MARK KIRSHNER
ORTHOTICS

Notice of Patient's Rights and Responsibilities

Patient Rights

- **Patients have the right to receive respectful compassionate care in a safe and non-threatening environment regardless of their age, appearance, diagnosis, addiction, disabilities, gender identity, language, income, national origin, race, religion, se assigned at birth, sexual orientation, or weight/size.**
- **Patients have the right to be identified by their current name and pronoun in all inter actions and contexts possible and as desired, and legal names only when legally required or needed to connect documentation.**
- **Patients have a right to know the identity and professional status of all health care team members providing care.**
- **Patients have the right to be informed about their diagnosis and prognosis, if it is known, and to be informed about the risks and benefits of all treatment options offered. They have the right tot written informed consent prior to any nonemergency medical procedure.**
- **Patients have the right to choose a primary care provider (PCP) and to transfer their care to another PCP within the heath care center or to another practice.**
- **Patients have the right to confidentiality and can expect that communications and records of their care are confidential, unless disclosure is permitted or required by law.**
- **Patients have the right to inspect their medical, dental or behavioral health record upon request and to receive a copy of their medical, dental, or behavioral health record without a fee. Patients have the right to receive a list of people to whom heir records have been disclosed.**
- **Patients have the right to privacy during medical treatment within the capacity of the facility.**
- **Patients have the right to request the presence of an escort during any type of examination.**

- **Patients and any family or friends they designate have the right to participate in decisions about their care, including the right to refuse treatment.**

- **Patients have the right to communication that they can understanding, including provision of language interpretation services, if needed at no cost to them.**
- **Patients have the right upon request to receive information regarding opportunities for financial assistance and free health care services.**
- **Patients have the right to refuse to be examined, observed, or treated by students or any other facility staff without jeopardizing their access to medical records.**
- **Patients have the right to refuse service as a research subject and to refuse any care of examination when the primary purpose is educational or information rather than therapeutic.**
  Patients have the right to life-saving treatment in an emergency without discrimination related to economic status or source of payment and without delaying treatment for purposes of prior discussion of the source of payment, unless such delay can be imposed without material risk to their health.
- **Patients have the right to examine and receive an explanation of their itemized bill, including 3rd party reimbursement regardless of the source of payment.**
- **Patients have the right to voice their concerns about the care they receive. If their concern is not resolved to their satisfaction they may contact:**

Compliance Office
2620 Mineral Springs Ave, Suite A.
Knoxville, TN 37917
Or Call (865)247-4809 ext. 1001

Signature:_____ Date:_____

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PATIENT RESPONSIBILITES

- Patients are expected to provide complete and accurate information regarding your name, date of birth, address, telephone number, and insurance carrier, when requested.
- Patients are expected to keep scheduled appointments, be on time, and call ahead if they cannot keep an appointment.
- Patients are expected to ask questions when they do not understand information or instructions. If they believe they cannot follow through with their treatment plan, they are responsible for informing their provider. They are responsible for the outcome if they do not follow the plan of care recommended by their provider.
- Patients ae expected to treat all staff and other patients with respect and not to behave in a disruptive, disrespectful, or threatening manner.
- Patients are expected to provide information necessary for claim processing and to be prompt in payment of your bills.

Signature_____ Date_____

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NEW PATIENT INTAKE FORM

PATIENT REGISTRATION INFORMATION:

NAME_____DATE OF BIRTH _____

HOME ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

PRIMARY CARE PHYSICIAN:_____

REFERING PHYSICIAN:_____

REASON FOR VISIT:_____

EMERGENCY CONTACT:

NAME:_____RELATIONSHIP TO PATIENT_____

PHONE NUMBER:_____

PRIMARY INSURANCE:

INSURANCE PROVIDER:_____

ARE YOU THE PRIMARY INSURANCE PROVIDER:_____

IF NO PLEASE FILL OUT THE INFORMATION BELOW:

PRIMARY INSURANCE HOLDER NAME:_____

DATE OF BIRTH:_____ RELATIONSHIP TO PATIENT:_____

- I hereby authorize Mark Kirshner Orthotics to obtain records from the other sources as may be needed in the treatment of this patient.
- I hereby authorize payment of insurance and benefits otherwise due to me to be made directly to Mark Kirshner Orthotics. I understand that I am responsible for any amount not covered by insurance copany.

A copy of this information shall be as valid as the original.

Signature_____ Date _____

HIPAA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14,2003. Many of the policies have been our practice for years. This from is a friendly version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protect Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is avail form the U.S. department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically include the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information. Which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in admirative areas such as the front office, examination room, etc. Those records will not be available to person other that office staff. You agree to the normal procedures utilized within the office for the handing of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, email, US mail, or by any mean convenient for the practice and/or requested by you. We may send you other communication informing you of changes to office policy and new Technoloy that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance pares in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purpose of marketing or advertising of products, good or reviews.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain polices used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

Signature_____ Date_____

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HIPPA CONTACT CONSECT FORM

We understand that medical information about you and your health is personal and we are committed to protecting it. In order to comply with HIPAA Health Insurance Portability and Accountability Act. Privacy Notice of 1990 we are requesting that you designate to whom we may disclose specifics of your health information, the laboratory and radiology results, necessarily follow up appointments. Etc.

What is the Primary phone number you would like us to contact you on?

_____

May we leave a message at this phone number?

Yes or No

If you are unavailable is there someone with whom we are authorized to speak with?

Name: _____ Relationship: _____

Phone Number: _____

Signature: _____

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Health Questionnaire

Have you experienced any of the following?

- Heart Problems
- Hypertension
- Vascular Disease
- Stroke
- Diabetes
- Kidney Disease
- Osteoporosis
- Hepatitis A or B
- Hepatitis C
- HIV Positive
- Rheumatoid Arthritis
- Obesity
- Pulmonary Disease
- Vision Problems
- Parkinson Disease
- Alzheimer Disease
- Psychiatric Problems
- Alcoholism
- MRSA/Staph Infections

Are you currently in a Home Health Episode? Yes or No

If yes please provide your Home Health Information and Admitting Reason:_____

_____

Are you currently in a Long-Term Care Facility? Yes or No

If yes please provide the facility name:_____

Who is financially responsible:_____

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Have you had any Amputations, Trama, or Falls? Yes or No

If yes please provide further information:

Condition:_____

Treating Physician:_____

Date:_____

Condition:_____

Treating Physician:_____

Date:_____

Height_____

Weight_____

Shoe Size_____

Signature:_____

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Cancellation Policy/ No Show Policy

Cancellation/No show policy for Scheduled Appointments

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another a patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, do to seemingly “fully” appointment Calander.

If an appointment is not cancelled at least 24 hours in advance you will be charged a fifty-dollar ($50) fee, this will not be covered by your insurance company.

Scheduled Appointments

We understand that delays can happen however we must try to keep the other patients and the clinic on time. If a patient is more then 15 minutes past their scheduled time, we willhave to reschedule the appointment.

Account Balances

We will require that patients with self-pay balances do pay their account balances to zero prior to receiving further services by our office.

Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to the office manager.

Patients with balances of $100 must make payment arrangements prior to future appointments being made.

Print Name:_____

Signature:_____

Date:_____

Knee and Back Pain Questionnaire

Patient Name:_____ DOB:_____

Please circle all the apply:

Do you suffer from knee or back pain? Yes or No

If yes:

Where is your knee pain located? Left Knee Right Knee Both

Where is your back pain located? _____

Is this pain caused by an injury? Yes or No

If yes:

When was the injury?_____ (Date)

Have you seen a doctor for this injury? Yes or No

If yes:

What is the name of the doctor?_____

when did you see them?_____ (Date)

How would you describe your pain? (Please circle all that apply)

Constant Intermittent Mild Severe

Does anything make your pain worse? (Please circle all that apply)

Prolonged Walking Prolong Standing Going up or down stairs Prolonged Sitting Getting up from a seated position Kneeling or Squatting Pivoting or Twisting

Does anything Help your pain? (Please circle all that apply)

Heat Ice Physical Therapy Prescription Medicine Other:_____

Do you have any ankle, neck or hip pain? Yes or No

If yes please explain:_____

Have you ever had a neck, knee or back brace? Yes or No

If yes please explain:_____