northcrest *health*

NORTHCREST PHYSICIAN SERVICES

Patient Information

(Please Print) Today's Date:

Patient Name:				Social Security:		Patient Sex:
Street Address:				**Race:**		**Ethnic:**
City:	State:	Zip code:	Date of Birth:	Age: **years**		Marital Status: **Unknown**
Cell Phone:	Home Telephone:	Work Telephone:		**Name of Spouse if Married:**		
Patient Employer	**Employer Name:**			**Employer Telephone Number:**		
	Employer Street Address:			**Occupation:**		
	Employer City:	**Employer State:**		**Employer Zip:**		
Emergency Contact	**Patient Emergency Contact:**			**Emergency Home Telephone:**		
	Street Address:			**Emergency Work Telephone:**		
	City:	**State**	**Zip:**	**Relationship to Patient:**		
Insured	**Subscriber Name:** **Insurance Name:**			**Relationship to Patient:**		
	Insurance ID: **Insurance Phone:**	**Sex:**	**Subscriber Date of Birth:**	**Age:**		
	Subscriber Employer:			**Work Telephone Number:**		
Contacting You (Circle which applies)	**May we leave a message concerning appointments on:** 6155457570	**Home**	**Cell**	**Work**	**Emg. Contact**	**None**
Release of Information	**Tell us who we can release Medical information to?**	**Name:**		**Phone number:**		
		Name:		**Phone number:**		
Advance Directives	**An Advance Directive is a document that explains your choice of treatment regarding a disabling illness. These documents are called Living will and Durable Power of Attorney for Healthcare. If you have these documents, please provide a copy to our office to be included in your medical records.**	**Living will**		**Yes**		**No**
		Durable Power of Attorney		**Yes**		**No**
		Have you provided a copy of these forms to our office?		**Yes**		**No**

The Information above is correct to the best of my knowledge. I understand that NorthCrest Physician Services files insurance as a courtesy and if for any reason insurance denies payment I am financially responsible for all charges associated with my visit.

Signature of Patient (Legal Guardian if Patient is a Minor): _____ _____

Date

Primary Care Physician:

Authorization for Release/Request of Medical Information

Patient Name: _____ Date of Birth: _____

SSN: _____ Daytime Phone: _____

I request medical records to/from:

NorthCrest Orthopedics
501 Northcrest Drive
Springfield, TN 37172
Phone: (615) 382-5204 Fax: (615) 382-4952

Request/Release the following:

☐ Entire Health Record
☐ Immunization Records Only
☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

I request medical records to/from:

Provider: _____

Address: _____ City, State: _____

Telephone: _____ Fax: _____

Purpose of Disclosure:

☐ Continuing Medical Treatment	☐ Relocation of Residence	☐ Second Opinion
☐ Patient Request	☐ FMLA	☐ Life Insurance
☐ Disability Insurance	☐ Other: _____	

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to NorthCrest Physician Services, attention Medical Release Correspondent, at the above address.
I hereby authorize NorthCrest Physician Services to disclose my medical information as requested. Information used or disclosed by this authorization may be subject to subsequent disclosure by the recipient and no longer be protected by this rule.

THERE MAY BE A SERVICE CHARGE FOR THE COPYING OF RECORDS

_____ _____

Signature of Patient / Parent / Guardian Date

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NORTHCREST ORTHOPAEDICS

www.northcrestortho.com

George A. Dahir, MD William Beauchamp, DO Stacy Nadler Ward, RN, FNP-C Josh Thornhill, PA-C Emily Saldana, PA-C

Policy for Completing Medical / Disability Forms

- Medical / Disability forms (i.e. FMLA, Worker's Comp, AFLAC, Short-Term Disability, etc.) are completed for $25 per form.
- A signed medical release of information from NorthCrest Orthopaedics & Sports Medicine must accompany any medical form requiring completion.
- Payment and signed medical information release must be received with the form at the time the request is made. Without payment, the form will be returned to the patient uncompleted.
- Blank forms will not be accepted. Forms will only be accepted for completion if the patient's name and other information have been completed. We may not be able to complete a form if the patient has not completed their portion of the form prior to submission.
- We legally have 7-14 business days to complete the forms. All forms will be completed in the order in which they are received.
- Forms will be held in the office for patients to pick up. Due to HIPAA regulations, the form will be released to the patient only. Federal law prohibits doctors' office from faxing or mailing medical information to non-medical facilities without patient's permission. We cannot be responsible for any delays or losses in the mail.

_____ _____

Print Patient's Name Date

_____

Patient's Signature

SPRINGFIELD LOCATION
501 NorthCrest Drive
Springfield, TN 37172

Phone (615) 382-5204
Fax (615) 382-4952

PLEASANT VIEW LOCATION
2536 Highway 49, Suite 120
Pleasant View, TN 37146

Phone (615) 746-1563
Fax (615) 746-1610

CLARKSVILLE LOCATION
1810 Madison Street, Suite B
Clarksville, TN 37043

Phone (931) 919-2820
Fax (931) 233-8540

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Pain Medication Policy

Our goal with pain medication is to reduce pain to a tolerable level over the short term.

Our goals with this policy are to:

- Educate patients to understand that complete resolution of pain is not always possible.
- Emphasize that as your Orthopedic Provider we handle short term pain issues, not chronic pain.
- Understand that pain medications are addicting and need to be limited.

Our patients need to understand the following:

- No pain medication will be filled after hours.
- No pain medication will be refilled on the weekends.
- No pain medication will be refilled on holidays.
- If you need refills on pain medication it must be done during normal office hours.
- NorthCrest Orthopaedics & Sports Medicine will not contribute or condone pain medication addiction or long term usage.
- Effective July 1, 2018 drugs like Percocet, Oxycodone, Lortab, Norco, or Hydrocodone are Scheduled II narcotics and require hand written prescriptions with NO refills. Any need for prescriptions should be addressed during office hours. We are no longer able to call in these medications under any circumstances.

Thank you for your consideration in these matters ahead of time.

_____ _____

Print Patient's Name Date

_____

Patient's Signature

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Fax (931) 233-8540

NorthCrest Orthopaedics

Name: _____

Email Address: _____

Place of Employment: _____

Reason for Visit

What is the reason for your visit today? _____

When did you first notice this problem? _____

Is this injury work related? _____

Location of the problem? _____

Is the problem painful? o Yes o No If so, what is the intensity? "O" being no pain: 0 1 2 3 4 5 6 7 8 9 10

Is the pain: o Sharp oDull oConstant oIntermittent

Are you currently being seen for Pain Management? oYes oNo If Yes, where? _____

Does it interfere with regular activities? oYes oNo

What makes it worse? _____

What makes it better? _____

Have you had this problem before? oYes oNo When? _____

If so, did you receive treatment? oYes oNo What Physician did you see? _____

Social History

Do you smoke? oYes oNo How many packs per day? _____

Do you drink alcohol? oYes oNo How much per day? _____

Do you use street drugs? oYes oNo What kind and how often? _____

Patient Medical History

Do you have or have you ever had any of the following:

- o High Blood Pressure
- o Heart Failure
- o Heart Attack
- o Stroke
- o Thyroid Problems
- o Diabetes
- o HIV
- o Hepatitis
- o Emphysema/COPD/Asthma or other lung issues
- o Arthritis
- o Prostate Problems
- o Painful or frequent Urination
- o Lack of bladder control
- o Kidney Disease/Failure
- o Cancer What type?

What Pharmacy do you use: _____ Pharmacy Phone # _____

Please list **ALL** medications:

Name of Medication	Dosage	How often

Allergies: Please check all that apply

○ None ○ Codeine ○ Penicillin ○ Morphine ○ Novocaine ○ Iodine ○ Latex ○ Adhesive/Tape

○ Demerol ○ Sulfa ○ Aspirin ○ Local Anesthetics ○ Seafood ○ Foods _____

Please list **ALL** surgeries:

_____

_____

_____

NORTHCREST PHYSICIAN SERVICES

CONDITIONS OF ADMISSION AND AUTHORIZATION FOR MEDICAL TREATMENT

I. CONSENT FOR MEDICAL PROCEDURES AND TREATMENT

Medical Consent for Treatment: Permission is hereby granted to NorthCrest Physician Services, Inc. for medical treatment as may be deemed necessary by my physician and/or his or her designee. I am aware that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me as to the results of treatments, or examinations.

II. NOTICE OF PRIVACY PRACTICES

I acknowledge, upon request, I can receive a copy of the NorthCrest Physician Services' Notice of Privacy Practices. I understand that if I have questions or complaints, I may contact the Practice Manager of NorthCrest Physician Services at (615) 382-5851.

III. RELEASE OF INFORMATION

I authorize NorthCrest Physician Services physicians involved in my care to release medical information and supporting documentation of same as compiled in my medical records to any organization which is or may be liable or responsible for payment of charges associated with my care and for all other purposes of benefit payment. If my injury is work related, I authorize NorthCrest Physician Services to release any information from my medical records to my employer and/or its designee. I acknowledge that data from my patient records will be accessible to all health care providers participating in my care or treatment, including but not limited to physicians, nurses, and technicians at the hospital, home health agencies, physical therapy centers and such other health care agencies involved with my care.

IV. HEALTH INFORMATION EXCHANGE

Northcrest Physician Services is participating in a Health Information Exchange with Vanderbilt and other facilities throughout the area. We will send your health care information to the Vanderbilt Health Affiliated Network (VHAN) Health Information Exchange (HIE). VHAN HIE is a secure electronic system through which your health care Providers participating in the VHAN HIE may view certain records of your care for purposes of treatment, payment and health care operations. You have two options with respect to the VHAN HIE: (1) you may permit authorized individuals at this and your other health care providers who also participate in the VHAN HIE to access your electronic health information through the HIE. If you choose this option, you need not take any further action; or (2) you may restrict access to all of your information that is sent to the VHAN HIE (except as required by law). This is called "opting-out". You cannot restrict access to certain information only. If you choose to "opt out" please check here: ☐ **Opt Out**

V. ASSIGNMENT OF BENEFITS

This assignment of benefits allows NorthCrest Physician Services Physicians to be paid directly by my health insurance carrier or other health benefit plan for the services NorthCrest Physician Services Physicians provide to me, my minor child, or other person entitled to health care benefits for this office visit.

VI. FINANCIAL AGREEMENT

In consideration of the services to be rendered to the patient, the undersigned (as parent, guardian, spouse, guarantor, agent or as the patient) individually promises to pay the patient's account at the rates stated in NorthCrest Physician Services' price list (known as the "Charge Master") effective on the date of service. In the event that NorthCrest Physician Services has to engage an attorney or collection agency to collect any unpaid balances that arise from the treatment consented herein, the undersigned agrees to pay the reasonable attorney's fees and collection expenses incurred by NorthCrest Physician Services.

It is the responsibility of the patient, the undersigned (as parent, guardian, spouse, guarantor, and agent or as the patient) to let the physician's office know at the time of service if your insurance has changed. All co-payments and deductibles are expected to be paid at the time of service. I understand that if I have a co-payment according to my insurance policy, I am responsible for making this payment at the time of each visit to the office. I further understand that failure to make this payment at time of service will result in my visit being rescheduled.

VII. MEDICARE PATIENT CERTIFICATION

I certify that the information given by me in applying to payment under Title XVIII and Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of the authorization to be used in place of the original and request payment of authorized benefits to be made on my behalf.

VIII. TOBACCO USE POLICY

NorthCrest Physician Services is a tobacco free facility. I understand that while I am a patient at NorthCrest Physician Services I may not use tobacco products.

I hereby certify and state that I have read, and that I fully and completely understand the above Conditions of Admission and Authorization for Medical Treatment, and that I have signed this Conditions of Admission and Authorization for Medical Treatment knowingly, freely, and voluntarily.

_____ _____ _____

Signature of Patient / Parent / Guardian / Conservator Date

Vanderbilt Health
—AFFILIATED NETWORK—

Health Information Exchange (HIE): What and Why?

The Vanderbilt Health Affiliated Network is committed to the quality and coordination of your medical care. That's why we're rolling out health information exchange (HIE) for our network providers.

HIE is the secure transfer of health information among health care organizations. Without HIE, your health information is shared by telephone, fax, mail, or limited computer networks. These processes can waste time and money. They can also make it harder for your providers to offer you high-quality care.

In the network's HIE, a provider can view information from another provider or hospital quickly and securely.

How HIE benefits you

- Your providers can make more informed decisions about your care with a more complete record of your health.
- You may save time and money by avoiding unnecessary or duplicate testing, clinic visits, hospital stays, and emergency room visits.
- Your providers can more easily review all your current medicines. This can help reduce your risk of allergic reactions to medicines or harmful interactions between two or more medicines.
- In an emergency, providers can quickly view your vital information.
- You may be able to avoid duplicate paperwork. You may also be able to avoid giving the same medical information to many different providers.

Access to your information

HIE shares your information for treatment, payment, and care operations only with:

- Providers directly involved in your care
- Providers coordinating your care
- Authorized support staff

Your privacy and security

Your information is protected and secure. HIE uses several security safeguards. Providers must obey all health privacy and security laws including HIPAA.

Your choices about your medical information

You can choose to opt out of HIE. This means your health information will not be available in the network HIE. To do this, ask any network provider for help.

- After you opt out, providers participating in the network HIE won't be able to see your health information. You will lose the benefits of sharing your information through HIE.
- You can opt back in at any time.

If you have questions about your privacy rights, read your provider's Notice of Privacy Practices. If you need a copy of that Notice, ask your provider.

Contact

Every provider and organization in the VHAN HIE has a Privacy Officer. When you have a question, ask for the Privacy Officer.

This document is for educational purposes only. VHAN HIE operations and the content of this document may change without notice.