Nashville:
2400 Patterson Street, Ste. 100
Nashville, TN 37203

Murfreesboro:
3053 Medical Center Pkwy, Ste. F
Murfreesboro, TN 37129

Dickson:
107 Natchez Park Drive, Ste. 202
Dickson, TN 37055

Union City:
1722 E Reelfoot Ave, Ste. 2
Union City, TN 38261

Welcome to our practice!

Thank you for choosing SJRI for your orthopedic care! We strive to make your experience with our office a pleasurable one.

In order to better serve you, we ask our patients to **arrive at least 30 minutes prior to your scheduled appointment to allow time for parking, X-rays and to obtain any additional medical information, if needed**.
Please consider utilizing the free Valet parking at the front of our building, Physician's Park.

In addition, we strongly encourage you to complete these New Patient Registration Forms and bring them to your appointment along with:

- Current Insurance Card(s)
- Drivers' License or Photo ID
- List of your current medications
- Name, Address and Phone Numbers of your Primary Care Physician and any other Specialists you have recently seen

If your insurance requires a referral and/or authorization, then please contact your PCP prior to the scheduled visit to obtain the referral and/or authorization. This can be faxed to our billing office at 615-329-4469. If the referral and/or authorization are not received prior to your appointment, then you may be asked to reschedule.

Payments of co-pays, deductibles and other out of pocket expenses are to be paid at time of service. For your convenience, we accept cash, checks, Visa, MasterCard and American Express.

Please feel free to contact our office at 615-342-0038 or 1-877-442-SJRI (toll-free) if any additional information is needed or if you are unable to keep your scheduled appointment.

Thank you for selecting our practice! We look forward to serving you!

Physicians and Staff of Southern Joint Replacement Institute

Phone: 615-342-0038 **Fax: 615-329-4469** **Office Hours: Mon - Fri 8am - 4:30pm**

PATIENT REGISTRATION FORM (eCW)

PATIENT INFORMATION (Please print)

Patient's Name: (Last) ______________________ (First) ______________________ (MI) __________

Preferred Full Name (if different from above): ______________________

Address: ______________________

City State Zip: ______________________

Home Phone Number (landline): __________ Cell: ______________ Work: ______________

E-Mail Address: ______________________ Date of Birth: ______________

Gender Identity: ☐ Female ☐ Male ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer ☐ Choose not to disclose
☐ Additional Gender category not listed ______________

Race: ■ American Indian/Alaska Native ■ Asian ■ Native Hawaiian/Pacific Islander ■ Black/African American ■ White ■ Hispanic
☐ Choose not to disclose ☐ Other not listed ______________

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Choose not to disclose

Preferred Language: ☐ English ☐ Spanish ☐ ASL ☐ Japanese ☐ Mandarin ☐ Korean ☐ French ☐ Indian: Hindi, Tamil, Gujarati etc
☐ Swahili ☐ Russian ☐ Arabic ☐ Vietnamese ☐ Haitian Creole ☐ Bosnian/Croatian/Serbian/Serbo-Croatian
☐ Albanian ☐ Burmese ☐ Tagalog ☐ Farsi-Iranian/Persian ☐ Portuguese ☐ Cambodian ☐ Other not listed_______

Social Security Number: ______ - ______- ______

RESPONSIBLE PARTY INFORMATION (*If not self*) (Information used for patient balance statements)

Responsible party: ■ Another patient ■ Guarantor ■ Self Check here if address and telephone information is same as patient ■

Responsible party name: (Last) ______________________ (First) ______________________ (MI) __________

Date of birth: MM ______/DD ______/YYYY_______ Sex: ■ Female ■ Male

Social Security Number: _________-______-_________ Phone number: ______________

Address: ______________________

City, State: ______________________ ZIP: ______________

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last) ______________________ (First) ______________________

Phone number: ______________________ Do you have a living will? ■ Yes ■ No

Emergency contact relationship to patient: ______________________ ■ Guardian

Address ______________________

City, State: ______________________ ZIP: ______________

Home phone: ______________________ Work home: ______________ Ext. _______

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition 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 the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, then we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant or clinical nurse specialist) and other health care providers, or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative: ______________________ Date: ______________________

Printed name of patient or personal representative: ______________________ Relationship to patient: ______________

SJRI MEDICAL HISTORY FORM

Name: ________________________________ **DOB**: _____________ **Height**: __________ **Weight**: _________

Reason for Visit (Please circle all that apply)

Hip Pain: Left Right Bilateral Previous surgery? Yes No If yes, what________________
Knee Pain: Left Right Bilateral Previous surgery? Yes No If yes, what________________
Shoulder Pain: Left Right Bilateral Previous surgery? Yes No If yes, what________________

Do you ever experience any of the following? (Please circle all that apply)

Pain Aching Throbbing Swelling Burning Giving way/buckling Limited range of motion Instability

Fever Popping Grinding Stiffness Locking Redness Tingling Numbness Catching Weakness

Have you had any of the following treatments? (Please circle all that apply)

Cortisone/steroid injections Viscosupplementation/Gel injections Physical Therapy Anti-Inflammatories/NSAIDS

Chiropractic Acupuncture Home exercises Bracing Topical creams/ointments CBD

Have you had any falls this past year? Yes No

Do you have any known allergies to metals? Yes No If yes, what reaction? ____________________

Do you have any known allergies to shellfish? Yes No If yes, what reaction? ____________________

Are you currently in pain management? If yes, please list the name and location of the clinic.

____

Work Status: Full-time Part-time Unemployed Disabled Self-employed Retired

If employed, what kind of work do you do? ____

Have you or a family member ever had any of the following?					
Condition/Diagnosis	Self	Family Member	Condition/Diagnosis	Self	Family Member
Alcoholism			Irregular heartbeat		
Asthma			Jaundice/liver disease		
Bladder Problems			Joint disease		
Blood clot			Kidney disease		
Cancer			Lung disease		
COPD			Prostate		
Depression/anxiety			Psych disorder		
Diabetes			Skin disease		
Epilepsy/seizures			Sleep apnea w/CPAP		
Glaucoma			Stomach problems		
Gout			Stroke		
Heart attack			Thyroid disorder		
Heart disease			Tuberculosis		
High blood pressure			Other:		
High cholesterol					

List current Medications, Frequency, and Milligram (Include supplements and over the counter)	
Current Medications	Dosage

List all medication allergies and the reactions	
Allergen	Reaction

List all previous surgeries and date if applicable	
Surgery	Date

Do you smoke? Yes No If yes, How many packs a day? ___________ **Former smoker:** Quit in __________

Do you use alcohol? Yes No If yes, how many drinks per week? ___________

Do you or have you used the following in the last three months? Marijuana Cocaine Heroine Methamphetamine

Primary Care Physician Information:

Name:_______________________________________ Phone #:________________________________

Address: ____

Pharmacy Information:

Name:_______________________________________ Phone #:________________________________

Address: ____

How did you hear about us? Circle any that apply: Please specify on the line below

Website Family/Friend Internet search Other healthcare facility Insurance network

____

PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

Location Name			
Patient Last Name (Printed)	Patient First Name (Printed)	MI	Date of Birth (MM/DD/YYYY)

Notice of Privacy Practice/clinics

________ (**Patient/Representative initials)** I acknowledge that I have received the Notice of Privacy Practice, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practice.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Communications about My Healthcare

I agree the Provider or an agent of the Provider or an independent physician's office may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice's/clinic's health care operations purposes (e.g., quality improvement activities). I understand that the practice/clinic retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications

If at any time I provide an email address or cellphone number at which I may be contacted, I consent to receiving unsecure instructions and other healthcare communications at the email or text address I have provided or you or your EBO Servicer have obtained, at any text number forwarded, or transferred from that number. These instructions may include, but not be limited to: post-procedure instructions, follow-up instructions, educational information, and prescription information. Other healthcare communications may include, but are not limited to, communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care.
Note: You may opt out of these communications at any time. The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Note: This location uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated locations that share an electronic health record in which you have a relationship.

PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

Location Name			
Patient Last Name (Printed)	Patient First Name (Printed)	MI	Date of Birth (MM/DD/YYYY)

Release of Information.

I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior service(s) at other HCA affiliated providers may be made available to subsequent HCA-affiliated providers to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

I certify that I have read and fully understand the above statements from all pages and consent fully and voluntarily to its contents.

Patient/Representative Signature	Relationship to Patient (self, parent, legal guardian/representative, etc)	Date

Practice:OPTIONAL ON FORM- REMOVE THIS Prescription Order Pick up Section **ONLY** if NA to your practice/clinic]

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

- ***I do want*** ____ (Patient/Representative Initials) to designate the following individual to pick up a prescription order on my behalf:

NAME	Relationship to Patient

- ***I do not want*** ____ (Patient/ Representative Initials) to designate anyone to pick-up my prescription order.

A photocopy of this consent shall be considered as valid as the original

Southern Joint Replacement Institute
Patient Consent for Financial Communications

Patient Name: ____
DOB: ____

Financial Agreement

- I acknowledge that, as a courtesy, SOUTHERN JOINT REPLACMENT INSTITUTE may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full, including but not limited to, any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand there is a fee for returned checks.

Third Party Collection: I acknowledge SOUTHERN JOINT REPLACEMENT INSTITUTE may use the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

Assignment of Benefits: I hereby assign to SOUTHERN JOINT REPLACEMENT INSTITUTE any insurance or other third-party benefits available for health care services provided to me. I understand SOUTHERN JOINT REPLACEMENT INSTITUTE has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to SOUTHERN JOINT REPLACMENT INSTITUTE, then I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

Medicare Patient Certification and Assignment of Benefit: I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to SOUTHERN JOINT REPLACEMENT INSTITUTE by the Medicare or Medicaid program.

Consent to Telephone Calls for Financial Communications. I agree that, in order for SOUTHERN JOINT REPLACEMENT INSTITUTE or Extended Business Office (EBO) Servicers and collection agents to service my account or to collect any amounts I may owe, I expressly agree and consent that SOUTHERN JOINT REPLACEMENT INSTITUTE or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or SOUTHERN JOINT REPLACMENT INSTITUTE or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

A photocopy of this consent shall be considered as valid as the original.

Patient/patient representative signature: ______________________________ **Date:** ________________

If you are not the patient, then please identify your relationship to the patient. Circle or mark relationship(s) from list below:

Spouse	Guarantor
Parent	Healthcare Power of Attorney
Legal Guardian	Other (please specify) ______________________________