Patient Registration Form

Account #	Date:	Primary Physician Name:		
Patient's First Name	Middle Name	Last	Birthdate	Age
Address	City	State	Zip Code	
Social Security #	Home Phone #	Mobile Phone #	Marital Status	Sex
Employer's Name	Work or Business Phone #			
Email Address	How Were You Referred?			
Pharmacy Of Choice	Pharmacy Phone #			
Emergency Contact				
Name	Emergency Phone #	Relationship To Patient		

Consent For Healthcare Messages

I_____ give permission to the physicians and their staff at TN Regenerative Sports
(please print patient name) Medicine to leave messages regarding my healthcare in the following manner when I am not available:

____May **ONLY** leave information with me. **(If you check here, no other choices should be marked, skip to Contact Information)**

(Please mark all that apply – If you checked the box above then these should be blank)
____May leave appointment reminders on my answering machine/voicemail.
____May leave lab results on my answering machine/voicemail.
____May leave general questions/information on my answering machine/voicemail.

If any are checked below, please list the name of the individual we may give information to:
____May leave appointment reminders to be given to the following person.
____May leave lab results to be given to the following person.
____May leave general questions/information to be given to the following person.

Name:_____ Relationship:_____

Patient Signature:_____ Date:_____

Witness Signature: _____ Date: _____

For Office Use Only

Patient Name:	**DOB:**
Referred by:	**Phone:**
Address:	**Fax:**

I, the undersigned, am the patient, or the patient's duly authorized representative, and do hereby voluntarily consent to and authorize medical care and treatment by TRSM, through its individual physicians, employees, and/or agents. This care and treatment encompasses all diagnostic and therapeutic treatments considered necessary or advisable in the judgment of the physician and provided by TRSM.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations performed by the physician or TRSM.

I acknowledge that I have received a copy of TRSM's Notice of Privacy Practices and I understand that the notice is also posted at each location where services are provided and on the internet at www.trsportsmedicine.com. I consent to be called on my cell phone concerning healthcare services rendered to me.

To protect against the transmission of blood-borne diseases such as Hepatitis B and Acquired Immune Deficiency Syndrome, I understand that it may be necessary to test my blood for certain diseases while I am a patient of TRSM. I understand and consent that my blood, as well as the blood of any person accidentally exposed to my blood, will be tested. I further understand that my blood will not be tested for these diseases unless ordered by my physician and that the results of all tests will be kept confidential.

I have read this form, or had it read to me, and I certify that I fully understand and accept its contents unless noted.

_____	_____	_____
Patient's Signature	Patient's Name (Printed)	Witness

Patient, _____, is a minor, or is unable to sign above because:

_____.
(Name Printed)

_____	_____	_____
Person Giving Consent	Relation to Patient	Witness

Tennessee Regenerative Sports Medicine, PLLC

Patient Private Contract and Financial Agreement

Thank you for choosing Tennessee Regenerative Sports Medicine, PLLC (the "Practice") as your health care provider. We are committed to providing you with quality and affordable health care. We ask all patients to review and sign this policy, asking questions as necessary. A copy will be provided to each patient upon request.

1. <u>NON-PARTICIPATION IN INSURANCE</u>: We do NOT accept or participate in any insurance plans. Neither Dr. Carlson or any other provider in the Practice is a participating provider with any managed care, insurance or other health plans, including Medicare and TennCare. So, we will not file insurance claims on your behalf.

YOU UNDERSTAND THAT YOU ARE SOLELY RESPONSIBILITY FOR PAYMENT FOR YOUR TREATMENT AT THE TIME IT IS RENDERED, REGARDLESS OF THE TERMS OF ANY INSURANCE COVERAGE YOU MAY HAVE.

You acknowledge that it is your responsibility to understand the terms of your insurance coverage, including which medical services are covered; where services can be performed; whether any other provider to whom you are referred is in-network; whether your employer has any specific guidelines regarding network providers; the amounts of any deductibles, copayments, or coinsurance; and an understanding of which referrals, if any, are required.

2. <u>MEDICARE OPT OUT</u>. Please choose <u>ONE</u> of the following by initialing the appropriate blank:

_____ **You are not Medicare-eligible and not otherwise enrolled in the Medicare program.** ***If you have checked this section, you may skip to the end of this form and sign in the blank provided.***

<u>OR</u>

_____ **You are a Medicare-eligible or a Medicare beneficiary.** ***If you have checked this box, please read the following carefully, ask any questions, and then initial and sign in the blanks provided.***

If you are a patient who is entitled to benefits under or is enrolled in Part B of Medicare (the "Medicare Program"), your signature below also indicates that you acknowledge and agree as follows:

(a) Dr. Carlson has not been excluded from the Medicare Program but has voluntarily elected to "opt out" of the Medicare Program ***effective as of June 11, 2018.*** That means that no reimbursement will be provided to you or to our Practice under the Medicare Program, or any Medigap or supplemental plan, for the fees or charges you incur for your treatment and health care services here. Likewise, Medicare Advantage insurance plans may elect not to reimburse you for any such fees.

(b) You understand that the Practice will not file any claims with Medicare, and you agree not to submit a claim (or request that our office submit a claim) under the Medicare Program or to any intermediary or carrier of the Medicare Program for any portion of the fees and charges for your health care services even if the services you receive are otherwise covered by Medicare or

even if this Agreement is terminated. You acknowledge and agree that you will be responsible for payment of all fees and charges.

(c) You understand that the limits the Medicare Program places on what a physician participating in the Medicare Program may charge for services rendered do not apply to fees charged by the Practice.

(d) You understand that you have the right to obtain Medicare-covered services from physicians who have not opted out of the Medicare Program, you represent that you are currently not facing an emergency or urgent health care situation, and you acknowledge that you have voluntarily elected to enter into this Agreement, which constitutes a private contract between you and the Practice for treatment and other health care services provided by Dr. Carlson and our Practice staff, some of which may otherwise be eligible for payment or reimbursement by Medicare if rendered by a physician who continued to participate in the Medicare Program subject to the submission of an appropriate Medicare claim.

Medicare Patient: **BY YOUR INITIALS HERE: _____ AND YOUR SIGNATURE BELOW, YOU ACKNOWLEDGE THAT YOU UNDERSTAND AND AGREE TO THE TERMS AND CONDITIONS OF PARTICIPATION IN THE PROGRAM AS A MEDICARE ELIGIBLE PATIENT.**

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read and understand the financial policy (including the Medicare provisions, if applicable) and agree to abide by its guidelines.

_____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

Date:_____

TRSM Tennessee Regenerative SPORTS MEDICINE

Health Information Questionnaire

Name: _____ DOB:_____

Primary Care Physician:_____

Preferred Pharmacy:_____ Telephone Number:_____

Current Medications:	Prescribed by:

Please check any symptoms below that you are currently experiencing:

Musculoskeletal:

____ Joint pain
____ Muscle pain
____ Joint swelling
____ Joint stiffness
____ Limb pain/swelling
____ Muscle cramps/weakness

Neurological:

____ Limb weakness
____ Difficulty walking
____ Numbness
____ Tremor
____ Radiating pain

Past Medical History: **Check all conditions that apply:**

	You:	Family Hx:		You:	Family Hx:		You:	Family Hx:
Anemia			Arthritis			Blood Disease		
Cancer			Cholesterol			Diabetes		
GI Disease			Genital/Urinary Disease			Heart Disease		
High Blood Pressure			Liver Disease			Lung disease/Asthma		
Phlebitis			Psychological			Seizures		
Stroke			Thyroid Disease			Weight		

Past Surgeries:_____

Allergies:_____

Social History:

Do you use tobacco products? Yes ☐ No ☐ Do you drink more than 2 alcoholic beverages per day? Yes ☐ No ☐

Marital Status: ____Married ____Single ____Divorced ____Widowed

What is the reason for your visit today?_____

Medical Records Release

Patient's name _____Phone # _____

Date of birth ____/____/____

Social Security Number _____-___-_____

Address _____

_____

Please release my medical records from:

Name of provider _____ Fax Number: _____

Provider's address _____

_____

to:

Tennessee Regenerative Sports Medicine

10307 Kingston Pike
Knoxville, TN 37922
(865)360-1140
fax: (865)773-0550

PLEASE FAX TO: 865-773-0550

Please release all records, including but not limited to, progress notes, operative notes, laboratory test results, diagnostic tests, and x-rays.

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS AS PROVIDED ABOVE.

_____Date: _____
Patient's Signature