HIPAA Compliance Patient Consent Form and Medical Release

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, you authorize/consent to the release of medical information/records to be sent to or released from ETCOE or Joseph Creazzo, Jr.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.
- The practice may phone, or leave a message to you to confirm appointments and any medical correspondence needed.

This consent was signed by: _____

(PLEASE PRINT)

Signature: _____ DATE: _____

Witness: _____ DATE: _____

Demographics

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone-Home: _____ Cell: _____ Work: _____

Date of Birth: _____/_____/_____

MARITAL STATUS: SINGLE / MARRIED / WIDOWED / DIVORCED

Social Security: _____

Primary Care Physician: _____ Referred By: _____

Emergency Contact: _____Phone Number: _____

Patient Employment

___ Employed ___ Retired ___ Other_____

Employer: _____ Phone Number: _____

Financial Information

Responsible for Account: _____ SSN: _____

Relationship: _____ Address: _____

Phone: _____ Employer: _____ Phone: _____

I UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR ANY PAYMENT NOT MADE BY MY INSURANCE COMPANY.

I hereby certify that the above information is true and accurate to the best of my ability.

Responsible Party Signature: _____ Date: _____

Responsible Party: _____ (Printed)

I understand that as part of ETCOE's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax or e-mail. **I fully understand and accept /decline the terms of this consent.**

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Other_____

[ ] Information is not to be released to anyone.

Patient Signature: _____ **Date:** ____/_____/_____

center for ORTHOPAEDIC excellence

ORTHOPEDIC HISTORY

Circle any that apply.

Ankle Fracture
Ankylosing Spondylitis
Bursitis
DISH
Epidural Injections, Spine
Fracture
Gout
Hip Fracture
HNP, Cervical
HNP, Lumbar
Metastatic Bone Disease
Osteoarthritis
Osteopenia
Osteoporosis
Primary Bone Sarcoma
Psoriatic Arthritis
Rheumatoid Arthritis
Rickets
RSD
Sciatica
Scoliosis
Spine Fracture
Soft Tissue Sarcoma
Spinal Stenosis, Cervical
Spinal Stenosis, Lumbar
Vertebral Compression Fracture
Vitamin D Deficiency
Wrist Fracture
None
Other_____

PEDIATRIC HISTORY

Breech Position
Cerebral Palsy
Flatfeet (Pes Planovalgus)
Genu Valgum (knocked knees)
Genu Varum (bow legs)
Hip Dysplasia
Neonatal Sepsis
Pavlik Harness as Infant
Spina Bifida
Spondylolisthesis
None
Other_____

Allergies:

(Please list known allergies)

☐ None

☐ I brought a list of my allergies

_____

_____

ORTHOPEDIC SURGERY HISTORY

Circle any that apply

Ankle Fracture ORIF: Left
Ankle Fracture ORIF: Right
Carpal Tunnel Decompression: Left
Carpal Tunnel Decompression: Right
Cervical Spine Surgery: ACDF
Distal Radius ORIF: Left
Distal Radius ORIF: Right
IMN Femur: Left (rod in thigh bone)
IMN Femur: Right (rod in thigh bone)
IMN Tibia: Left (rod in shin bone)
IMN Tibia: Right (rod in shin bone)
Joint Replacement: **Hip** (Left)
Joint Replacement: **Hip** (Right)
Joint Replacement: **Knee** (Left)
Joint Replacement: **Knee** (Right)
Joint Replacement: **Shoulder** (Left)
Joint Replacement: **Shoulder** (Right)
Knee Arthroscopy: Left
Knee Arthroscopy: Right
Kyphoplasty/Vertebroplasty
Lumbar Spine Decompression
Lumbar Spine Fusion
Lumbar Spine Disc Replacement
Rotator Cuff Repair: Left
Rotator Cuff Repair: Right
None
Other_____

Medications:

(Please list all current medications)

☐ None

☐ I brought a list of my medications

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Allergy reaction

_____

_____

SOCIAL HISTORY DETAILS

Smoking Status

- Current every day smoker
- Former smoker
- Never smoked
- Quit Smoking ____/____/____ (MM/DD/YYYY)
- Packs per day?_____
- Total years smoking_____yrs

Drug use

- Drug use? **YES / NO**
- IV Drug Use? **YES / NO**

Drinking Status (drink alcohol)

- none
- less than 1 drink per day
- 1-2 drinks per day
- 3 or more drinks per day

How often do you exercise?

- Several times a day
- Once a day
- A few times a week
- A few times a month
- Never

What is your caffeine use?

- Several times a day
- Once a day
- A few times a week
- A few times a month
- Never

Family History:

circle all that apply

Diabetes

Mother Father Sister Brother Daughter Son

Hypertension

Mother Father Sister Brother Daughter Son

Osteoarthritis

Mother Father Sister Brother Daughter Son

Rheumatoid Arthritis

Mother Father Sister Brother Daughter Son

NAME_____ DATE_____ _____

PAST MEDICAL HISTORY

CIRCLE any that apply

Anemia, Chronic
Asthma
Atrial fibrillation
Breast Cancer
Chronic Pain
Colon Cancer
COPD
Coronary Artery Disease
Diabetes, Insulin Dependent
Diabetes, Non Insulin Dependent
End Stage Renal Disease
GERD (reflux)
Hepatitis
HIV / AIDS
Hypercholesterolemia
Hyperparathyroidism
Hypertension (high blood pressure)
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Multiple Myeloma
BPH (enlarged prostate)
Prostate Cancer
Radiation Therapy
Seizures
Stroke
Diabetic ulcers
None
Other_____

ALERTS

CIRCLE any that apply

allergic to metal
allergy to latex
allergy to adhesive
allergy to shellfish/iodine
cardiac stents
blood thinners
pacemaker
defibrillator
diabetes
glaucoma
rheumatoid arthritis
Psoriasis
RSD
under pain management
pregnant or planning pregnancy
Hepatitis C
DVT (blood clots)
MRSA infection

PAST SURGICAL HISTORY

CIRCLE any that apply

Appendix (Appendectomy)
Breast : Lumpectomy (Left Breast)
Breast : Lumpectomy (Right Breast)
Breast : Mastectomy (Left Breast)
Breast : Mastectomy (Right Breast)
Colon Cancer Resection
Colon (Colectomy) : Diverticulitis
Colon: Inflammatory Bowel Disease
Gallbladder (Cholecystectomy)
Heart : Biological Valve Replacement
Heart : Coronary Artery Bypass
Heart : Heart Transplant
Heart : Valve Replacement
Heart : PTCA
Kidney : Kidney Stone Removal
Kidney : Kidney Transplant
Liver: Hepatectomy
Liver: Liver Transplant
Liver: Shunt
Ovaries: Tubal Ligation
Prostate Cancer
Prostate (Prostatectomy) : TURP
Rectum: APR
Rectum: Low Anterior Resection
Skin : Basal Cell Carcinoma
Skin : Melanoma
Uterus Hysterectomy
Uterine Cancer
Uterus Cervical Cancer
Foot surgery
None
Other_____

Ebola Risk:

- Fever >= 100.4 (F) / 38.0 (C)
- Resided or Traveled To Country with wide-spread Ebola transmission in the last 21 days
- Contact with an Ebola Patient without proper protective equipment in the last 21 days
- Headaches, weakness, muscle pain, vomiting, diarrhea, abdominal pain, and/or hemorrhage

Primary care provider

_____

Preferred pharmacy:

_____

Pharmacy Address:

_____

REVIEW OF SYSTEMS

CIRCLE any that apply

- joint pains
- joint swelling
- joint stiffness
- unsteady gait
- numbness
- tingling
- dizziness
- headaches
- tremors
- fatigue
- unexpected weight loss
- weight gain
- fever
- chills
- poor healing wounds
- redness
- rash
- itching
- easy bleeding
- easy bruising
- enlarged lymph nodes
- immunosuppression
- chest pain
- palpitations
- fainting
- heart murmur
- leg cramps
- excessive thirst or urination
- heat/cold intolerance
- nose bleeds
- ringing in ears
- hoarseness
- corrective lenses
- blurred vision
- heartburn
- nausea/vomiting
- constipation
- diarrhea
- bloody/tarry stools
- frequent urination
- difficult/painful urination
- urinary incontinence
- blood in urine
- shortness of breath
- wheezing
- cough
- hurts to breath
- nervousness
- anxiety
- depression

Thank you for choosing East TN Center for Orthopaedic Excellence. We strive to make your experience as pleasant as possible. We will make all attempts to bill your insurance company. Please review the information below and contact your insurance company for specific coverage details and your financial responsibilities. Please contact us with any questions or concerns regarding your treatment or billing.

Patient Consent and Agreement to Pay Form

I acknowledge that every billing effort will be made to my insurer for the reimbursement of services and in the event of insurance denial to pay I agree to be responsible for the full amount of the billed charges or the remaining balance after my insurer has paid. I understand that billing is done automatically through East TN Center for Orthopaedic Excellences' Practice management system and will be turned to collections if not paid in full, which will result in additional charges for the patient.

Insurance Authorization: I request that the payment of authorized benefits be made to East TN Center for Orthopaedic Excellence on my behalf, for any services provided to me. I authorize any holder of medical and other information about me to release to any insurance company responsible of paying such benefits; any information needed to determine these benefits for related services.

I give valid consent of the release of all medical record documentation to any insurance company for determination of reimbursement for the treatment procedure. I also authorize all benefit information pertaining to my insurance be released to help in the reimbursement process. My consent is valid for whatever time frame necessary until further notice

I have read, understand and have a copy of the Consent and Agreement to Pay Form and accept all terms listed above.

Patient or Legal Guardian Signature: _____

Patient Evaluation

Name: _____ **Date:** _____

Primary Care Provider _____

What are you being seen for today? What hurts you? RIGHT or LEFT? _____

Is your pain getting WORSE / NO CHANGE / BETTER? **How long has this hurt you?** _____

Please Explain _____

_____

_____

Have you had x-rays for this problem? _____

Where and when? _____

What is your pain level today?	1	2	3	4	5	6	7	8	9	10
What is your pain level on a bad day?	1	2	3	4	5	6	7	8	9	10
What is your pain level on a good day	1	2	3	4	5	6	7	8	9	10

How would you describe your pain? Aching / Deep / Throbbing / Sharp / Comes and goes / 24 – 7 / Numbness and tingling / Burning / swelling

What medications are you taking for this problem?

Tylenol (acetaminophen)	Celebrex (celecoxib)	Nabumetone (Relafen)	Meloxicam (Mobic)	Diflunisal (dolobid)
Ibuprofen (advil, motrin)	Indomethacin (Indocin)	Oxaprozin (Daypro)	Salsalate	Ketoprofen (orudis)
Diclofenac sodium (cataflam)	Voltaren, Arthrotec)	Etodolac (lodine)	Sulindac (clinoril)	Piroxicam (Feldene)
Naproxen (Naprosyn / aleve)	NARCOTICS			

Have you had injections of steroid (cortisone)? Yes / No **How many?**_____ **Did it help?** Yes / No

Have you had gel injections (synvisc, Rooster comb)? Yes / No **How many?**_____ **Did it help?** Yes / No

Have you had physical therapy? Yes / No **Where?**_____ **Did it help?** Yes / No

Does your pain...

Limit your daily activities?	Yes / No	**Affect your lifestyle?**	Yes / No	**swelling?**	Yes / No
Disturb your sleep?	Yes / No	**Prevent you from exercising?**	Yes / No	**Limping?**	Yes / No
Affect your ability to work?	Yes / No	**Have you tried to lose weight?**	Yes / No	**Difficulty with lifting?**	Yes / No
Difficulty with stairs?	Yes / No	**Make walking painful?**	Yes / No		

Have you had surgery for this problem? Yes or No. **Are You Glad You Had The Surgery?** Yes / No

Percent Improvement since Surgery: 0 10 20 30 40 50 60 70 80 90 100

If not satisfied, why not? _____

_____

Circle any that apply

- joint pains
- joint swelling
- joint stiffness
- unsteady gait
- numbness
- tingling
- dizziness
- headaches
- tremors