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

SOUTHERN BONE & JOINT SPECIALISTS
*1500 ROSS CLARK CIRCLE DOTHAN, AL 36301
*345 HEALTHWEST DRIVE, DOTHAN, AL 36303
(334) 793-2663 / 1-800-460-2663 / FAX (334) 836-2248

INITIAL PATIENT QUESTIONNAIRE

Name: ____ Date:___________________________

Address: ______________________________________ History #:________________________

City:______________________ State:______ Zip: ______ Home Phone: _____________________

Sex:_____ Age:_____ Date of Birth ________________ Work Phone: _____________________

Height: __________ Weight:__________ Temp: __________ Blood Pressure:_________/ _______

Your Referring Physician's Name:___________________________ Physician's Phone:______________

Address: ____

Type of Practice (Internist, Surgeon, etc.):____

CHIEF COMPLAINT:

Do you have?	Yes	No
Neck pain	____	____
Shoulder pain	____	____
Arm pain	____	____
Upper back pain	____	____
Lower back pain	____	____
Hip/leg pain	____	____

Any other complaints____

If more than one area, which is worse? ____

How long have you had this problem?____

Did your symptoms follow an injury? ______ If yes; _____at work _____auto accident _____other

Describe:____

Circle your least and greatest pain levels over the past two weeks:

(None) 0---1---2---3---4---5---6---7---8---9---10 (Severe)

Describe your pain (check all that apply)

Constant ____ Deep____ Dull____ Sharp____ Intermittent____ Throbbing____

Stiffness____ Aching____ Shooting____ Cramping____ Burning____ Stabbing____

Is your pain worse (check one)

At night____ in the mornings____ at the end of the shift/day____

No difference between day and night____ on a wet/cloudy day____

Indicate which of the following activities increases (I) or decreases (D) your pain

When I first get out of bed	____	Standing	____
Getting up	____	Walking	____
Sitting	____	Bending back	____
Lying on my back/side	____	Lying on stomach	____
Leaning forwards	____	Coughing/Sneezing	____
Lifting/bending forwards	____	Twisting	____
Straining	____	Reaching over	____
Look up/turn head sideways	____	Washing/combing hair	____
Climbing stairs/walking up ramp	____	Going down stairs/ramp	____
Long car rides	____	Other_______________	____

Have you had neck/back symptoms before? Y___ N___

Have you ever had previous back or neck surgery? Y___ N___

If yes, describe:____

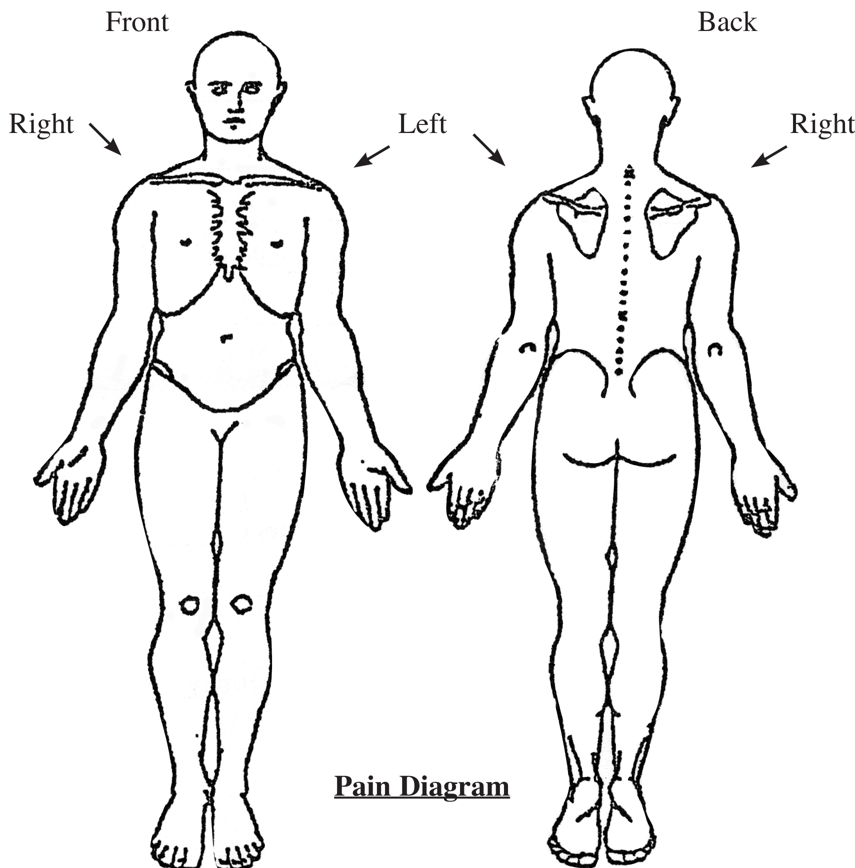
Have you had prior episodes of back symptoms for which you received Worker's Compensation?_______

Is the purpose of this exam to determine disability status for the government or an insurance agency? _____

Are you currently receiving any type of financial compensation for your back problem?________

Do you have an attorney for your back problem?_______

Mark in the areas of your body where you now feel your typical pain. Include all affected areas. Use the appropriate symbols indicated below: PAIN = XXXXXX NUMBNESS = OOOOOO



Pain Diagram

Please list previous radiology studies you have had for this problem.

	Date	Location
MRI		
CT Scan		
Myelogram		
Bone Scan		
EMG		
Xrays		

PREVIOUS TREATMENT:

Put a check next to each type of treatment you have had for your back/neck in the past. Then check the column that best describes the effect of the treatment.

Treatment	Check if you have had this	Did it make things Better	Worse	No change
Hot packs/ice	________	_____	_____	_____
Ultrasound	________	_____	_____	_____
Massage	________	_____	_____	_____
TENS/Electrical Stim	________	_____	_____	_____
Yoga/Tai-Chi	________	_____	_____	_____
Exercises	________	_____	_____	_____
Traction/DRS	________	_____	_____	_____
Bed Rest	________	_____	_____	_____
Pool therapy	________	_____	_____	_____
Biofeedback	________	_____	_____	_____
Injections	________	_____	_____	_____
Braces/Splints	________	_____	_____	_____
Medication	________	_____	_____	_____
Acupuncture	________	_____	_____	_____
Chiropractic Adjustments	________	_____	_____	_____

MEDICAL HISTORY:

Have you ever had:

____AIDS or HIV testing
____Asthma/Breathing problems
____Cancer
____Radiation/Chemotherapy
____Migraine or other severe head pain
____High Blood Pressure
____Chronic Fatigue Syndrome
____Phlebitis or blood clots
____Stroke
____Thyroid trouble
____Kidney Infections
____Heart Attack
____Diabetes
____Fibromyalgia
____Kidney Stones
____Arthritis
____Seizures
____Ulcer
____Tuberculosis
____Hepatitis
____Other: ___________

PAST SURGICAL HISTORY:

Year | Operation | Place Hospitalized

____

____

____

If you had previous back surgery;

What were your symptoms before the surgery? (indicate **R** for right side, **L** for left side, **B** for both sides and circle all that applies)

Neck pain____ Shoulder pain/numbness/weakness____
Arm pain/numbness/weakness____ Wrist/hand pain/numbness____
Back pain____ Hip/buttock/thigh pain/numbness/weakness____
Leg pain/numbness/weakness____ Ankle/foot pain/numbness/weakness____
Urinary complaints____ Bowel complaints____ Impotence____
Walking/gait disturbances____ Balance/falls/clumsiness____

Did your symptoms improve after surgery?_______ If yes, how long afterwards?_________

Did you get worse after surgery?______ If yes, explain:_____________________________________

Were you released back to work after surgery?_______ If so, when?________

ALLERGIES

Name of medicine/substance | Type of reaction | Date

____

____

____

MEDICINES: List all medicines that you have taken recently. Include vitamins and nonprescription medicine.

1. _________________________________
2. _________________________________
3. _________________________________
4. _________________________________
5. _________________________________
6. _________________________________
7. _________________________________
8. _________________________________

FAMILY HISTORY:

Spinal Problems Y____N____ If yes, describe:____

Bleeding Disorders Y____N____ If yes, describe:____

Heart Disease Y____N____ If yes, describe:____

Cancer Y____N____ If yes, describe:____

Diabetes Y____N____ If yes, describe:____

SOCIAL HISTORY:

How many years of schooling? (circle one)

Less than high school   High School Graduate   Technical School Diploma   1-3 years of college

College Graduate   Post Graduate or Professional Degree

Marital Status: Single_____ Married_____ Divorced_____ Remarried_____ Widowed_____ Separated_____

How many years?____________

Number of children?_________________________   Ages:______________________

Who lives with you at home?____

Work status: Working_____ Not Working_____ Student_____ Disabled_____ Retired_____

Primary Occupation: _______________________________   Employer: ___________________________

How long have you worked at your present job?___________   If not working, last date worked: __________

Spouse's Occupation:____

Have you ever smoked?________ Type/Amount:_______________ Years:________ If quit, when? ________

Amount of alcohol consumed in a typical week?________________ Cups of caffeinated drinks per day? _____

Have you used: Marijuana _______ Cocaine _______ Heroin_______ Other_________________

Do you get any regular exercise? Describe: ____

REVIEW OF SYSTEMS:

Check all that apply.

Constitutional	**Allergy/Immune**	**Neurologic**	**Musculoskeletal**
Fever____	Drug allergy____	Paralysis____	Joint stiffness/swelling____
Chills____	Seasonal allergy____	Tremors____	Muscle pain/swelling____
Night sweats____	Food allergy____	Spasticity____	Fatigue____
*Weight loss*____	*Iodine allergy*____	Seizures____	Fractures____
Loss of appetite____	Transplant____	Muscle atrophy____	
		Double vision____	
Hemo-lymphatic	**CV/respiratory**	**GI**	**Endocrine**
Anemia____	Shortness of breath____	Difficulty swallowing____	Obesity____
*Excessive bleeding*____	Wheezing____	Heartburn____	Thyroid disorder____
Easy bruising____	Cough____	Nausea/vomiting____	*Diabetes*____
Lymphoma____	Coughing up blood____	Constipation____	Menopause____
Leukemia____	Chest pains____	Diarrhea____	Menstrual irregularities____
Cancer____	Palpitations____	Blood in stool____	Pelvic Pain____
Lymph node swelling___	Leg swelling____	Stomach pain____	Addison's disease____
HENT	**Skin/integumentary**	**GU**	**Psychiatric**
Loss of vision____	Rash____	Pain urinating____	Poor sleep____
Eye Redness____	Ulcer____	Incontinence____	Depression____
Headaches____	Eczema____	Blood in urine____	Anxiety____
Dizziness____	Hives____	Dribbling____	Stress at work/home____
*Glaucoma*____		Sexual Difficulties____	Panic spells____
		Pregnant____; LMP____	

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