PLEASE COMPLETE ALL ATTACHED FORMS

FAILURE TO COMPLETE THESE FORMS

OR

FAILURE TO BRING ALL X-RAYS, MRI, CT,

AND OTHER RELATED SCANS

MAY RESULT IN YOUR APPOINTMENT

BEING DELAYED OR RESCHEDULED ADDITIONALLY, ALL

REQUIRED CO-PAYS WILL BE EXPECTED TO BE PAID AT THE TIME

THE SERVICE IS RENDERED.

Thank you for your assistance

MISSED APPOINTMENT POLICY

Our time together is important. We request that you cancel your appointment 24 hours in advance, or pay the missed appointment fee in full. The policy requires a payment of $50 for all appointments that are missed.

_______________________________ ___________

Signature Date

DIRECTIONS

SPINE SURGERY ASSOCIATES, P.C.
979 EAST THIRD STREET SUITE
C-225 CHATTANOOGA, TN 37403
423-756-6623

We are located on 3rd Street and Central at the main Erlanger Hospital campus. Park in the main parking garage for the hospital and stay to the right of the parking garage. You will see a sign that says to do this. (if you go left, you will be put to the main hospital entrance and have to walk all the way over to the medical mall) You may park on any level. When you get out of your vehicle go to the elevator and take it to the 1 st floor. When you get out of the elevator in the garage go left into the breezeway that connects the medical mall to the garage. You will know you are in the medical mall when you see Starbucks coffee on the right and Moore and King Pharmacy on your left. Directly behind the pharmacy are the C elevators. Take the elevator to the 2nd floor. We are on the 2nd floor in suite 225. The name on the door is Spine Surgery Associates, P.C. and the lobby is glassed in, so you should be able to see our waiting room.

Paul A. Broadstone, MD
Richard G. Pearce, MD

SPINE SURGERY ASSOCIATES, P. C.

Todd C. Bonvallet, MD
James M. Osborn, MD
David M. Lowry, DO

Patients' Name Last First M.I.

M F Age Birth date / / Social Security #: - -

Address: (H) Home Phone: ( )

City, State, Zip: (W) Work Phone: ( )

Spouse's Name: Age: Birth date: SSN

Emerg. Contact: Emerg. Phone:

Alternative Contact: Pager: Cell Phone:

********* FINANCIAL INFORMATION *********

Person Responsible for Payment: -- Relationship to Patient:

Address: Daytime Phone:

City, State, Zip:

********* IF THE PATIENT IS IN SCHOOL, COLLEGE OR IS A MINOR *********

Patient's School: In What Grade/Level:

Marital Status of Parent(s): D Married D Divorced D Single Parent D Legal Guardian D Separated

Father's Name/Legal Guard: Mother's Name/Legal Guard:

Address: Address:

(If different from patient) (If different from patient)

City, State, Zip: City, State, Zip:

Social Security #: Social Security #:

Age: Birthdate: Age: Birthdate:

H. Phone: W. Phone: H. Phone: W. Phone:

Employer: Employer:

********* EMPLOYMENT INFORMATION *********

Patient's Employer: Spouse's Employer:

Address: Address:

City, State, Zip: City, State, Zip

Insurance Contact: Insurance Contact:

Phone: ( ) Phone: ( )

********* PRIMARY PHYSICIAN / REFERRAL PHYSICIAN *********

Primary Care Physician: Phone: ( )

Referring Physician: Phone: ( ) Referral #

SPINE SURGERY ASSOCIATES, P.C. - Financial and Insurance Policies

Please be advised that you as the guarantor (patient, the parent or guardian, or the insured) **are responsible for payment of all fees regardless of insurance coverage.** I f you are insured through a government sponsored plan or a managed care organization, we may be contracted with that plan and we may have agreed not to bill you for any balances other than the deductibles and co-pays. If your insurance coverage denies payment for services rendered, you then become the responsible party. If your valid insurance does not reimburse Spine Surgery Associates, P.C. within 90 days of our sending a claim, the amount due will be reclassified as the guarantor's responsibility. Additionally, if the account remains unpaid after 150 days from the date of service, we may assign your account for further processing and you will be responsible for any associated fees.

Date of First Symptoms/Date of Injury ___________ Related to Job? Vehicle Acc?

Patient' s Name ____ **Birthdate** _________________

Primary Insurance _______________ **Insured's Name** _______________________ **DOB** ____/___/___

Claims Address ____________________________ City _________________State ___ Zip _______

Group # __________ Patient ID# __________ School Ins Y N Employer Ins Y N

**If Insurance is through employer, name of Employer ___________________________

Secondary Insurance _______________Insured's Name ___________________ DOB __ / __ / __

Claims Address ____________________________ City _________________State ___ Zip _____

Group # ___________ Patient ID# _____________________School Ins Y N Employer Ins Y N

**If Insurance is through employer, name of Employer ___________________________

In order for us to file an insurance claim on your behalf and the insurer to process the claim, your consent to release medical information is required.

I authorize the release of medical information necessary to *process* my *insurance claim. Furthermore, I authorize payment of medical benefi*ts to *Spine Surgery Associates, P.C. for services rendered by Dr. Paul Broadstone, Dr. Richard Pearce, Dr. Todd Bonvallet,* Dr. *James Osborn, Dr. David Lowry, and any Spine Surgery Associates staff.*

***Authorized signature** ___________________________________ Date __________________
*Pleased be advised that insurance will not be filed without your signature to release information to the insurance company.

By signing this sheet, you agree that the above information given to Spine Surgery Associates, P.C. is accurate and complete. Furthermore, you agree that you are responsible for payment of fees, deductibles, and/or co-pays, unless specifically exempt by contract and that you understand our financial policies as described above.

****Authorized Signature** ______________________________________ Date__________________
**Failure to sign and accept financial responsibility for services rendered may result in cancellation of your appointment/denial of services.

I have the right to expect that my protected health information will remain private. I have had the opportunity to obtain the Spine Surgery Associates Notice of Privacy Practices (as required by law).

Authorized signature ____ Date ______

Form 7382
Revised 3-08

Paul A. Broadstone, M.D
Richard G. Pearce, M.D

Todd C. Bonvallet, M.D
James M. Osborn, M.D
David M. Lowry, M.D

Spine Surgery Associates, P. C

Date: ____/____/____ Name: ______________________________

PAST MEDICAL HISTORY:

Tuberculosis	Y	N	Glandular Disorders	Y	N
Diabetes	Y	N	Skin Disease	Y	N
Blood Disease	Y	N	Neurologic Disorders	Y	N
Heart Disease	Y	N	Emotional Disorders	Y	N
Kidney Disease	Y	N	Blood Transfusions	Y	N
High Blood Pressure	Y	N	Pregnancies # ____	Y	N
Liver Disease	Y	N	Ulcer	Y	N
High Cholesterol	Y	N	Other ____________	Y	N

PAST SURGICAL HISTORY:

Surgical Procedure	Yr.	Surgeon	Hospital

Any Other hospitalizations? Y N (If Y, please explain by giving dates/names of physicians)

Reason	Yr.	Physician	Hospital

Cancer History Y N (If Y, please explain type of cancer or location)

____

FAMILY HISTORY:

	Living	Deceased	Cause of Death	Age
Father				
Mother				
Brother(s)				
Sisters(s)				

Please mark the following if found in the family:

	Mother	Father	Sister	Brother
Cancer				
Diabetes				
High Blood Pressure				
Heart Disease				
Kidney Disease				
Lung Disease				
Seizures				
Spinal Problems				
Stroke				

SOCIAL HISTORY:

Activity Limitations: (What you cannot do because of the spinal problem)

____

____

Martial Status: Married Single Divorced Separated Widowed
Number of Children: ______Ages: ________________#living at home: __________
Education Completed(years): 9 10 11 12 13 14 15 16 16+
Alcohol Use: ______#Beers /drinks per day _____ # Beers / drinks per week
Tobacco Use ______ packs per day # of years _______ Ceased smoking________ years ago

PLEASE TURN THE PAGE OVER AND COMPLETE

Paul A. Broadstone, M.D
Richard G. Pearce, M.D
Todd C. Bonvallet, M.D
James M. Osborn, M.D
David M. Lowry, M.D

Spine Surgery Associates, P. C

WORK STATUS: (If Applicable)
Usual Occupation: ______________________________
Current Job If Different from Usual: ______________________
Employer (Name and Address): ________________________

1) Are you presently off work due to your injury? Y N
2) Have you been on disability due to this injury? Y N
   If so, what is your last day at work: ______________
3) Is this a disability examination? Y N
   If so, who is the party requiring the exam: ______________
3) Is there legal action pending?
   If so, Attorney's Name and Address: ________________

CURRENT MEDICATIONS: (List all current medications not just those for back problems)

Name	Dosage	Physician Name	How long

ALLERGIES:(Specify the name of MEDICATIONS and type of REACTION like Itching, Rash, Hives, Wheezing)

Medications	Type of Reaction

Please list Foods, Pollen, or other environmental factors that effects you:

____
____
____

Paul A. Broadstone, M.D
Richard G. Pearce, M.D

Todd C. Bonvallet, M.D
James M. Osborn, M.D
David M. Lowry, M.D

Spine Surgery Associates, P. C

REVIEW OF SYSTEMS

Constitutional:

Good general health	Y N
Recent weight change Gain or Loss	Y N
Fever / Chills	Y N

Ophthalmologic:	None
Glaucoma	Y N
Cataracts	Y N
Wear Glasses / Contact lens	Y N

Cardiovascular:	None
Heart attack / Congestive heart failure	Y N
Mitral valve prolapse	Y N
Irregular heart rhythm	Y N
Angina	Y N
Pacemaker	Y N
Hypertension	Y N
High Cholesterol	Y N

Respiratory:	None
Asthma	Y N
Tuberculosis	Y N
Chronic obstructive pulmonary disease / Emphysema	Y N
Shortness of breath	Y N
Chronic cough	Y N
Sleep Apnea	Y N

Gastrointestinal:	None
Reflux/ GERD (Gastro Esophageal Reflux Disease)	Y N
Hiatal hernia	Y N
Change in bowel habits	Y N
Ulcers	Y N
Hepatitis	Y N
Cirrhosis	Y N

Genitourinary / Renal:	None
Stones	Y N
Kidney disease	Y N
Dialysis	Y N
Blood in urine	Y N
Change in force when urinating	Y N
Frequency	Y N

Integumentary:	None
Edema (Swelling in extremities)	Y N
Varicose vein	Y N

PLEASE TURN PAGE OVER AND COMPLETE

Psychiatric:	None
Memory loss or confusion	Y N
Anxiety/Depression	Y N
Bipolar	Y N
Hematologic / Lymphatic:	None
Clotting problems	Y N
Aspirin use	Y N
Non-steroidal anti-inflammatory drug use	Y N
Coumadin or Plavix use	Y N
Blood Clot	Y N
Blood disease	Y N
Anemia	Y N
Endocrine / Diabetes:	None
Thyroid	Y N
Steroid use	Y N
Non-Insulin Dependent Diabetes Mellitus	Y N
Insulin Dependent Diabetes Mellitus	Y N
Immunologic:	None
HIV	Y N
History of Infection	Y N
Immuno-Suppression	Y N
Autoimmune Disease	Y N
Musculo / Skeletal:	None
Back pain	Y N
Neck pain	Y N
Rheumatoid arthritis	Y N
Osteoarthritis / Deformities	Y N
Difficulty walking	Y N
Neurological:	None
Headaches / Migraines	Y N
Paralysis	Y N
Stroke	Y N
Weakness	Y N
Dizziness	Y N
Bowel / Bladder Incontinence	Y N

Other:
Please list any other medical conditions that are not listed on this form

____

____

SPINE SURGERY ASSOCIA TES, PC 979 E THIRD STREET C-225 MEDICAL MALL CHA 7TANOOGA, TENNESSEE 37403

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Please Review It Carefully

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal mandate that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, or paper, or orally, are kept properly confidential. The Act gives you, the patient, new rights to understand and control how your health information is used.

As required by HIPM, Spine Surgery Associates has prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records, without notice, for each of the following purposes: ongoing treatment or testing, payment, and health care business operations.

- **TREATMENT or TESTING** means providing, coordinating, or managing your health care and related services by one or more health care providers. An example of this would be sending you for an MRI.
- **PAYMENT** means any activities related to obtaining reimbursement for services provided and may include confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your surgery to your insurance company for payment.
- **HEALTH CARE BUSINESS OPERATIONS** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal chart review for compliance with federally mandated documentation requirements.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about current or alternative treatment protocols or other health-related benefits and services that may be of interest to you.

The following is a list of other uses and disclosures allowed by the privacy rule

- **Controlling Disease -** As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

- **Child Abuse & Neglect** - We may disclose protected health information to public authorities as allowed by law to report child abuse or neglect.
- **Food and Drug Administration (FDA)** - We may disclose to the FDA your protected health information relating to adverse effects with respect to products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.
- **Victims of Abuse, Neglect, or Domestic Violence** - We can disclose protected health information to governmental authorities to the extent the disclosure is authorized by statute or regulation and in the exercise of professional judgment the doctor believes the disclosure is necessary to prevent serious harm.
- **Oversight Agencies** - Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities to include audits, civil, administrative or criminal investigations, inspections, licensures or disciplinary actions.
- **Judicial/Administrative Proceedings** - We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, or as directed by a proper court order or administrative tribunal, provided that only the protected health information released is expressly authorized by such order, or in response to a subpoena, discovery request or other lawful process.
- **Law Enforcement** - We may disclose your protected health information for law enforcement purposes as required by law, such as when required by court order, including laws that require reporting of certain types of wounds or injuries.
- **Research** - We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information has approved their research.
- **Specialized Governmental Functions** - We may disclose your protected health information for specialized government functions as authorized by law such as to armed forces personnel, for national security purposed, or to public assistance program personnel.
- **Workers Compensation** - If you are seeking compensation/health coverage through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Office Manager:

- ✓ The right to inspect and receive a copy of your protected health information.
- ✓ The right to amend your protected health information.
- ✓ The right to receive an accounting of disclosures of protected health information. The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to have it removed.

- ✓ The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations .
- ✓ The right to obtain a paper copy of this notice from us.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency. We may use and disclose you protected health information to assist in disaster relief efforts.

We are associated with various medical training programs. Medical students, Interns, and Residents in Training may participate in your provision of care or they may access your records for training purposes. The students and physicians in training will treat your protected health information as if they were employees of SSA and will not disclose your protected health information.

Our policy is to destroy medical records no less than ten years after your last examination or treatment This destruction will be accomplished while maintaining the privacy of your protected health information.

If it becomes necessary to assign your account to an accounting service for further processing, we will only divulge enough information to allow for collection of any monies due. The accounting service will treat your protected health information in the same manner as outlined in this document.

This notice is effective as of October 1, 2002 and we are required to abide by the terms of the Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will make the revised Notice of Privacy Practices available to you if necessary.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact the Office Manager for more information or for more information about HIPAA or to file a complaint, you may contact:

The U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Wasbington, D.C. 20201
(202) 619-0257

Rev 4-10-2008

Print Form

PLEASE PRINT

PAUL A. BROADSTONE, M.D,
Spinal Surgery

RICHARD G. PEARCE, M.D.
Spinal Surgery
Pediatric Orthopaedic Surgery

TODD C. BONVALLET, M.D.
Spinal Surgery

JAMES M. OSBORN, M.D..
Adult and pediatric Spinal Deformities
Reconstructive Spine Surgery

DAVID M. LOWRY, D.O.
Physical Medicine and
Spine Rehabilitation

PATIENT NAME ____________________ DATE OF BIRTH ____________

I give permission for Spine Surgery Associates, P.C. and any member of the staff to disclose Protected Health Informationo to the following individuals.

Name ____________________ Relationship ____________

Name ____________________ Relationship ____________

Name ____________________ Relationship ____________

Name ____________________ Relationship ____________

This authority will remain intact until revoked by me or by a court of jurisdiction.

☐ I give permission for the practice to leave a message on my home answering machine.

☐ I DO NOT give permission for the practice to leave a message on my home answering machine.

Signature ____________________ Date ____________

Erlanger Medical Mall
Suite C-0225
979 East Third Street
Chattanooga, TN 37403-3314

Telephone 423-756-6623
Fax 423-778-7894