Patient Information

Today's Date: ___/___/___ Birth Date ___/___/___ Gender ☐ M ☐ F Social Security: ___/___/___

First Name: _____ M.I. _____ Last Name _____

Marital Status: ☐ Single ☐ Married ☐ Other **Email Address:** _____

Home Address: _____ City _____ ST _____ Zip _____

Phone Numbers (home): ___-___-___ (cell): ___-___-___ (work): ___-___-___

Is your injury due to a car accident or work related injury? ☐ Yes ☐ No **Do you have an attorney for your injury?** ☐ Yes ☐ No

If YES to the above questions, please STOP and contact the FRONT OFFICE!

Messages can be left on: ☐ Home ☐ Cell ☐ Work

Employer / School Name or Affiliation: _____

☐ Employed ☐ Unemployed ☐ Disabled ☐ Retired ☐ Student

May we leave message with family members? ☐ Yes ☐ No If "YES" Names _____

Emergency Contact Name: _____ Relation to Patient: _____

Emergency Contact Phone: ___-___-___

Information below is collected pursuant to the requirements of the TN Dept. of Health in compliance with TN State Law. (PLEASE ANSWER BOTH)

1. **RACE:** ☐ White ☐ Black/African American ☐ American Indian or Alaska Native ☐ Asian or Pacific Islander ☐ Hispanic ☐ Asian ☐ Unknown Race

2. **ETHNICITY:** ☐ Hispanic Origin ☐ Not Hispanic Origin ☐ Unknown If of Hispanic Origin

Person responsible for the account: ☐ **SELF**

Name: _____ SSN: ___/___/___ DOB: ___/___/___

Relation to Patient: _____ Address (if different from patient): _____

Guarantor- Employment Status: ☐ Employed ☐ FT Student ☐ PT Student ☐ Self Employed ☐ Retired

Guarantor's Employer Name: _____ Employer Phone: ___-___-___

DO YOU HAVE INSURANCE?: ☐ **YES** ☐ **NO**

Primary Insurance Co.: _____ Group#: _____ Policy#: _____

Name of Insured: _____ SSN: ___/___/___ DOB: ___/___/___

Relation to Patient: _____

Secondary Insurance Co.: _____ Group#: _____ Policy#: _____

Who referred you to our office: _____ **Primary Care Physician:** _____

Phone: ___-___-___

Are you in Pain Management? ☐ YES ☐ NO If YES, Where? _____

Are you under the care of other physicians or specialists? ☐ YES ☐ NO

PHARMACY NAME: _____ City: _____ ST: ___ Phone: ___-___-___

RiverRun HEALTH

1724 Hamill Road, Suite 204, Hixson, TN 37343 | p: 423.877.4705 | f: 423.877.9970 | RiverRunHEALTH.com

Release Of Medical Information

NAME *(Please print)*: _____

By Signing Below, I Authorize RiverRun HEALTH Sports + Ortho To Release My Medical And Billing Information To:

RELATIONSHIP			**NAME OF DESIGNATED PERSON**
SPOUSE	☐ YES	☐ NO	_____
CHILDREN	☐ YES	☐ NO	_____
IN-LAWS	☐ YES	☐ NO	_____
CAREGIVERS	☐ YES	☐ NO	_____
PARENTS	☐ YES	☐ NO	_____
OTHERS	_____		

PATIENT SIGNATURE _____ DATE ____/____/____

PARENT SIGNATURE _____ DATE ____/____/____

We ask that if you have any change in this request, that you please inform the receptionist.

RiverRun HEALTH Sports + Ortho may leave appointment information on my voicemail:

HOME	☐ YES	☐ NO	_____
WORK	☐ YES	☐ NO	_____
RELATIVE	☐ YES	☐ NO	_____

PATIENT SIGNATURE _____ DATE ____/____/____

I authorize the following to pick up prescriptions, X-rays, etc.

RELATIONSHIP			
SPOUSE	☐ YES	☐ NO	_____
RELATIVE	☐ YES	☐ NO	_____
CAREGIVER	☐ YES	☐ NO	_____

PATIENT SIGNATURE _____ DATE ____/____/____

I understand that RiverRun HEALTH Sports + Ortho will ask for identification of the person picking up patient medical information or products.

RiverRun HEALTH
ORTHO + SPORTS

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Patient Evaluation

Patient Name: _____ **DOB:** ____/____/____ **Date:** ____/____/____

Is this due to a non-work related injury? ☐ Yes ☐ No

If yes, when? _____ where? _____ what time? _____

Is this due to a work injury? ☐ Yes ☐ No **If yes, Date of Injury** _____

Has this been reported to your employer? ☐ Yes ☐ No **Are you still working?** ☐ Yes ☐ No

Problem being seen for today: _____ ☐ Right ☐ Left

What symptoms are you experiencing? _____

_____

How long have you had this problem? _____

Have you experienced this problem in the past? ☐ Yes ☐ No If yes, please describe: _____

_____

What makes your pain *worse?* _____

_____

What makes your pain *better?* _____

Have seen another physician for this problem? ☐ Yes ☐ No Please explain: _____

_____

Have you had prior treatment for this problem? ☐ Yes ☐ No Please explain: _____

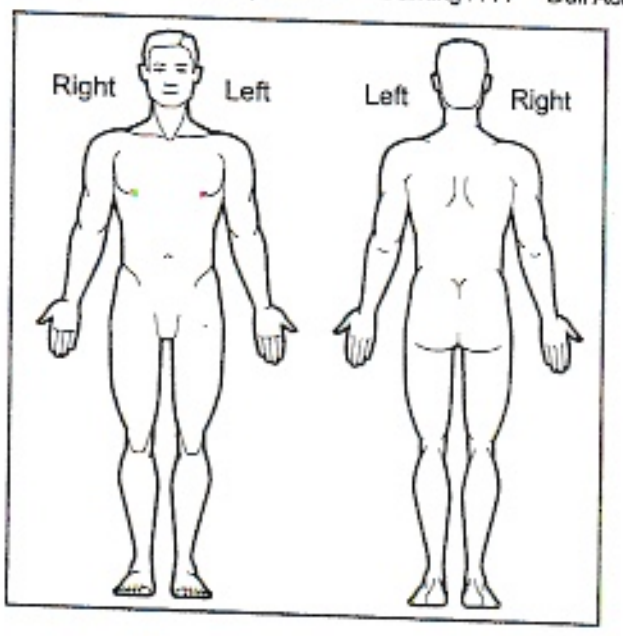
_____

Had any prior testing? (Please check) ☐ X-rays ☐ MRI ☐ CT Scan ☐ EMG ☐ DEXA (Bone scan)

If yes, Where? _____ When? _____

On the illustration below, please use the following symbols to explain your symptoms:

Aching ^ ^ ^ ^ Sharp < < < < Burning / / / / Dull Ache = = = = Numbness x x x x Pins/Needles * * * *



Pain Scale (Please Check)

☐ 0 **No pain**
☐ 1
☐ 2
☐ 3
☐ 4
☐ 5 **Moderate Pain**
☐ 6
☐ 7
☐ 8
☐ 9
☐ 10 **Severe Pain**

Height _____ Weight _____

RiverRun HEALTH
ORTHOPEDICS

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Medical Information

Patient Name: _____ **DOB:** ___/___/_____ **Date:** ___/___/_____

Height: _____ **Weight:** _____

Current Medications Including Prescriptions, Over the Counter Medications, Vitamins & Herbs

Name of Medication	Strength	Frequency	Condition

Please list Allergies to Medications, Dyes, Latex or Metals AND Reactions ie: rash, hives.

_____

_____

_____

_____

Please list Surgeries with Dates AND any hospitalizations.

_____

_____

_____

_____

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Medical History

Patient Name: _____ **DOB:** ___/___/_____ **Date:** ___/___/_____

REVIEW OF SYSTEMS: Have you recently experienced (Please Check):

Cardiovascular
- ☐ Chest Pain
- ☐ Dizziness
- ☐ Fluid Accumulation
- ☐ Irregular Heartbeat
- ☐ Shortness of Breath
- ☐ Palpitations

ENT
- ☐ Decreased Hearing
- ☐ Difficulty Swallowing
- ☐ Ringing in Ears
- ☐ Wears Dentures

Gastrointestinal
- ☐ Gastric Reflux/GERD
- ☐ Abdominal Pain
- ☐ Nausea
- ☐ Heartburn
- ☐ Blood in Stool

General/Constitutional
- ☐ Chills
- ☐ Cough
- ☐ Cold
- ☐ Fatigue
- ☐ Fever
- ☐ Headache
- ☐ Insomnia
- ☐ Significant Weight Gain
- ☐ Significant Weight Loss

Genitourinary
- ☐ Abdominal Pain
- ☐ Blood in Urine
- ☐ Difficulty Urinating
- ☐ Painful Urination
- ☐ Urinary Incontinence

Hematology
- ☐ Easy Bruising
- ☐ Recent Transfusion
- ☐ Prolonged Bleeding
- ☐ Anemia

Musculoskeletal
- ☐ Pain in Joints
- ☐ Swollen Joints
- ☐ Weakness
- ☐ Leg Cramps
- ☐ Joint Stiffness
- ☐ Muscle Aches

Neurologic
- ☐ Loss of Use of Extremity
- ☐ Low Back Pain
- ☐ Seizures
- ☐ Tremors
- ☐ Tingling/Numbness
- ☐ Balance Difficulty
- ☐ Gait Abnormality
- ☐ Loss of Strength
- ☐ Neck Pain

Ophthalmology
- ☐ Blurred Vision
- ☐ Wears Glasses
- ☐ Wears Contacts

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Suicidal Ideation
- ☐ Claustrophobic
- ☐ Bipolar Disorder
- ☐ Difficulty Sleeping
- ☐ Substance Abuse
- ☐ Suicidal Thoughts
- ☐ Mental or Physical Abuse

Respiratory
- ☐ Cough
- ☐ Pain with Inspiration
- ☐ Shortness of Breath at Rest
- ☐ Shortness of Breath with Exertion
- ☐ Wheezing

Skin
- ☐ Color Change
- ☐ Pallor
- ☐ Rash
- ☐ _____
- ☐ Wound
- _____

PAST MEDICAL HISTORY (Please Check):

- ☐ Alzheimer's Disease
- ☐ Anemia
- ☐ Angina/Chest Pain
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Autoimmune Disorder
- ☐ Blood Clots
- ☐ BPH/Enlarged Prostate
- ☐ Cancer Type_____
- ☐ Clotting Disorder
- ☐ COPD/Emphysema
- ☐ Crohn's Disease
- ☐ CVA/Stroke
- ☐ Depression
- ☐ Diabetes Type_____ Insulin Dependent_____
- ☐ Fibromyalgia
- ☐ Gallbladder Disease
- ☐ GERD/Acid Reflux
- ☐ Gout
- ☐ Hepatitis A___B___C___
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Insomnia
- ☐ Irritable Bowel Disease
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lupus
- ☐ MI/Heart Attack
- ☐ Migraines
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Peptic Ulcer Disease
- ☐ PTSD
- ☐ Recurrent UTI
- ☐ Rheumatoid
- ☐ Seizure Disorder
- ☐ Thyroid Disease
- ☐ Other:

Any Medical Conditions not listed? ☐ Yes ☐ No Please list: _____

Are you Pregnant or nursing? ☐ Yes ☐ No If yes, details: _____

FAMILY HISTORY:

Please list diagnosed family health problems

Father ☐ Alive ☐ Deceased age _____

Mother ☐ Alive ☐ Deceased age _____

Siblings How many brothers? _____ Sisters? _____

Children How many sons? _____ Daughters? _____

Social History

Patient Name: _____ **DOB:** ___/___/_____ **Date:** ___/___/_____

Do you smoke? ☐ No ☐ Never ☐ Yes ☐ Quit Age Started _____ Year Stopped _____

How many packs per day? _____ ☐ E-cigarette _____ ☐ Vape _____ ☐ Other _____

Alcohol Use? ☐ No ☐ Yes

Did you have a drink containing alcohol in the past year? ☐ Yes ☐ No

If Yes: How often did you have a drink containing alcohol in the past year?

☐ Never ☐ Occasionally ☐ Moderate

If Yes: How many drinks did you have on a typical day when you were drinking in the past year?

☐ Never ☐ Occasionally ☐ Moderate

If Yes: How often did you have 6 or more drinks on one occasion in the past year?

☐ Never ☐ Occasionally ☐ Moderate

Previous drug abuse? ☐ Yes ☐ No

If yes, list details _____

_____

_____

Employed? ☐ Yes ☐ No Please check: ☐ Full ☐ Part Time ☐ Retired ☐ Disabled ☐ Student

Occupation: _____

Job Duties: _____

Do you use assistive devices? ☐ None ☐ Cane ☐ Walker ☐ Crutches ☐ Wheelchair

Are you: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Partner

Do you live alone? ☐ Yes ☐ No If no, who do you live with? _____

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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 Patient/Debtor. The word "account" means the account that has been established in your name to which the 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 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 we 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 the service or as updated information is provided.
- Provide your health insurance carrier with information to determine benefits. This may include medical records and/or a copy of your insurance card.

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.

We accept the following: CASH, CHECK, CREDIT CARD (Visa, MasterCard, Discover, and American Express)
A twenty-five ($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.

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 you fail to pay on time and we refer your account(s) to a third party for collection, a collection fee will be assessed and will be due at the time of the referral to the third party. The fee will be calculated at the maximum percentage permitted by applicable law, not to exceed 18 percent. In addition, we reserve the right to deny future non-emergency treatment for any and all debtor-related unpaid account balances.

CONSENT TO CONTACT: I grant permission and consent to AdvancedHEALTH and its agents, assignees, and contractors (which may include third party debt collectors for past due obligations): (1) to contact me by phone at any number associated with me, if provided by me or another person on my behalf; (2) to leave messages for me and include in any such messages amounts owed by me; (3) to send me text message or emails using any email address I provided or any phone number associated with me, if provided by me or another person on my behalf; and (4) to use prerecorded/artificial voice messages and/or an automated telephone dialing system (an auto dialer) as defined by the Telephone Consumer Protection Act in connection with any communications made to me as provided herein or any related scheduled services and my account. I understand that my refusal to provide the consent described in this paragraph will not affect, directly or indirectly, my right to receive healthcare services.

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

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 ____/____/____

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