Patient Consent

I, (printed name)_____understand that as part of my healthcare, **Southern Bone & Joint Specialists (SBJS)** originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I confirm I have received a copy of the SBJS ***Notice of Privacy Practices*** and that it is available at each of our locations and our website www.southernbone.com. The ***Notice of Privacy Practices*** provides a more complete description of information uses and disclosures. **SBJS** complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Medication Protocol for Patients of SBJS: In an attempt to provide the best possible care for our patient, the following protocol for prescribing medication has been established. It is important that you read and understand these policies.

1. Your physician will not prescribe pain medication for chronic pain or pain lasting three months or longer.
2. Post-operative medication will be decreased in 4-6 weeks during the post-op period and will slowly be completely eliminated.
3. Pain medications will not be called in and/or written after business hours, on weekends or holidays.
4. Our staff will be given 24 hours to call in your prescriptions.
5. If you are experiencing pain lasting for more than three months, you will be referred to pain management.
6. Due to recent DEA policy changes, Hydrocodone prescriptions can no longer be called in or sent electronically to pharmacies. All prescriptions for any type of Hydrocodone medication (Hydrocodone, Lortab, Norco, Vicodin, etc.) must now be printed and signed by a physician and picked up at our office (photo ID required).
7. We are not responsible for written prescriptions lost in the mail and will not be able to replace/refill the prescription until the appropriate time (expiration of the previous prescription).
8. In order to continue receiving prescriptions for pain medications, you must keep scheduled follow-up appointments.

Please list below the names of any individuals who we may disclose any medical and/or account billing information on your behalf. These people will be allowed to act as your **Personal Representative**. Please identify anyone you authorize to pick up prescriptions for you.

Name	Relationship	Authorized to pick-up Prescriptions
_____	_____	❒
_____	_____	❒
_____	_____	❒

RELEASE, ASSIGNMENT, AUTHORIZATION FOR TREATMENT AND FINANCIAL AGREEMENT: I authorize release of my medical and financial records to my referring physician, my parent or guardian, my employer if the injury is job-related, school officials if injury is school related, insurance companies, third party administrators or payor, or government agencies or their agents who may be responsible for payment. I certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I understand that certain services/procedures may not be covered by my insurance carrier. I agree to be financially liable for any payments not covered by my insurance. I understand that if my account becomes delinquent it will be placed with a collection agency. Further, I agree to the following terms regarding any outstanding balance that I owe: (1) I will incur interest at the rate of 1 and ½ percent per month(18% PER ANNUM) (2) I agree and hereby consent that I will be responsible for reasonable collection costs, attorney's fees and costs of court incurred by this office in the collection of same, whether such outstanding balance is satisfied prior to, after initiation of a lawsuit or after a judgment has been issued in a lawsuit; and (3) I agree and hereby consent that any lawsuit and/or legal proceeding surrounding the outstanding balance and debt, and fees and costs thereon, shall be initiated and litigated in the court of appropriate jurisdiction of Houston County, Alabama, and I hereby waive any and all defenses and/or objections to said jurisdiction and I waive all right to claim exemption. By signing below, I consent to the terms contained herein and affirmatively acknowledge that I have read the same before signing. Furthermore, I agree that if a cell phone number has been provided I can be contacted regarding my balance on said cell phone. Additionally, if I reside in Florida I agree to waive my right to any exemption that would prohibit a wage garnishment should same become necessary to secure payment of any outstanding balance. I also agree that at any time if my balance has not been paid according to policy I understand my credit history will be investigated and thoroughly reviewed. I consent to treatment as ordered by my physician and outlined in the treatment plan of care. I understand the risks and benefits of treatment and I understand that I can ask the treating staff at any time questions regarding the treatment.

_____ _____

Patient or Guardian's Signature **Date**

Patient Intake

Patient's Name _____
(Last) (Suffix) (First) (Middle Initial)

Address_____

City _____ ST _____ Zip Code _____ Home # ( )_____

Cell # ( ) _____ Employer/School_____ Work # ( )_____

Preferred Method of Contact ❒ Cell Phone ❒ Home Phone

Preferred Method for Appointment Reminders ❒ Phone ❒ Text ❒ Email_____

Date of Birth_____ Social Security Number_____

Gender ❒ Male ❒ Female Marital Status ❒ Single ❒ Married ❒ Widow ❒ Divorced

Race ❒ American Indian ❒ Asian ❒ Black/African American ❒ White ❒ Decline

Ethnicity ❒ Central American ❒ Cuban ❒ Dominican ❒ Hispanic or Latino/Spanish American ❒ Spaniard
❒ Latin American/Latin, Latino ❒ Mexican ❒ Not Hispanic or Latino ❒ Puerto Rican ❒ South American ❒ Decline

Preferred Language ❒ English ❒ Spanish ❒ Other _____

Is this problem due to an accident? ❒ Yes ❒ No If Yes, please list date of accident: _____

Accident occurred in State of _____ Type of Accident ❒On-the-Job ❒ Auto ❒ Home ❒ Other_____

Were you referred to SBJS? ❒ Yes ❒ No If Yes, who referred you? _____

INSURANCE INFORMATION - Specialty Physician Co-Pay $_____

Primary Insurance _____
Contract #_____
Policyholders Name _____
Relationship to Patient _____
DOB _____ SS# _____

Secondary Insurance _____
Contract #_____
Policyholders Name _____
Relationship to Patient _____
DOB _____ SS# _____

PHARMACY PREFERENCE

Name _____ Location_____ Phone # _____

RESPONSIBLE PARTY INFORMATION

Name of Father/Guardian _____
Date of Birth_____
Address_____
City_____ ST_____ Zip_____
Social Security # _____
Cell # _____
Employer _____
Work # _____

Name of Mother/Guardian _____
Date of Birth_____
Address_____
City _____ ST_____ Zip_____
Social Security # _____
Cell # _____
Employer _____
Work # _____

EMERGENCY CONTACT INFORMATION

Emergency Contact_____Relationship_____ Phone ( )_____

_____ _____
Patient Signature Date

Medical Questionnaire

Patient Name (Print):_____Date:_____

Age: _____ Sex: ❒ F ❒ M Height: _____/_____ Weight: _____ Dominant Hand: ❒ R ❒ L

Who referred you to our office? (Name) _____ ❒ MD ❒ Employer ❒ Self-Referral

Who is your Primary Care Physician? _____

Are you under a pain management contract? ❒ Y ❒ N If Yes, who is your physician? _____

What body part is the reason for your visit? Please mark below:

Neck and radiates to ❒ R Arm ❒ L Arm ❒ Neither						**Back** and radiates to ❒ R Leg ❒ L Leg ❒ Neither					
Shoulder	❒ R ❒ L	**Arm**	❒ R ❒ L	**Elbow**	❒ R ❒ L	**Wrist**	❒ R ❒ L	**Hand**	❒ R ❒ L	**Finger** T 2 3 4 5	❒ R ❒ L
Pelvis	❒ R ❒ L	**Hip**	❒ R ❒ L	**Knee**	❒ R ❒ L	**Ankle**	❒ R ❒ L	**Foot**	❒ R ❒ L	**Toe** B 2 3 4 5	❒ R ❒ L

How long have you had this problem? _____ Have you had this problem before? ❒ Y ❒ N

Check the **ONE box** which best describes how your problem started:

- ❒ Injury or Accident **NOT** related to Auto or Work _____
- ❒ Injury at Work Date:_____ _____
- ❒ Auto Accident Date:_____ Accident occurred in what state?_____
- ❒ No Injury; onset ❒ gradual or ❒ sudden _____

Pain

On a scale of 0 – 10 (10 is the worst), how severe is your pain? ❒1 ❒2 ❒3 ❒4 ❒5 ❒6 ❒7 ❒8 ❒9 ❒10

What is the quality of your pain? ❒ Sharp ❒ Dull ❒ Stabbing ❒ Throbbing ❒ Aching ❒ Burning

The pain is ❒ Constant ❒ Comes and goes Does your pain wake you from sleep? ❒ Yes ❒ No

Do you have? ❒ Swelling ❒ Bruising ❒ Numbness ❒ Tingling ❒ Weakness ❒ Loss of control bowels/bladder

Review of Symptoms:

Are you **currently** experiencing these symptoms?

GI ❒ Heartburn, ulcers ❒ Nausea, vomiting ❒ Blood in stool ❒ Hepatitis ❒ Liver disease
ENDO ❒ Thyroid disease ❒ Heat or Cold intolerance
CON ❒ Weight loss ❒ Frequent Fever ❒ Loss of appetite
EYE ❒ Blurred Vision ❒ Double Vision ❒ Vision loss
ENT ❒ Hearing Loss ❒ Hoarseness ❒ Trouble swallowing
CV ❒ Chest Pain ❒ Palpitations
RS ❒ Chronic Cough ❒ Shortness of Breath
CV ❒ Painful Urination ❒ Blood in Urine ❒ Kidney problems
SK ❒ Frequent Rashes ❒ Skin Ulcers ❒ Lumps ❒ Psoriasis
NEU ❒ Headaches ❒ Dizziness ❒ Seizures
PSY ❒ Depression ❒ Drug addiction ❒ Alcohol addiction ❒ Sleep disorder
HEM ❒ Easy bleeding ❒ Easy bruising ❒ Anemia

Page 2 Medical Questionnaire

Patient Name (Print):_____Date:_____

Tests/Scans – Have you had any tests or scans for this problem?

❒ X-rays ❒ MRI ❒ CAT scan ❒ Bone scan ❒ Nerve test (EMG) NVC

Facility where tests/scans were performed: _____

Medications

Are you **allergic** to any medications? ❒ Yes ❒ No If yes, please list and describe reaction:

Medication _____ Reaction _____

Medication _____ Reaction _____

Medication _____ Reaction _____

Have you ever had a reaction to anesthesia? ❒ Yes ❒ No

What medications do you take? Include over-the-counter, prescriptions and vitamins along with dosage.

_____

_____

_____

_____

_____

_____

Family History – Indicate **M** for Mother; **F** for Father; **S** for Sister, **B** for Brother

❒ No current problems/disabilities	_____	❒ Family history of Thyroid disorder	_____
❒ Arthritis	_____	❒ Gout	_____
❒ Asthma	_____	❒ Heart disease	_____
❒ Autoimmune disease	_____	❒ Mental health problem	_____
❒ Blood coagulation disorder	_____	❒ Obesity	_____
❒ Cerebrovascular accident	_____	❒ Osteoarthritis	_____
❒ Community acquired pneumonia	_____	❒ Osteoporosis	_____
❒ Dementia	_____	❒ Rheumatoid arthritis	_____
❒ Diabetes mellitus	_____	❒ Sudden cardiac death	_____
❒ Family history of cancer	_____		

Social History

Marital Status: ❒ Married ❒ Single ❒ Divorced ❒ Widowed ❒ Live alone ❒ Live with others

Occupation: _____ ❒ Student ❒ Retired

Exercise Level: ❒ None ❒ Occasional ❒ Moderate ❒ Heavy

Difficulty walking or climbing stairs? ❒ Yes ❒ No ❒ Sometimes

Smoking status: ❒ Never smoked ❒ Former smoker ❒ Current smoker

Chewing Tobacco: How much? _____

Years of use of any kind of tobacco? _____

Patient Name (Print):_____Date:_____

Surgical History – Please check **ALL** that apply:

- ❒ None
- ❒ Amputation
- ❒ Ankle or Foot Surgery
- ❒ Back Surgery
- ❒ Caesarean Section
- ❒ Cancer Surgery
- ❒ Carpal Tunnel Surgery
- ❒ Cubital Tunnel Release
- ❒ De Quervain's
- ❒ Elbow Surgery
- ❒ ENT or Sinus Surgery
- ❒ Fracture
- ❒ Gallbladder
- ❒ Gastric Bypass
- ❒ Gastrointestinal Surgery
- ❒ General Surgery
- ❒ Hand Surgery
- ❒ Hernia Repair
- ❒ Hysterectomy
- ❒ Joint Replacement
- ❒ Knee Surgery
- ❒ Neck Surgery
- ❒ Orthopedic Surgery
- ❒ Plastic Surgery
- ❒ Pacemaker/Defibrillator
- ❒ Shoulder Surgery
- ❒ Spine Surgery
- ❒ Stent
- ❒ Thyroid
- ❒ Tonsils/Adenoids

Other:_____

Past Medical History – Please check **ALL** that apply:

- ❒ AIDS/HIV
- ❒ Acid Reflux (GERD)
- ❒ Adrenal Disease
- ❒ Anemia
- ❒ Anesthesia Complications
- ❒ Aneurysm
- ❒ Anxiety/Depression
- ❒ Aortic Valve Disease
- ❒ Arthritis
- ❒ Artificial Joints
- ❒ Asthma
- ❒ Bleeding Disorder
- ❒ Blood Clot
- ❒ Brain Injury
- ❒ Bronchitis
- ❒ COPD
- ❒ Cancer
- ❒ Cerebral Palsy
- ❒ Chemotherapy
- ❒ Cirrhosis
- ❒ Congestive Heart Failure (CHF)
- ❒ Coronary Artery Disease
- ❒ Coumadin/Warfarin Therapy
- ❒ Dementia
- ❒ Diabetes
- ❒ Diabetes-Insulin
- ❒ Dialysis
- ❒ Diet Pills
- ❒ Emphysema
- ❒ Enlarged Heart
- ❒ Epilepsy/Seizures
- ❒ Gastrointestinal Disease
- ❒ Gout
- ❒ Head Injury/Concussion
- ❒ Headaches
- ❒ Heart Attack (MI)
- ❒ Heart Disease
- ❒ Heart Failure
- ❒ Heart Rhythm Changes
- ❒ Hepatitis
- ❒ Hernia
- ❒ High Blood Sugars
- ❒ Home Oxygen
- ❒ Hypertension
- ❒ Kidney Disease
- ❒ Kidney Stones
- ❒ Leg or Foot Ulcers
- ❒ Liver Disease
- ❒ Loose Teeth
- ❒ Lupus
- ❒ Lyme Disease
- ❒ MRSA
- ❒ Mitral Valve Disease
- ❒ Multiple Sclerosis
- ❒ Murmur
- ❒ Neuropathy
- ❒ Obstructive Sleep Apnea
- ❒ Oral Infections
- ❒ Osteoporosis
- ❒ Pacemaker
- ❒ Paralysis
- ❒ Peripheral Vascular Disease
- ❒ Plavix Therapy
- ❒ Pneumonia
- ❒ Pregnant
- ❒ Prodaxa Therapy
- ❒ Prostate Disease
- ❒ Pulmonary Embolism
- ❒ Radiation Treatments
- ❒ Recurrent Sinusitis
- ❒ Rheumatic Fever
- ❒ Rheumatoid Arthritis
- ❒ Sickle Cell Disease
- ❒ Sleep Apnea
- ❒ Stroke
- ❒ Thyroid Disease
- ❒ Tuberculosis
- ❒ Ulcers
- ❒ Urinary Problems

The information provided on this Medical Questionnaire is accurate to the best of my knowledge.

_____ _____

Signature Date

Southern Bone & Joint Specialists - Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location within the practice, and if such is maintained by the practice, on it's web site.

You have the right to authorize other use and disclosure - This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and obtain a copy your PHI - This means you may inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by professional, state, or federal guidelines.

You have the right to request a restriction of your PHI - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You may have the right to request an amendment to your protected health information - This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability - This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our office.

You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

f you have questions regarding your privacy rights, please feel free to contact our Privacy Manager.
Contact information is provided below under Privacy Complaints.

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office, for fund-raising activities, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices, and each such notice will include instructions for opting out.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Health Information Organization - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of the PHI, then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures - We are also permitted to use or disclose your PHI without your written authorization for the following purposes: as required by law; for public health activities; health oversight activities; in cases of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral directors; organ donation; criminal activity; military activity; national security; worker's compensation; when an inmate in a correctional facility; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying the Privacy Manager at:

Southern Bone & Joint Specialists Attn: Privacy Manager P.O. Box 729 Dothan, AL 36302 or 334-836-2255

We will not retaliate against you for filing a complaint.

Effective Date 08/05/2016 Publication Date 08/05/2016