Cullman Regional Orthopedics and Sports Medicine, P.C.

David Dueland, M.D. Ben Gomez, M.D. Denise Gardner, DNP,CRNP Thomas Mullican, PA-C

PLEASE PROVIDE ALL INFORMATION REQUESTED

FAILURE TO COMPLETE PAPERWORK WILL RESULT IN APPOINTMENT DELAY

PATIENT INFORMATION: E-Mail:_____

PATIENT NAME: LAST:_____ FIRST :_____ MIDDLE INITIAL:_____
DATE OF BIRTH: _____ SS#: _____
ADDRESS: _____ PRIMARY PHONE: (_____)_____
CITY: _____STATE: _____ ZIP: _____ SECONDARY PHONE: (____)_____
SEX: _____RACE: _____ MARITAL STATUS (circle one): M S D W
EMPLOYER: _____ WORK #: (_____)_____

GUARANTOR INFORMATION:

SPOUSE'S NAME: _____ EMPLOYER: _____ WORK #: (____)_____
MOTHER'S NAME (if minor): _____ EMPLOYER: _____ WORK #: (____)_____
FATHER'S NAME (if minor):_____ EMPLOYER: _____WORK #: (____)_____

CONTACT INFORMATION:

CONTACT **OUTSIDE** OF YOUR HOME: _____
RELATIONSHIP: _____ PHONE: (_____)_____
CONTACT **OUTSIDE** OF YOUR HOME: _____
RELATIONSHIP: _____ PHONE: (_____)_____

INSURANCE INFORMATION: **IS THIS A WORKMAN COMPENSATION CASE:** ☐ YES ☐ NO

PRIMARY: _____ SECONDARY: _____
POLICY HOLDER: _____ POLICY HOLDER: _____
POLICY HOLDER'S DATE OF BIRTH: _____ POLICY HOLDER's DATE OF BIRTH: _____

CONSENT FOR TREATMENT: I CONSENT TO NECESSARY TREATMENT INCLUDING DRUGS, PERFORMANCE OF OPERATIONS, AND X-RAYS, OR OTHER STUDIES THAT MAY BE USED BY THE ATTENDING PHYSICIAN, HIS NURSE, OR STAFF.
AUTHORIZIATION FOR RELEASE OF INFORMATION: I AUTHORIZE CROSM TO FURNISH ANY MEDICAL INFORMATION REQUESTED BY INSURANCE COMPANY WITH WHOM I HAVE COVERAGE, WITH ANY PUBLIC AGENCY WHICH MAY BE ASSISTING IN PAYMENT, OR MY EMPLOYER WHO IS PROVIDING PAYMENT OF MY MEDICAL BILLS DUE TO AN ON THE JOB INJURY.
AUTHORIZATION TO VERIFY MEDICATION HISTORY: I AUTHORIZE CROSM TO ELECTRONICALLY VERIFY MY MEDICATION HISTORY.
ASSIGNMENT OF BENEFITS: I HEREBY AUTHORIZE PAYMENT DIRECTLY TO CROSM OF BENEFITS OTHERWISE PAYABLE TO ME INCLUDING MAJOR MEDICAL INSURANCE, AND PAYMENT OF SURGICAL OR MEDICAL BENEFITS, BUT NOT TO EXCEED THE CROSM CHARGES NOT COVERED BY THIS AGREEMENT. I AUTHORIZE THE REFUND OF OVERPAYMENT OF INSURANCE BENEFTS WHERE MY COVERAGES ARE SUBJECT TO COORDINATION OF BENEFITS.
GUARANTEE OF ACCOUNT: FOR SERVICES RENDERED BY CROSM I HEREBY GUARANTEE THE PAYMENT OF ALL ACCOUNTS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. I ALSO UNDERSTAND THAT IF MY ACCOUNT IS TURNED OVER TO COLLECTIONS, I AM RESPONSIBLE FOR ALL COLLECTION CHARGES.

SIGNATURE:_____DATE:_____
(IF MINOR-UNDER 19 YEARS OF AGE- PARENT OR LEGAL GUARDIAN SIGNATURE REQUIRED)

1942 AL HWY 157
CULLMAN, AL 35058
256.737.5115 256.737.5003 FAX

Cullman Regional Orthopedics and Sports Medicine, P.C.

NAME: _____

DOB: _____

MEDICAL INFORMATION RELEASE (HIPAA RELEASE FORM)

Cullman Regional Orthopedics and Sports Medicine, P.C. is dedicated to protecting the privacy of each and every patient. It is your right to receive quality care without concern that your personal health information will be shared or disclosed to others. Your medical information is protected by law and will only be used in treatment, payment and healthcare operation scenarios. Employees of Cullman Regional Orthopedics and Sports Medicine, P.C. and affiliated business associates have signed confidentiality statements and contractual agreements agreeing to follow the policies and procedures of our practice in protecting your privacy. While disclosures of personal health information to doctors, nurses and specialists is often necessary for treatment, your medical information will not be sold to any outside agency or pharmaceutical company nor will it be released for any reason other than treatment, payment, healthcare operations or when required by state or federal laws without your written authorization. You have the right to access and request changes to your medical record, find out what disclosures have been made and request restrictions on uses and disclosures of your health information. If at any time you have any questions or concerns you may contact our Compliance Officer at 256.737.5115. This privacy notice is subject to change.

☐ **DO NOT COMMUNICATE MY INFORMATION WITH ANYONE.**

☐ I hereby authorize and give Cullman Regional Orthopedics and Sports Medicine, P.C. (CROSM) consent to communicate my Protected Health Information including:

- ☐ Billing/Financial Information
- ☐ Appointment Reminders
- ☐ Medical Information (Including returned phone calls)
- ☐ Prescription Refills
- ☐ Test Results

To the following persons:

NAME	RELATIONSHIP	NAME	RELATIONSHIP

SIGNATURE: _____

DATE: _____

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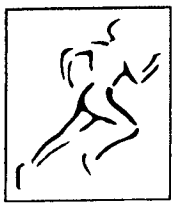

Cullman Regional Orthopedics and Sports Medicine, P.C.

NAME: _____

DOB: _____

PRIMARY CARE PHYSICIAN: _____ HEIGHT: _____ WEIGHT: _____

REFERRING PHYSICIAN: _____

LIST ANY OTHER DOCTORS YOU HAVE SEEN FOR THIS PROBLEM: _____

☐ EMPLOYED ☐ RETIRED ☐ FULL TIME STUDENT

OCUPATION: _____

PLACE OF WORK: _____ MISSED SCHOOL/WORK: _____ DATES MISSED: _____

SCHOOL: _____ GRADE IN SCHOOL: _____

SPORTS/RECREATIONAL ACTIVITIES: _____

REASON FOR APPOINTMENT:

CHIEF COMPLAINT (Describe Complaint): _____

DATE OF INJURY OR ONSET OF SYMPTOMS: _____

TREATMENT ATTEMPTED (Ice, Brace, Medication, MRI, etc.): _____

ANY PREVIOUS INJURY RELATED TO CURRENT PROBLEM: _____

REVIEW OF SYSTEMS: (Please check any symptoms you have experienced in the last 6 months.)

☐ **NONE**	☐ FEVER	☐ WEIGHT GAIN	☐ CONSTIPATION
☐ CHEST PAIN	☐ SHORTNESS OF BREATH	☐ BLACKOUTS	☐ PERSISTENT COUGH
☐ DIARRHEA	☐ VISION CHANGES	☐ PAINFUL URINATION	☐ NAUSEA/VOMITING
☐ HEARTBURN	☐ BLADDER/KIDNEY INFECTION	☐ LOSS OF APPETITE	☐ NON HEALING WOUNDS
☐ DEPRESSION	☐ NIGHT CHILLS/SWEATS	☐ SIGNIFICANT WEIGHT LOSS	☐ IRREGULAR HEARTBEAT
☐ HEADACHES	☐ PARALYSIS OR WEAKNESS	☐ DIZZINESS	☐ HIVES/RASHES

MEDICAL PROBLEMS: (Do you have or have you recently had any of the following?)

☐ **NONE**	☐ CROHN'S DISEASE	☐ HEART ATTACK	☐ NEUROPATHY
☐ ANEMIA	☐ DEAFNESS	☐ HEART FAILURE	☐ OSTEOARTHRITIS
☐ ANXIETY	☐ DEPRESSION	☐ HEPATITIS A, B , C	☐ PROSTATE
☐ ASTHMA	☐ DIABETES	☐ HIATAL HERNIA	☐ PSORIASIS
☐ BIPOLAR DISORDER	☐ DIALYSIS	☐ HIGH BLOOD PRESSURE	☐ REFLUX
☐ BLEEDING DISORDER	☐ DIVERTICULITIS	☐ HIGH CHOLESTEROL	☐ RHEUMATOID ARTHRITIS
☐ BROKEN BONES	☐ ECZEMA	☐ HIV	☐ SCHIZOPHRENIA
☐ CHRONIC BACK PAIN	☐ EMPHYSEMA		☐ SEIZURES
☐ CHRONIC BRONCHITIS	☐ FIBROMYALGIA	☐ KIDNEY FAILURE	☐ SLEEP APNEA
☐ CHRONIC NECK PAIN	☐ GLAUCOMA	☐ KIDNEY STONES	☐ STROKE
☐ CHRONIC STEROID USE	☐ GOUT	☐ LIVER DISEASE	☐ THYROID DISORDER
☐ CIRRHOSIS	☐ HEADACHES	☐ LUPUS	☐ TOOTH DECAY

☐ OTHER _____

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Cullman Regional Orthopedics and Sports Medicine, P.C.

NAME: _____

DOB: _____

MEDICATIONS THAT UPSET STOMACH: _____

PHARMACY: _____ PHONE: (____) _____

MEDICATIONS: ☐ **NONE**

NAME	REASON FOR TAKING	NAME	REASON FOR TAKING

PRIOR ORTHOPEDIC INJURIES (Please list dates): ☐ **NONE**

_____

_____

PRIOR SURGICAL HISTORY: ☐ **NONE**

☐ APPENDIX ☐ GALLBLADDER ☐ HYSTERECTOMY ☐ TONSILLECTOMY

☐ HEART STENTS DATE: _____

☐ ARTHROSCOPY ☐ RIGHT ☐ LEFT | ☐ SHOULDER ☐ KNEE

☐ TOTAL JOINT REPLACEMENT ☐ RIGHT ☐ LEFT | ☐ SHOULDER ☐ KNEE ☐ HIP

☐ OTHER: _____

DRUG ALLERGIES: ☐ **NONE**

DRUG	REACTION

SOCIAL HISTORY:

RECREATIONAL DRUG USE ☐ NO ☐ YES TYPE: _____

TOBACCO USE ☐ NO ☐ YES TYPE: ☐ CIG. ☐ SMOKELESS PACKS PER DAY: _____ YEARS: _____

ALCOHOL USE ☐ NO ☐ YES TYPE: _____ GLASSES/CANS PER DAY: _____

LAWSUIT INVOLVED: ☐ NO ☐ YES

WHO DO YOU LIVE WITH? (SPOUSE, PARENTS, GRANDKIDS): _____

FAMILY HISTORY (Have any relatives had the following illnesses?):

☐ DIABETETES ☐ HIGH BLOOD PRESSURE ☐ HEART DISEASE ☐ KIDNEY DISEASE

☐ STROKE ☐ RHEUMATOID ARTHRITIS ☐ OSTEOARTHRITIS ☐ THYROID DISEASE

☐ CANCER ☐ TUBERCULOSIS ☐ SEIZURES ☐ ALCOHOLISM

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CULLMAN, AL 35058
256-737-5115

Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

PATIENT NAME _____ **DATE** _____

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Cullman Regional Orthopedics & Sports Medicine may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Cullman Regional Orthopedics & Sports Medicine has a detailed document called the ***'Notice of Privacy Practices'***. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the *'Notice'* before signing this agreement. If I ask, Cullman Regional Orthopedics & Sports Medicine will provide me with the most current *Notice of Privacy Practices*.

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*. My signature means that I agree to allow Cullman Regional Orthopedics & Sports Medicine to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Cullman Regional Orthopedics & Sports Medicine has taken action relying on this consent.

SIGNATURE (Patient or Legal Custodian/Authorized Representative) _____ **DATE** _____

Relationship to Patient if signed by another party _____ **DATE** _____

You may obtain a copy of our *Notice of Privacy Practices*, including any revisions of our *'Notice'* at any time by contacting: Cullman Regional Orthopedics & Sports Medicine..

FORM Us