree to pay all court costs and collection expenses incurred by us in the collection of any amount you owe us under [this Agreement]. If you default and we refer your account for collection to an attorney who is not our salaried employee, you agree to pay the lesser of 1) attorney's fees of 33 1/3 % of the amount owed or 2) the attorney's fees in the amount customarily awarded by Sessions Court for the county where the suit is filed. *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.

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 and/or referral. Failure of either by patient may render patient responsible for ALL expenses associated with any visit.

**Signature:* ____ *Date:* ______________________________