



For Sports Medicine & Orthopaedics

Because Life Happens In Motion

GENERAL CONSENT TO TREATMENT

1. GENERAL CONSENT TO TREATMENT: By signing below, I (or my authorized representative on my behalf) authorize the Chattanooga Orthopaedic Group, PC and staff to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess and maintain my health and to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my healthcare provider to explain to me the reason/s for any particular diagnostic examination, test or procedure, the available treatment options and the common potential risks and benefits associated with these options.

2. INFORMED CONSENT FOR INJECTION THERAPIES: By signing below, I (or my authorized representative on my behalf) authorize the Chattanooga Orthopaedic Group, PC and staff to administer injections if my healthcare provider deems necessary. I understand that all injection treatments are commonly but not always accompanied by possible risks including, but not limited to bruising, temporary increase in pain, inflammation and temporary numbness. I also understand that more serious reactions may but do not always occur, including but not limited to infection, allergic reaction, prolonged numbness, weakness, paralysis, spinal headache from dural puncture, lung puncture or death as a result of or related to injection treatment. I understand that there are various types of injections that are commonplace in the practice of orthopedics including, but not limited to trigger point, intramuscular, intraarticular (joint), tendon, ligament or other forms of injections.

3. RIGHT TO REFUSE TREATMENT: I acknowledge that I am given the opportunity to discuss the nature and purpose; alternate methods of treatment; the risks, potential complications and associated risks associated with any treatment or procedure recommended by my healthcare provider. I also understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my healthcare provider. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment. I further acknowledge that I will ask any questions I have regarding my evaluation and treatment to my satisfaction, and I understand that I may ask any additional questions I may have at any time.

(Complete with Ink Pen Only)

Patient Name (print): _____

Patient Signature: _____ **Date:** _____

Authorized Representative (if applicable): _____ **Relationship:** _____

CONSENT TO TREATMENT OF A MINOR UNACCOMPANIED BY PARENT/GUARDIAN:

I, the undersigned parent or legal guardian of (child's name) _____, consent to/authorize the Chattanooga Orthopaedic Group, PC and staff to provide treatment, including but not limited to diagnostic examinations, tests, medical treatment and/or therapy necessary to effectively assess and maintain my child's health and to assess, diagnose and treat illness or injury when I am not immediately available in person or by a telephone call to (Phone Number): _____.

I understand that this consent is given in advance of any specific diagnosis or treatment and allows the Chattanooga Orthopaedic Group, PC and staff to diagnose and treat my child even when I (the parent or guardian) am not present.

I have the legal right to preauthorize the Chattanooga Orthopaedic Group, PC and staff to deliver said medical treatment to my child, and I have specified any limitations/restrictions below.

Limitations

Identify any limitations/restrictions regarding the kinds of medical services for which this authorization is given. If none, state "none."

Identify any limitations/restrictions regarding the time frame for which this authorization is given. If none, state "none."

In the event the nature of the medical care is not routine or requires consideration due to the limitations/restrictions stated above, please try to contact me or the designated individual/s below, whom I give authorizing authority. **ONLY CONTACT PARENT.**

1. Name: _____ **Relationship to Child:** _____ **Phone:** _____

2. Name: _____ **Relationship to Child:** _____ **Phone:** _____

Patient Name: _____ **DOB:** _____

Parent/Guardian Name and Signature: _____

Witness (Confirms Driver's License/ID): _____

Date: _____ (This consent will remain in effect until withdrawn in writing by the child's parent or guardian.) GS111 Rev. 7/09



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Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of Your Protected Health Information

Your protected health information will be used by the Center for Sports Medicine and Orthopaedics or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information. The Center for Sports Medicine and Orthopaedics may or may not agree to restrict the use or disclosure of your protected health information. If the Center for Sports Medicine and Orthopaedics agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices

The Center for Sports Medicine and Orthopaedics reserves the right to modify the privacy practices outlined in the notice.

Signature

I have reviewed this consent form and the Notice of Privacy Practices and give my permission to the Center for Sports Medicine and Orthopaedics to use and disclose my health information in accordance with it.

Name of Patient (Print or Type): _____

Signature of Patient: _____

Date: _____

Signature of Patient Representative: _____

Relationship of Patient Representative to Patient: _____

AUTHORIZATION SECTION

I authorize the following individuals access to my medical file information with the indicated password verification. I understand that if I do not list an individual's name that he/she will not be authorized to receive my information, such as financial, medical, etc.

NAME: _____ PASSWORD: _____

Authorize access to (circle all that apply): Medical Financial All

NAME: _____ PASSWORD: _____

Authorize access to (circle all that apply): Medical Financial All

CENTER FOR SPORTS MEDICINE AND ORTHOPAEDICS, P.C.
PATIENT HISTORY – PLEASE COMPLETE ENTIRE FORM
(COMPLETE IN BLACK INK ONLY.)

PATIENT LABEL

Date of Birth _____ Age at this visit _____

Family Physician / Primary Care Provider _____

Specialists: _____

PAST MEDICAL HISTORY:

Have you ever been diagnosed with or experienced the following? CHECK YES or NO TO EACH ITEM

ALLERGIC/IMMUNOLOGIC:

- Yes No
 Seasonal / Environmental allergies
 Contact dermatitis
 HIV/Immunosuppressive Disorders

CARDIOVASCULAR:

- Yes No
 Irregular heartbeat
 High blood pressure
 Congestive heart failure
 Mitral valve prolapse
 Varicose veins
 Heart disease
 Heart murmur
 Heart attack
 Pacemaker
 Implantable defibrillator
 Peripheral vascular disease
 AV shunt for dialysis Rt Lt

HEMATOLOGIC/LYMPHATIC:

- Yes No
 Bleeding disorder
 Blood clots in lungs or legs
 Cancer:
 Type _____

- Yes No
 Clotting disorder
 Previous transfusions
 Anemia

MUSCULOSKELETAL:

- Yes No
 Previous fractures
 Previous muscle or tendon injury
 Osteoarthritis
 Rheumatoid arthritis
 Scleroderma
 Fibromyalgia
 Lupus
 Scoliosis

INTEGUMENTARY / SKIN:

- Yes No
 Eczema
 Psoriasis
 Scars
 Tattoos
 Body piercing

METABOLIC / ENDOCRINE:

- Yes No
 Irregular menstrual cycles
 Diabetes Insulin Non-insulin
 Hypoglycemia

- Yes No
 Gout
 Hypothyroidism
 Hyperthyroidism
 Hyperparathyroidism
 Hashimotos goiter
 Paget's disease

EYES / EARS:

- Yes No
 Deafness Rt Lt
 Hard of hearing / hearing aid
 Cataracts
 Glaucoma
 Blindness
 Glasses
 Contacts

NEUROLOGIC:

- Yes No
 Alzheimer's disease
 Parkinson's disease
 Stroke
 Seizure disorder

PULMONARY:

- Yes No
 Asthma
 Bronchitis
 Emphysema
 TB or exposure

GASTROENTEROLOGIC:

- Yes No
 Gastric reflux
 Ulcer disease
 Irritable bowel syndrome
 Crohn's or ulcerative colitis
 Hiatal hernia
 Cirrhosis
 Hepatitis A B C

RENAL/GU:

- Yes No
 Kidney disease/impairment
 Dialysis
 Kidney stones
 Prostate problems
 Frequent urinary tract infections

PSYCHOLOGIC:

- Yes No
 Depression
 Anxiety disorder

Other: _____

REVIEW OF SYSTEMS:

Are you experiencing any of the following? CHECK YES or NO TO EACH OF THE FOLLOWING

- Yes No
 Increased energy
 Decreased energy
 Recent weight loss
 Recent weight gain
 Generalized weakness
 Fever for unknown reason
 Chills for unknown reason
 Night sweats

- Yes No
 Recent onset of high blood pressure
 Cold extremities
 Joint swelling
 Joint pain
 Numbness
 Tingling

- Yes No
 Muscle pain with any activity or rest
 Back pain
 Rashes
 Headaches
 Blurred vision
 Shortness of breath
 Chronic cough

- Yes No
 Problems breathing
 Diarrhea
 Constipation
 Poor bladder control
 Burning on urination
 Increased urinary frequency
 Depression

Other: _____

*** PLEASE COMPLETE OTHER SIDE ***

PATIENT LABEL

PAST SURGICAL HISTORY: (Please list ALL previous surgeries)

FAMILY HISTORY - IMMEDIATE FAMILY - NOT PATIENT

History of Heart disease Heart attack Lung disease Diabetes Rheumatoid arthritis Cancer
 Stroke TB Anesthesia complications Patient adopted - no history available No problems
 Blood clots in lungs or legs Other: _____

SOCIAL HISTORY

Marital Status: Married Single Separated Divorced Widowed
Available Assistance and Support:
Do you live in: House / Apartment Assisted living Residential care home Other: _____
Number of dependent children _____
Do you use, Tobacco: Yes No Rarely Occasionally Regularly _____ packs per day
or have you ever used: Alcohol: Yes No Rarely Occasionally Regularly _____ drinks per day
Recreational drugs: Yes No Explain _____
IV drugs: Yes No Date last used: _____

PREVIOUS DIAGNOSTIC STUDIES: Did you bring them with you? Yes No

Test Done (i.e. MRI, CT scan, etc.)	Date Done	Facility (i.e. Memorial, Chattanooga Outpatient Center)	Films / Reports
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE SIGN BELOW

The information provided by me on this form is true and accurate to the best of my knowledge.

Patient _____ Date: _____

Nurse/MA Initials: _____ Date: _____ Provider Signature: _____ Date: _____



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Dear New Patient,

Thank you for choosing the Center for Sports Medicine and Orthopaedics. We are pleased to help you meet and maintain your Orthopaedic needs during treatment, while ensuring your privacy and confidentiality. To assist us in maintaining your privacy and confidentiality, Congress passed the Health Insurance Portability and Accountability Act (HIPAA) regulations in 1996. Within these regulations healthcare facilities must adopt practices by April 14, 2003 to ensure your privacy and confidentiality is protected at all times.

Enclosed you will find information that will assist in providing the quality of care you deserve during your visit at the Center. A Notice of Privacy Practices is included to explain how medical information about you may be used and disclosed and how you can get access to your information. Upon reviewing the Notice of Privacy Practices please sign the Consent to the Use and Disclosure of Protected Healthcare Information and complete the additional enclosed documents. We ask you to return the completed packet to the receptionist at your scheduled appointment to expedite your visit.

You may be asked to reschedule your appointment in the event you do not have the following essential items for your appointment:

- Current Insurance Card
- Referral from your primary care provider if required by insurance
- Current written authorization for workers compensation appointments
- Current prescribed medications from all physicians
- Appropriate co-payment

If you have had the following diagnostic tests within the past 12 months please bring them to your appointment.

- X-Rays
- MRI's
- CT Scan
- Bone Scan
- Medical records that pertain to the visit

As always we thank you for choosing the Center for Sports Medicine and Orthopaedics and we look forward to providing you with the best possible care.

Management Staff
Center for Sports Medicine and Orthopaedics