MIDDLE TENNESSEE SURGICAL SPECIALISTS, PLLC
203 NORTH CEDAR AVENUE
COOKEVILLE, TN 38501

PATIENT INFORMATION SHEET

Date: _____ MTSS Physician: _____

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

DOB: _____ Sex: Male / Female Marital Status: M / S / W / D

Home Phone: _____ Social Security #: _____

Cell Phone: _____ Email: _____

Preferred Phone: Cell / Home / Other: _____

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Employer: _____ Phone: _____

Emergency Contact: _____ Phone: _____
(other than someone living in your home)

Name of Spouse: _____ Phone: _____

Optional: Race: _____ Ethnicity: Latino? Yes or No

PLEASE GIVE THE RECEPTIONIST YOUR INSURANCE CARDS AND ID

Primary Insurance: _____ ID#: _____

Secondary Insurance: _____ ID#: _____

IS THE INSURED SOMEONE OTHER THAN THE PATIENT? Yes or No

Insured's Name: _____ Insured SS#:_____

Relationship to Patient: _____Insured DOB: _____

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Name: _____ DOB: _____

Does your insurance require a referral? Yes or No

If yes, please make certain you have a referral from your primary care physician. Also, be advised it is the responsibility of the patient to obtain the referral required by their insurance carrier. If you have any questions about this, or need help in doing so, please ask a member of our staff. We will be happy to assist you.

Authorization and Release:

I hereby authorize you to release and/or request any information including the diagnosis and records of any treatment or examination rendered to my child or me during the period of such care to third party payers and/or other health practitioners, including test results, which may include drug and/or alcohol, psychological conditions or Acquired Immunodeficiency Syndrome. I authorize and request my insurance company to pay insurance benefits otherwise payable to me directly to the physician or physician group. I understand my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

Signature: _____Date:_____

Medicare Authorization:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Middle Tennessee Surgical Specialties, PLLC, for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature: _____Date:_____

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MEDICAL PROFILE

PATIENT NAME: _____

DATE OF BIRTH: _____

What symptoms brought you to our office? _____

Year of last tetanus shot: _____

GENERAL	Y	N
Weight change (gain or loss)	__	__
Fever/Chills	__	__
Night sweats	__	__
Dizziness	__	__
ENDOCRINE		
Heat/Cold intolerance	__	__
Thyroid problems	__	__
Neck surgery/irradiation	__	__
Diabetes	__	__
Increased urination, thirst or hunger	__	__
HEMATOLOGIC		
Excessive bleeding after cuts or surgery	__	__
Anemia	__	__
Blood thinners	__	__
NEUROLOGIC		
Headache	__	__
Epilepsy/seizures	__	__
Stroke	__	__
temporary stroke	__	__
SKIN		
Moles	__	__
Rash	__	__
Itching	__	__
Bleeding	__	__
Non-healing areas	__	__

EYES	Y	N
Visual disturbance	__	__
EARS, NOSE, AND THROAT		
Hearing difficulty	__	__
Ringing in ears	__	__
Nose bleeds	__	__
Hoarseness	__	__
Sinusitis	__	__
Awkwardness, room spinning, dizziness	__	__
Difficulty swallowing	__	__
CARDIOVASCULAR		
Chest pain	__	__
Irregular heartbeat	__	__
Pacemaker	__	__
Leg swelling, edema	__	__
Varicose veins	__	__
LUNGS		
Breathlessness	__	__
Cough/dry	__	__
Cough/productive	__	__
Wheezes/asthma	__	__
Tuberculosis/positive skin test	__	__
Pneumonia	__	__
Work inhalation	__	__

Smoking/tobacco heavy moderate light former never

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PATIENT NAME: _____ DOB: _____

GASTROINTESTINAL	Y	N
Nausea/retching/vomiting	__	__
Vomiting blood	__	__
Blackened stool	__	__
Difficulty swallowing	__	__
Indigestion/heartburn	__	__
Abdominal pain	__	__
Abdominal swelling	__	__
Jaundice (yellow skin)	__	__
Bloody stools	__	__
Diarrhea	__	__
Constipation	__	__
Hernia	__	__
Hemorrhoids	__	__
Ulcers	__	__
Gall bladder disease	__	__
Pancreatitis	__	__
Alcohol intake	__	__

GENITOURINARY	Y	N
Frequent urination	__	__
Painful urination	__	__
Kidney stones	__	__
Incontinence	__	__
Unusual discharge	__	__

MUSCULOSKELETAL		
Joint stiffness	__	__
Joint pain	__	__
Joint swelling	__	__
Leg cramping	__	__

Last colonoscopy _____

Last mammogram _____

PAST HOSPITALIZATIONS AND SURGERY

When	Where	Why

PLEASE LIST PERSONAL ILLNESSES THAT INVOLVE CANCER, HEART DISEASE, DIABETES, HYPERTENSION OR OTHER MEDICAL ILLNESSES

Disease:

_____
_____
_____
_____

PLEASE LIST FAMILY ILLNESSES THAT INVOLVE CANCER, HEART DISEASE, DIABETES OR OTHER MEDICAL ILLNESSES

Disease	Relationship

Doctor's Initials	Date
_____	_____
_____	_____
_____	_____

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PAYMENT POLICY

Thank you for choosing us as your surgical provider. As a courtesy to our patients, we are providing you with a copy of our Payment Policy. Please read it and ask any questions you have regarding our policy. Once you fully understand our policy, please sign in the space provided. A copy will be provided to you upon request.

1. **Insurance:** We participate in most insurance plans, including Medicare and Blue Cross. If you do not bring a copy of your most current insurance cards to your first appointment, you will be responsible for the full balance of your visit that day. Knowing your insurance benefits and finding a provider in network is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. If you do not have insurance, you will be required to pay $100.00 upfront for your appointment.

2. **Co-pays and deductibles:** All co-pays and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-pays and deductibles from patients can be considered fraud. Please be aware that failure to pay your co-pay or deductible prior to surgery can result in cancellation of your surgery.

3. **Payment Options:** We accept cash, checks and credit cards for all balances owed by you. If you are unable to pay your balance in full, we offer Care Credit as our financing plan. Care Credit is a separate line of credit to cover you and your family's healthcare needs. They offer flexible financing options, no annual fees or prepayment penalties and a credit decision usually only takes a few minutes. If you are interested in applying for Care Credit, please call and request an application or speak with our receptionist the day of your appointment.

4. **Non-covered services:** Please be aware that some, and perhaps all, of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

5. **Proof of insurance:** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely-manner, you may be responsible for the balance of a claim.

6. **Claims submission:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

7. **Coverage changes:** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

8. **Nonpayment:** If your account is over 90 days past due, you will receive a letter stating you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may seek legal services in order to collect. You will be responsible for any fees incurred in trying to collect your account.

9. **Discharge:** There are certain situations in which we will be forced to discharge you from our practice. These include but are not limited to: failure to pay after reasonable attempts to collect balance due, refusal to follow your doctor's advice, and excessive cancellations. These situations are rare but we must make you aware of them. If this is to occur, you will be notified by certified mail that you have 30 days to find alternative medical care. We will continue to provide medical care for you during this 30 days while you seek another physician for any new conditions. You will need to remain with your current surgeon for any post-operative care for the 90-day global period.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient **Date**

_____ _____

Signature of representative if patient unable to sign **Relationship**

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NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT

PATIENT NAME: _____

DATE OF BIRTH: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the Uses and Disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, the practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

SIGNATURE: _____

DATE: _____

_____
Relationship to patient (if signed by a personal representative of patient)

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RELEASE OF INFORMATION

PATIENT NAME: _____

DATE OF BIRTH: _____

I give Middle Tennessee Surgical Specialists, PLLC, permission to discuss medical information regarding _____ with the following people:

1. _____ Relationship to patient:_____

2. _____ Relationship to patient:_____

3. _____ Relationship to patient:_____

4. _____ Relationship to patient:_____

I understand it is my responsibility to notify Middle Tennessee Surgical Specialists, PLLC if I change any information contained in this release.

SIGNATURE: _____

DATE: _____

_____
Relationship to patient (if signed by a personal representative of patient)

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PATIENT RECORD OF DISCLOSURES

PATIENT NAME: _____

DATE OF BIRTH: _____

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

- ☐ Home Telephone: _____
  - ☐ O.K. to leave message with detailed information
  - ☐ Leave message with call-back number only
- ☐ Mobile Telephone: _____
  - ☐ O.K. to leave message with detailed information
  - ☐ Leave message with call-back number only
- ☐ Written Communication
  - ☐ O.K. to mail to my home address
  - ☐ O.K. to mail to my work/office address
  - ☐ O.K. to fax to this number: _____
- ☐ Other _____
  _____

_____ _____
Patient Signature Date

_____ _____
Print Name DOB

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly will constitute an adequate record.
Note: Uses and disclosures for third-party organizations may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	To Whom (Address or Fax Number)	1	Description of Disclosure	By Whom	2	3

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STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF
PROTECTED HEALTH INFORMATION

PATIENT NAME: _____

DATE OF BIRTH: _____

Information to be Used or Disclosed
The information covered by this authorization includes:
___Medical Records_____
_____

Persons Authorized to Use or Disclose information
Information listed above will be used or disclosed by:

_____
Name of person or organization

_____
Name of person or organization

Persons to Whom Information may be Disclosed
Information described above may be disclosed to:
__Middle Tennessee Surgical Specialists_____
Name of person or organization

_____
Name of person or organization

Expiration Date of Authorization
This authorization is effective for **ten (10) years after date signed** unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to **Middle Tennessee Surgical Specialists, PLLC**. You should **contact Brian Hardin** to terminate this authorization.

Potential for Re-disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Signature:

_____ _____
Signature of Patient Date

_____
Name of Patient (print or type)

_____
Signature of Patient Representative

_____
Relationship of Patient Representative to Patient

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MEDICATION LIST

PATIENT NAME:_____DATE: _____

DATE OF BIRTH:_____ REFERRING PHYSICIAN:_____

PRIMARY CARE PHYSICIAN:_____

WEIGHT: _____ HEIGHT: _____ BP: _____ AGE: _____

ALLERGIES: _____

_____

REASON FOR OFFICE VISIT: _____

PHARMACY:_____

Medications	Dose	Times Taken Daily