Campbell Clinic
901-759-3100
1400 S. Germantown Road
Germantown, TN 38138

[Barcode]

Please Print | Patient Registration | Please Print

PATIENT INFORMATION

Last Name
First Name
Middle Initial
Preferred Name
Previous Last Name
Sex
DOB
SSN
Address
Address Line 2
Zip
City
State
Home Phone
Mobile Phone
Employer Name
Employer Phone
Email
Doctor seeing today
Preferred Language English | Español Other:
Marital Status
Race: Circle One White / Caucasian, Black / African American, Hispanic, Asian / Pacific Islander, Native American , Other / Unknown
Primary Care Physician
Referring Physician
Emergency Contact Name
Emergency Contact Relation
Emergency Contact Phone

RESPONSIBLE PARTY INFORMATION

Patient's Relationship to Resp. Party
Resp. Party Last Name
Resp. Party First Name
Resp. Party Middle Initial
Resp. Party DOB
Resp. Party Address
Resp. Party Address Line 2
Resp. Party Zip
Resp. Party City
Resp. Party State
Resp. Party SSN
Resp. Party Phone
Resp. Party Employer Name
Resp. Party Employer Phone

PRIMARY INSURANCE INFORMATION

Primary Insurance Co.
Policy Holder
Policy Number
Policy Holder SSN
Policy Holder DOB
Policy Holder Sex

OTHER INSURANCE INFORMATION

Other Insurance Co.
Other Policy Holder
Policy Number
Other Policy Holder SSN
Other Policy Holder DOB
Other Policy Holder Sex

I __ do ___ do not give my permission of Campbell Clinic to send automated calls and text messages to my wireless phone.

I hereby authorize (a) payment of insurance benefits otherwise due to me to be made directly to Campbell Clinic, (b) release of information including protected health information to insurance companies as needed to file for payment for services incurred, (c) Campbell Clinic to obtain records from other sources as may be necessary in the diagnosis or treatment, (d) for purposes of disability and/or FMLA disclosures, release of information in order for my disability and/or leave status to be reviewed, and (e) understand that I am financially responsible for payment to Campbell Clinic for charges related to services provided or incurred by me or my dependents.

Signature (Responsible Party) Date

Campbell Clinic ORTHOPAEDICS

901-759-3100

[Barcode]

HEALTH HISTORY

Date: _____

Name _____ Age _____ Were you referred by a Physician? Yes _____ No _____

Who requested our services? _____ Family Physician _____

Reason for seeking medical attention _____ Right Left Both

Date of injury or duration of symptoms _____ **WORK RELATED?** Yes _____ No _____ Are you right or left handed? _____

What is your occupation? _____

Have you had any diagnostic studies for this condition, such as MRI, Bone Scan, etc? Please list _____

Have you seen anyone else regarding this condition? Yes No If yes, list names and dates

Have you ever been diagnosed with any of the following medical conditions:

	Y	N		Y	N		Y	N
Asthma			Cancer			Bleeding Tendencies		
Kidney Disease			Diabetes			High Blood Pressure		
Lupus			Goiter			Rheumatoid Arthritis		
Heart Disease			Lung Disease			Nervous Syst. Disorder		
Epilepsy			Tuberculosis			Osteoarthritis		
Polio			Sleep Apnea			Sickle Cell Disease		
Hepatitis			Colitis			Alcoholism		
DVT (Blood Clot)			Stroke			Depression / Anxiety		
Anemia			Stomach Ulcers			COPD		
Migraines			Pelvic Radiation			HIV+ / AIDS		

Tobacco / Alcohol History

Never Smoker:	
Current Everyday Smoker:**	
Current Someday Smoker:**	
Former Smoker:**	

**	Date Began Smoking:	
**	Date Stopped Smoking:	
**	Packs Per Day:	

Alcoholic Beverages Per Day: _____

Alcoholic Beverages Per Week: _____

Beer ____ Wine ____ Liquor _____

Other Medical Conditions: _____

Are there lawsuits pending on your orthopaedic condition? _____

Please list any orthopaedic surgeries and dates:

Please list any other surgeries and dates:

Preferred Pharmacy Name:

Pharmacy Phone Number:

Pharmacy Address:

Please list all current medications and dosages:

Are you allergic to: (check if you are)

	Y	N	Reaction
Cephalosporin			
Penicillin			
Sulfa			
Latex			

Has anyone in your family had: (check all that apply)

	Family	Father	Mother	Sibling	Child
High Blood Pressure					
Heart Disease					
Diabetes					
Lung Disease					
DVT (Blood Clots)					
Cancer*					

*If yes, what type(s) of cancer? _____

Other Medication Allergies: _____

Food / Other Allergies: _____

Please explain allergic reaction: _____

Have you recently had any of the following problems or symptoms:

	Y	N		Y	N		Y	N
Chest Pain			Dizziness			Headaches or Migraines		
Breathing Difficulties			Fever or Chills			Unexpected Weight Loss		
Numbness or Tingling			Nausea or Vomiting			Loss of Control of Bladder		
Vision Changes			Blood in Urine			Loss of Control of Bowels		
Abdominal Pain			Fainting Spells			Difficulty Starting Urine		
Irregular Heart Beat			Cough with Blood			Pain or Burning on Urination		
Cough			Diarrhea			Bloody or Black Tarry Stools		

Have you been vaccinated for:

	Y	N
Influenza		
Pneumonia		

Clinic Use Only

Ht: _____ **Wt:** _____

Patient Signature _____ Physician's Signature _____ Date: _____

(I have reviewed this information with the patient)

[Barcode]

Campbell Clinic
901-759-3100

Patient Name:
DOB:
Age:
Gender:

PATIENT/RESPONSIBLE PARTY FINANCIAL POLICIES

Date: _____

In order to establish a complete understanding of the financial responsibilities associated with the care provided by Campbell Clinic, the financial policies outlined herein are provided for your review. If you have any questions about these, please feel free to ask one of our Patient Account Representatives for clarification.

It is our desire that you receive the maximum benefit possible from your health insurance. In order to achieve this, we need your assistance in providing complete and accurate personal and insurance information requested on our Patient Registration Form. Please complete this form in its entirety and provide your insurance card to be copied.

For patients for whom we have verified health insurance coverage, with an insurance plan with which we participate, we will submit a claim to your insurance company, but require payment of any unpaid deductible, co-payments and coinsurance for services provided in the office at the time services are rendered. In the event your insurance company subsequently denies payment for services provided by Campbell Clinic, the responsibility for full payment rests with the patient or responsible party. For patients without verified health insurance, or with a plan with which we do not participate, we require payment in full at the time services are rendered. We do not accept third party liability, such as automobile insurance, pending litigation, and other indirect insurance responsibilities, and thus ask for full payment for your office care at the time services are rendered. We accept cash, check, money order, MasterCard, Visa, or Discover. Returned checks are subject to a $35.00 processing fee.

For outpatient or inpatient surgical procedures, we require payment of the unpaid deductible, and applicable coinsurance and co-payments, prior to the surgery. For surgical services covered by your health insurance, we will submit a claim to your insurance company; once the company has processed the claim, the patient or guarantor is responsible for any remaining balance. Any services not covered by insurance are to be paid in full prior to surgery. Custom orthotics will be charged at the time they are ordered.

We have found that many insurance plans provide payment at levels significantly lower than our fee. We take great care in setting our charges within the prevailing norms for similar services in this area. Many insurance companies no longer recognize these norms, but rather establish their own reimbursement schedules. If you find that your insurance plan does not cover certain services or pays below our usual charge, we encourage you to discuss such issues with your insurance carrier.

In order to accommodate the needs and requests of our patients, we have enrolled in numerous managed care insurance programs. While we are pleased to provide this service to you, it is extremely difficult for us to keep track of all the individual requirements of the plans. Within the same insurance company, plans may differ depending upon the type of contract your employer negotiated. Providing quality medical care for our patients is our primary concern; we are more than willing to provide that care within your insurance contract guidelines if you inform us at the time of service exactly what guidelines apply. Oftentimes preapproval or precertification for certain services or goods is required; accordingly, there may be a delay or wait if we are unable to obtain approval from your insurance company immediately. If you do not inform us of any special requirements in your contract and we subsequently order services, such as x-rays, physical therapy, medical supplies or equipment, which are not covered, we will bill you directly for those charges; payment is then your responsibility.

We ask you to assume responsibility for informing us if your coverage has any special requirements, such as precertification for hospital admission or surgery, second surgical opinion, or a referral from your primary care physician. If a referral is required under your insurance plan, it is the patient's responsibility to obtain the necessary approvals. We will be pleased to assist in providing clinical information to primary care physicians upon request, but ask that you obtain all necessary referrals in advance of your scheduled appointment.

Unless we have signed a participating provider or similar agreement with the insurance carrier, any charges not covered in full are payable by patient/guarantor. We ask you to remember that the ultimate responsibility for full payment, including any collection fees or late charges for our services, rests with the adult patient or guarantor.

Campbell Clinic meets and collaborates with orthopaedic device manufacturing companies for the purpose of improving the quality of patient care. That patient care is the focus of our practice, as is our adherence to the highest ethical standards. Campbell Clinic also occasionally receives compensation from some of these companies in order to conduct research, provide consulting service, or as payment for Campbell Clinic's contribution to the design or improvement of devices or methods of treatment that are licensed or sold to industry. In your treatment, the staff physicians at Campbell Clinic may elect to use products, devices, or methods from some of the companies with which Campbell Clinic has a financial relationship or in which the staff physician has a financial investment. As a matter of Campbell Clinic's policy, the selection of any particular product, device, or method is not based on any compensation received by Campbell Clinic from industry. Rather, the selection of any particular product, device or method is based on your Campbell Clinic's physician's determination of what is best suited for the treatment of your medical condition.

DISABILITY/FMLA POLICY: Payment is required prior to completion of FMLA and/or Disability forms.

NO SHOW POLICY – Effective October 11, 2016
Campbell Clinic understands that situations arise in which you are unable to make your scheduled appointment. If you must miss a scheduled appointment, please call our office as soon as possible so that we may have the opportunity to reschedule.

Patients who do not show up for their appointment, or call within 24 hours to cancel an office appointment or procedure will be considered as **NO SHOW/SAME DAY CANCELLATION**. Patients who No Show OR Same Day Cancel **three (3) or more consecutive times**, regardless of provider, in a rolling 12 month period, may be dismissed from the practice and denied any future appointments.

I have read and understand this financial policy and agree to accept responsibility as described herein.

Responsible Party Signature: _____ Date: _____

Campbell Clinic
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[Barcode]

Patient Name:
DOB:
Age:
Gender:

PATIENT NOTICE

Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF THE PATIENT NOTICE

I, _____, do hereby acknowledge receipt of Campbell Clinic's
Patient Name (please print)
Patient Notice on _____.
Date

Patient Signature

_____

Campbell Clinic
901-759-3100

[Barcode]

Patient Name:
DOB:
Age:
Gender:

AUTHORIZATION TO DISCLOSE INFORMATION

Date: _____

For information about how your medical information may be used or disclosed, please see the patient notice. You have the right to review the Notice before you decide to sign this form. The Notice is subject to change. You may request a copy of the Notice from the Privacy Officer of Campbell Clinic. The notice is also posted at Campbell Clinic's offices and on our website at www.campbellclinic.com.

YOU MAY REFUSE TO SIGN THIS FORM; HOWEVER, IT MAY PREVENT US FROM COMPLETING A TASK YOU HAVE REQUESTED. WE WILL NOT CONDITION YOUR TREATMENT ON AN AUTHORIZATION, EXCEPT FOR AN AUTHORIZATION FOR RESEARCH-RELATED TREATMENT.

THIS AUTHORIZATION IS VOLUNTARY

TO BE COMPLETED BY PATIENT OR PATIENT REPRESENTATIVE

By my request, I hereby authorize Campbell Clinic to disclose information regarding my treatment, insurance issues and payment issues to the people listed below. These individuals will be asked to identify themselves and state the patient's social security number and zip code.

Name (please print)	Relationship (please print)
_____	_____
_____	_____
_____	_____

I understand that this authorization is voluntary. I understand that the person to whom I authorize disclosure of my personal data is not a health plan, health care provider or clearinghouse and that the released information, in their possession, may no longer be protected by federal privacy regulation. I understand that I may withdraw my authorization in writing to the Privacy Officer of Campbell Clinic at any time, except to the extent that action has been taken in reliance on this statement. I understand that even if I do not withdraw authorization that this statement will expire 10 years from this date. I have carefully read and understand the above, and do herein expressly and voluntarily authorize the disclosure of the above information about my condition to those persons or agencies listed above.

_____ _____
Signature of patient or patient's representative Date

Printed name of patient's representative _____

Description of the Representative's authority to act for the patient _____

Relationship to the patient _____

Patient #: _____

[Barcode]

Campbell Clinic ORTHOPAEDICS

Authorization for Release of Patient Photographs

Patient Name: _____ DOB: _____

I consent to the taking of photographs/videos/testimonials by Campbell Clinic Orthopaedics staff member or designee of me or parts of my body in connection with the procedure(s) to be performed by Campbell Clinic Orthopaedics. I understand that such photographs/videos/testimonials shall become the property of Campbell Clinic Orthopaedics and may be retained by Campbell Clinic Orthopaedics. I give consent for the photographs/videos/testimonials to be released by Campbell Clinic Orthopaedics for the following purposes:

Marketing: For inclusion in brochures, portfolios, websites, newspaper or other media advertisements and other materials that show examples of services performed by the staff of the facility.
Educational: For use by staff during or in connection with professional lectures or seminars, in articles submitted, trade and other journals or periodicals, or in educational textbooks for use by health care professionals.
Health care professionals participating in or attending seminars or lectures performed by Campbell Clinic Orthopaedics

Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the photographs/videos/testimonials may portray features that will make my identity recognizable. I understand that the information disclosed, or some portion thereof, may be protected as PHI by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 (“HIPAA”).

I understand that I may refuse to authorize the release of any health information and that my refusal to consent to the release of health information will prevent the disclosure of such information, but will not affect the services I presently receive, or will receive, from Campbell Clinic Orthopaedics.

I understand that I have the right to inspect and copy the information that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time, but if I do so it won’t have any effect on any actions taken prior to my revocation. This agreement will remain in effect for ten years after the date it was signed.

I release and discharge Campbell Clinic Orthopaedics and all parties acting under its license and authority from all rights that I may have in the photographs photographs/videos/testimonials (considering the exceptions checked above) and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs.

I certify that I have read the above Authorization and Release and fully understand its terms.

Signature: _____ Date: _____

I have read the above Authorization and Release. I am the parent, guardian, or conservator of:

Patient Name: _____

I am authorized to sign this authorization on his/her behalf and give this authorization voluntarily.

Signature: _____ Date: _____

Campbell Clinic ORTHOPAEDICS

[Barcode]

Consent to Treatment of a Minor

The undersigned parent or legal guardian of _____ authorizes the person(s)
(Child's Name)
listed below to consent to treatment of the child, including, but not limited to, emergency, x-ray, DME, casting, injections, MRI, and or PT services when I am not immediately available in person, or by a telephone call to _____.
(Phone Number)

It is understood that this consent is given in advance of any specific diagnosis or treatment and allows the physician/provider to diagnose and treat the child even when the parent or guardian is not present.

1. Person(s) who may consent to treatment (please print)

Name: _____ Relation to Child: _____Phone:_____

Name: _____ Relation to Child: _____Phone:_____

Name: _____ Relation to Child: _____Phone:_____

2. Medical Concerns: _____

3. Known Allergies: _____

___I give permission for my minor child to consent to any follow up treatment without a representative.
(Please initial)

Name of Parent or Legal Guardian: _____ **Relation to Child:** _____

Contact Number (s): _____, _____, _____

Address: _____ **City, State, Zip:** _____

Signature: _____ **Date:** _____

This consent is effective until withdrawn in writing by the child's parent or guardian.

Rev 3/17