Registration Information

Last Name _____ Home Phone (_____) _____

First Name _____ Middle Initial: ____ Cell Phone (_____) _____

Address _____ Social Security# _____ Age _____

City _____ State ___ Zip _____ ☐Female ☐Male Date of Birth ____ / ____ / _____

email address _____ ☐Single ☐ Married ☐ Divorced ☐ Widowed

SPOUSE (OR PARENT) INFORMATION ☐ Spouse ☐ Parent

Last Name _____ Home Phone (_____) _____

First Name _____ Middle Initial: ____ Cell Phone (_____) _____

Address (If different) _____ Social Security# _____

City _____ State ___ Zip _____ Date of Birth ____ / ____ / _____

PERSON RESPONSIBLE FOR THE ACCOUNT ☐ Self

Last Name _____ Relation to the Patient _____

First Name _____ Middle Initial: ____ Social Security# _____

Address (If different) _____ Home Phone (_____) _____

City _____ State ___ Zip _____ Other _____ Date of Birth ____ / ____ / _____

OCCUPATION INFORMATION

Patient Employer _____ Occupation _____

Business Address _____ Business Phone _____

City _____ State ___ Zip _____ Business Fax _____

REFERRAL INFORMATION

How did you choose us?

☐I heard about you from my Doctor/Practitioner
Dr. _____

☐I Came on my own ☐ER

☐I knew about you and asked to be referred

If you were NOT referred by a Physician, Please tell us how you became aware of the practice.

☐Word of Mouth ☐Friend/Relative ☐Newspaper

☐Saw the Sign ☐Internet/Facebook ☐Trainer

☐Insurance Plan ☐Worker Comp. ☐Attorney

PRIMARY INSURANCE

Please give your insurance card(s) to the receptionist along with this form

Insurance Company _____ Identification Number _____ Group Number _____

Cardholder's Name _____ Relation to Insured _____

SECONDARY INSURANCE

Insurance Company _____ Identification Number _____ Group Number _____

Cardholder's Name _____ Relation to Insured _____

REASON FOR VISIT

Body Part _____ ☐LT ☐RT ☐Car Accident ☐Work ☐School ☐Other _____

If you were injured, How? _____ Date of Injury _____ Time _____ ☐AM ☐PM

Signature of Patient _____ **Date** _____

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Revised 10.29.2017

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Thomas L. Gautsch, M.D., F.A.C.S. I 570 Hartsville Pike I Gallatin, TN 37066 I Phone: 615.452.3320 I Fax: 615.452.2668

Medical History Form

Date: _____

Name: _____ Prefer to be Called: _____ Birthdate: _____

☐Male ☐Female Height: ____ (ft) ____ (in) Age: ____ Weight: _____ (lb) Family Doctor: _____

What is the main problem? _____

What doctor (s) have you seen for it? _____

What do you think caused it? _____

What date did it first start? _____

What treatment (s) have you had for it? _____

What makes it worse? _____

What makes it better? _____

Having any other symptoms? _____

Have you or a blood relative ever had any of the following problems?

	SELF		FAMILY	
	Yes	No	(who?)	Please briefly explain
High Blood Pressure	☐	☐	☐ _____	_____
Heart Attack	☐	☐	☐ _____	_____
Stroke	☐	☐	☐ _____	_____
Blood Clots	☐	☐	☐ _____	_____
Anemia	☐	☐	☐ _____	_____
Blood Transfusion	☐	☐	☐ _____	_____
Other Blood Problems	☐	☐	☐ _____	_____
Other Heart Problems	☐	☐	☐ _____	_____
Asthma	☐	☐	☐ _____	_____
Bronchitis	☐	☐	☐ _____	_____
Emphysema	☐	☐	☐ _____	_____
Fluid in Lungs	☐	☐	☐ _____	_____
Ankle Swelling	☐	☐	☐ _____	_____
Congestive Heart	☐	☐	☐ _____	_____
Other Breathing Problems	☐	☐	☐ _____	_____
Ulcers	☐	☐	☐ _____	_____
Diabetes	☐	☐	☐ _____	_____
Thyroid Problems	☐	☐	☐ _____	_____
Hepatitis	☐	☐	☐ _____	_____
Jaundice	☐	☐	☐ _____	_____
Liver Problems	☐	☐	☐ _____	_____
Intestinal Problems	☐	☐	☐ _____	_____
HIV / AIDS	☐	☐	☐ _____	_____
Cancer	☐	☐	☐ _____	_____
Prostate Problems	☐	☐	☐ _____	_____
Kidney Problems	☐	☐	☐ _____	_____
Dizziness	☐	☐	☐ _____	_____
Convulsions/Seizures	☐	☐	☐ _____	_____

Any other Problems? _____

Please list ALL Medications
(Try to include dose & how often):

_____

What Medicines are you allergic to:

_____

Please list all Surgeries or Hospitalizations you have had
(Try to give approximate dates):

_____

Do you smoke cigarettes, pipe, cigar?
☐Yes ☐No How Much? _____

Do you use chewing tobacco/snuff/vape?
☐Yes ☐No How Much? _____

Do you drink alcohol?
☐Yes ☐No How Much? _____

Patient Signature: _____ Date: _____

Physician's Signature: _____ Date: _____

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Authorization For Medical & Hospital Records

To Whom it May Concern:

This will authorize you to give the bearer of this document all information you may have, without limitation, regarding my physical condition as revealed by your evaluation or treatment, past, present, and future. This includes history, physical examinations, test results, X-rays, diagnosis, prognosis, and access to records for reexamination and photocopying.

This authorization extends to any party who has medical information concerning my physical condition, past present and future. This authorization, therefore, includes any physician's records pertaining to the examination or treatment of myself, the undersigned patient. It also applies to present, past, and prior employers and any insurance carrier who may have records of my physical condition.

I am willing that a photocopy of this authorization be accepted with the same authority as the original.

PATIENT NAME: _____

DATE OF BIRTH: _____

SOCIAL SECURITY NUMBER: _____

_____ _____

SIGNED DATE

_____

WITNESS

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Contact Sheet

What phone number(s) should we use to contact you? _____

Please list other people, their phone number(s) and their relationship to you, whom we may call if we are unable to reach you at the above number.

Person	Number	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

May we text you? ☐ Yes ☐ No

May we leave messages on your phone? ☐ Yes ☐ No

May we leave messages on your voice mail at work? ☐ Yes ☐ No

With whom may we discuss your health information?

Spouse ☐ Yes ☐ No

Parent(s) ☐ Yes ☐ No

Other family member (please list name) ☐ Yes ☐ No _____

Friend (please list name) _____

Other _____

We will only discuss your private health information with those listed above.

Effective Date: April 1, 2003

I have read and understand my rights to my personal health information as outlined in this document.

This signed document will be filed in the patient's chart.

_____ _____

PATIENT SIGNATURE ***must be signed by patient*** **DATE**

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Patient Information

Has your insurance changed since your last visit?

☐ Yes *(Please show your new card at the front so we can bill them for you.)*
☐ No, it's the same as last visit.
☐ This is my first visit.

Please help me by taking a few minutes before we see each other to answer the following:

I'm having Problems with:

Right Shoulder	☐ none	☐ mild	☐ moderate	☐ severe
Left Shoulder	☐ none	☐ mild	☐ moderate	☐ severe
Right Knee	☐ none	☐ mild	☐ moderate	☐ severe
Left Knee	☐ none	☐ mild	☐ moderate	☐ severe
_____	☐ none	☐ mild	☐ moderate	☐ severe
_____	☐ none	☐ mild	☐ moderate	☐ severe

Where would you like us to send any Prescriptions?

- ☐ CVS Gallatin
- ☐ CVS Hendersonville
- ☐ CVS Portland
- ☐ Perkins Gallatin
- ☐ Perkins Fairvue
- ☐ Fred's Gallatin
- ☐ Fred's Lafayette
- ☐ Fred's Portland
- ☐ Kroger Old Gallatin
- ☐ Kroger Marketplace
- ☐ Kroger 24hr Hendersonville
- ☐ Kroger Hendersonville Glenbrook
- ☐ Living Well
- ☐ Rite Aid Gallatin
- ☐ Rite Aid E Main, Hendersonville
- ☐ Rite Aid W Main, Hendersonville
- ☐ Walgreen's Gallatin (NV Pike)
- ☐ Walgreen's Greanlea
- ☐ Walgreen's Portland
- ☐ Walmart Gallatin
- ☐ _____

Please tell me about your symptoms/problems now: (Check all that apply)

1. Pain
- ☐ none/minimal
- ☐ sharp or stabbing
- ☐ burning
- ☐ throbbing
- ☐ aching

2. Other feelings of:
- ☐ swelling
- ☐ tightness
- ☐ stiffness
- ☐ popping
- ☐ grinding
- ☐ catching
- ☐ locking up
- ☐ looseness
- ☐ giving out
- ☐ numbness
- ☐ tingling
- ☐ weakness

3. When?
- ☐ at rest
- ☐ with activity
- ☐ with sports
- ☐ affecting work
- ☐ affecting chores
- ☐ affecting sleep

other _____

4. What makes it worse?
- ☐ reaching up/out
- ☐ reaching back/around
- ☐ gripping/lifting
- ☐ pushing/pulling
- ☐ standing
- ☐ walking
- ☐ squatting/crawling
- ☐ getting up/down
- ☐ going up/down stairs

5. Are you having any associated:

Fevers	☐ yes	☐ no
Chills	☐ yes	☐ no
Rash	☐ yes	☐ no
Sores	☐ yes	☐ no
Chest Pain	☐ yes	☐ no
Shortness of Breath	☐ yes	☐ no

6. Have you ever had:

MRSA	☐ yes	☐ no
Blood Clot/DVT	☐ yes	☐ no
Pulmonary Embolism	☐ yes	☐ no

Infection or problems after surgery?
What/When? _____
_____
_____
_____
_____

7. Have had a flu shot this year?
☐ yes ☐ no
Date: _____

8. Have you tried these?	**Was it:**	
Rest	☐ better	☐ no help
Heat	☐ better	☐ no help
Ice	☐ better	☐ no help
Splint/brace	☐ better	☐ no help
Time off	☐ better	☐ no help
Chiropractic	☐ better	☐ no help
Physical Therapy	☐ better	☐ no help
Ointments/rubs	☐ better	☐ no help
Tylenol/ Aspirin/Goody's	☐ better	☐ no help
Advil/ibuprofen	☐ better	☐ no help
Aleve/Naprosyn/naproxen	☐ better	☐ no help
Mobic/meloxicam	☐ better	☐ no help
Relafen/nabumetone	☐ better	☐ no help
Lodine/etodolac	☐ better	☐ no help
Steroid/Dosepak	☐ better	☐ no help
Shot/Injection(s)		
L R Cortisone/Steroid	☐ better	☐ no help
L R Synvisc/Supartz/Gel	☐ better	☐ no help

Signature _____ **Date** _____

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Interpreter Services

ADI — Southern Sports Medicine Institute has arranged for language assistance services free of charge. Call 1-866-237-0173 and use access code 99148

ENGLISH — If you speak English, language assistance services, free of charge, are available to you.

SPANISH — Si usted habla español, tiene a su disposición servicios de asistencia con el idioma sin costo alguno.

ARABIC — إذا كنت تتحدث العربية، فستتوفر لك خدمات المساعدة اللغوية مجانًا.

CHINESE — 如果您讲汉语普通话，则可以免费向您提供语言协助服务。

VIETNAMESE — Chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị, nếu quý vị nói tiếng Việt.

KOREAN — 모국어가 한국어일 경우 무료 언어지원 서비스가 제공됩니다.

FRENCH — Si votre langue est le français, des services d'assistance linguistiques sont mis gratuitement à votre disposition.

LAOTIAN — ຖ້າທ່ານເວົ້າ ພາສາລາວ ການບໍລິການຊ່ວຍເຫຼືອພາສາຟຣີໆກໍ່ມີພ້ອມໃຫ້ທ່ານ.

AMHARIC — አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ዕርዳታ አገልግሎቶችን፣ በነጻ ያገኛሉ።

GERMAN — Wenn Sie deutsch sprechen, stehen Ihnen kostenlos Sprachhilfen zur Verfügung.

GUJARATI — તમે ગુજરાતી બોલતા હો, તો વિના મૂલ્યે, ભાષા સહાય સેવાઓ તમને ઉપલબ્ધ છે.

JAPANESE — 日本語を話される場合には、無償の言語支援サービスがご利用いただけます。

TAGALOG — Kung nagsasalita ka ng Tagalog, may magagamit kang mga serbisyo sa lengguahe na walang bayad.

HINDI — अगर आप हिन्दी बोलते हैं तो भाषा सहायता सेवा निःशुल्क उपलब्ध है।

RUSSIAN — Если ваш язык — русский, то вам могут быть предоставлены бесплатные услуги переводчика.

PERSIAN (FARSI) — اگر شما به فارسی صحبت میکنید، خدمات کمکهای زبان بطور رایگان در دسترس شما می باشند.

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Patient Financial Policy

This is an agreement between AdvancedHEALTH, as creditor, and the Patient/Debtor named on this form and indicated by patient/debtor signature below.

In this agreement the words "you", "your" and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us" and "our" refer to AdvancedHEALTH. By executing this agreement, you are agreeing to pay for all services that are rendered.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect. A copy of your signed financial agreement will be provided to you.

HEALTH INSURANCE - It is YOUR responsibility to:

- Ensure we have been provided with the most current insurance information relative to filing your claim including insurance card, ID number, employer, birth date and patient address. This information will be located on our patient registration form.
- Ensure we are contracted with your insurance carrier to receive maximum benefits.
- Pay your co-payment or patient portion at the time of service.
- Inform us of any insurance changes made after this signed agreement/date of service. Insurance carriers have specific timely filing guidelines and pre-authorization requirements for certain services. If revised insurance information is not provided to us within your insurances' timely filing limits, you will be required to pay for services in full. If prior authorization was required for services already received and your claim is denied for lack of authorization, you will be required to pay for services in full.
- Contact your insurance company if no correspondence is received by you within 45 days of the date of service.

It is OUR responsibility to:

- Submit a claim to your health insurance carrier based on the information provided by the patient/debtor at the time of service or as updated information is provided.
- Provide your health insurance carrier with information necessary to determine benefits. This may include medical records and/or a copy of your insurance card.
- Provide MVA patients a courtesy health insurance claim form for their records upon request.

PAYMENT OPTIONS: Per our contracted agreement with your insurance carrier, we are required to collect your co-payment on the day of service. If you do not have insurance, you are required to pay for treatment at the time of service unless other arrangements have been formally made. A separate self-pay financial agreement will be provided to you. Our office collects all copays plus estimated coinsurance and deductibles at the time of service

We accept the following: Cash Check Credit Card *(Visa, MasterCard, Discover, American Express)*

A twenty-five dollar ($25.00) returned check fee will be assessed to the patient account per incident.

For convenience, payments may be made online at **www.ePayItOnline.com.** To utilize this service you will need your account number, access code, and Code ID. This information can be found on the patient statement you will receive reflecting your balance. ***Patients who no-show may be subject to a no-show fee.***

PENDING APPROVALS FOR SERVICES: In the event we are unable to obtain approval for services and you wish to proceed, we will not bill your insurance. Services will be reduced to the in-network insurance allowable amount and will apply to the patient's responsibility.

_____ Initials

Patient and/or Debtor Signature: _____ Date _____/_____/_____

Additional financial explanations are continued on the back side of this page

AdvancedHEALTH

WORKERS' COMPENSATION INJURIES: Written approval/authorization by your employer and/or workers' compensation carrier prior to your initial visit is needed. We will contact your case manager and/or supervisor to confirm your workers' compensation injury. If this claim is denied, for any reason by your employer or your employer's workers' compensation carrier, you will be responsible for payment in full. If denial is made by workers' compensation, health insurance can be filed for these denied services and you will be held responsible for the account.

MOTOR VEHICLE ACCIDENTS (MVA's) – Yes, I was involved in a MVA on _____/ _____/ _____. Unless prior agreement has been reached or I am a Medicare recipient, my **health insurance** will be filed for services related to this accident. In the event I do not provide insurance information upon initial visit, I understand insurance denials may occur depending on type of service(s) received or carrier specific filing requirements. I agree, as the patient or patient's guardian, I am ultimately responsible for all balance(s) due to this facility and/or its physician(s) for services rendered regardless of insurance denial(s) or unfavorable case outcomes. If I have chosen an attorney to oversee my case, this financial agreement will serve as a Letter of Protection to my attorney. I further understand my account may be handled by an outside entity that specializes in attorney lien accounts at the facilities discretion.

_____ Yes, I have chosen to retain an attorney. Signed: _____ Date: _____/_____/_____

Attorney Name: _____ Phone: _____

BILLING INFORMATION

STATEMENTS:
A statement of account will be provided to you if insurance has paid leaving a patient portion, denied or no response is received. Due to the type of service we provide, you may receive billing from more than one practice, otherwise known as split billing. The balance on your statement is due and payable within 30 days of receipt unless other arrangements are made with our billing department. The statement will be sent to the address provided at the time of service. In the event your mailing address changes after your service date and your account has not been paid in full, you are required to notify our billing office of this change by calling 615.851.6033 ext. 2067. In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child at time of service will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, court documentation is required for any guarantor address changes, otherwise, it is the authorizing/custodial parent's responsibility to collect from the other parent. Any account with a credit balance of less than <$5.00> will not be refunded without specific request from the patient/debtor.

DELINQUENT ACCOUNTS:
We review past due accounts frequently and at every statement cycle. Your communication and involvement to ensure your balance is paid timely is important to us. It is imperative that you maintain communications and fulfill your financial agreement and arrangements to keep your account active and in good standing.

If your account becomes sixty (60) days past due, further steps to collect this debt may be taken. If we have to refer your account to a collection agency, you agree to pay all of the collection costs, which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer fees which we incur plus all court costs. In case of suit, you agree the venue shall be Davidson County, Tennessee. In addition, we reserve the right to deny future non emergency treatment for any and all debtor-related unpaid account balances.

WAIVER OF CONFIDENTIALITY:
You understand if your account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

MEDICAL RECORDS:
You will be required to request in writing or sign a medical authorization form for the release of your medical records to any organization or physician. We charge a **$20 flat rate** for 1-5 pages plus .50 per additional page and postage.

General Consent For Treatment

As the patient, you have the right to be informed about your conditions and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify appropriate treatment and/or procedure for any identified condition(s).

I request and authorize medical care as my provider, his assistant or designees (collectively called "the providers") may deem necessary or advisable. This care may include, but is not limited to, routine diagnostics, radiology and laboratory procedures, administration of routine drugs, biological and other therapeutics, and routine medical and nursing care. I authorize my provider(s) to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my (the patient) care is directed by my provider(s) and that other personnel render care and services to me (the patient) according to the provider(s) instructions.

I understand that I have the right and the opportunity to discuss alternative plans of treatment with my provider and to ask and have answered to my satisfaction any questions or concerns.

In the event that a healthcare worker is exposed to my blood or bodily fluid in a way which may transmit HIV (human immunodeficiency virus), hepatitis B virus or hepatitis C, I consent to the testing of my blood and/or bodily fluids for these infections and the reporting of my test results to the healthcare worker who has been exposed. _____ **(initial)**

I HAVE READ OR HAD READ TO ME AND FULLY UNDERSTAND THIS CONSENT; I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS AND HAD THESE QUESTIONS ADDRESSED.

Name of Patient: _____

Signature of Patient: _____ Date: _____

☐ Consent of Legal Guardian, Patient Advocate or Nearest Relative **if patient is unable to sign**

☐ Consent Caregiver **if patient is unable to sign**

Name of Legal Guardian, Patient Advocate, Nearest Relative or Other: _____

Relationship: _____ Telephone: _____

Address: _____

Signature of the above: _____ Date: _____ Time: _____

Signature of Witness: _____ Date: _____

AdvancedHEALTH

Notice Of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

Patient Name or Legal Guardian: _____

Signature: _____

Date: _____

PRACTICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date: _____ Initials:_____

Reason: _____

_____

AdvancedHEALTH