BACK AND NECK PAIN CENTER

MURFREESBORO VASCULAR & INTERVENTIONAL

Patient Name: _____ Date: _____

DOB: _____ Male ☐ Female ☐ SS# _____-_____-_____

Cell Phone: _____ Other Phone: _____

May we send appointment reminders to your cell phone via TEXT? Yes ☐ No ☐

Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Pharmacy: _____ Phone: _____

Pharmacy Address: _____

Referring Physician: _____

Primary Care Physician: _____

Emergency Contact: _____ Phone: _____

Relationship to Patient: _____

Primary Insurance: _____

Policy Holder Name: _____ DOB: _____

Secondary Insurance: _____

How did you hear about us? _____

Patient Health History

Patient Name:_____ Date of Birth:_____

****CIRCLE ALL THAT APPLY TO YOU ****

Respiratory	Musculoskeletal	Cardiovascular
Cough	Joint pain	Chest pain
Shortness of Breath	Neck Pain	Calf pain
Wheezing	Back Pain	Heart palpitations
	Muscle Weakness	Leg Swelling
		Non- healing wounds

Neurological	Gastrointestinal	Psychiatric	Genitourinary
Arm Weakness	Abdominal Pain	Depression	Urinary urgency
Leg Weakness	Nausea/Vomiting	Anxiety	Frequent Urination
Headache	Constipation	Insomnia	Bladder Incontinence
Memory loss	Bowel Incontinence	Bipolar	

****PAST SURGICAL HISTORY ****
(If pertains to a side please note what side)

Cardiac Bypass	Neck Surgery	Knee Replacement	Tubal/Hysterectomy
Heart Valve Replacement	Back Surgery	Hip Replacement	Mastectomy
Cardiac Stent	Spinal Cord Stimulator	Kyphoplasty	Bladder Stimulator
Heart Angio	Brain Surgery	Vein procedures	Peripheral Arteriogram

Other Surgeries:_____

****PAST MEDICAL HISTORY****

COPD/emphysema	Diabetes	Compression Fracture	Anxiety
Asthma	Peripheral Vascular Disease	Rheumatoid Arthritis	High Cholesterol
Pulmonary Embolism (PE)	Congestive Heart Failure (CHF)	Fibromyalgia	Kidney Stones
Blood Clot (DVT)	Abdominal Aortic Aneurysm	Scoliosis	Hepatitis C/B
High Blood Pressure	Non-healing Wounds	Osteoporosis	HIV/AIDS
Heart Attack	Atrial Fibrillation	Multiple Sclerosis (MS)	Depression
Stroke	Kidney Failure	Cancer:_____	Other:_____

****FAMILY HEALTH HISTORY****

Diabetes Heart Failure (CHF) Heart Attack High Blood Pressure Anxiety Depression Hepatitis C/B

Varicose Veins Stroke Blood Clot (DVT) Pulmonary Embolism (PE) Clotting Disorder Cancer: _____

Patient Health History

Patient Name:_____ **Date of Birth:**_____

Height:_____ Weight: _____

Reason for today's visit?_____ When problem began?_____

Is injury due to an accident? Work accident Car accident Other:_____

Employer Name:_____ Phone: _____ Job title:_____

Marital Status: Married Single Divorced Widowed Domestic Partner Separated

Tobacco use: Smoker - how much? _____ Never Quit (year) _____ Vape Chew/Snuff/Dip

Alcohol use: Yes No If yes, how much? _____

Allergies: Please list any allergies below and what reactions you have to each allergy **NONE**

1._____ 3._____

2._____ 4._____

Are you allergic to the following:

Latex Adhesive tape Lidocaine Iodine CT Contrast dye Gadolinium (MRI contrast dye)

Medications: Please list all your medications and dosages you are currently taking, include all over the counter medications. (If you have a separate list with you, we are able to make a copy) **NONE**

Naproxen Motrin Advil Aleve Ibuprofen Goody's BC powder

1._____ 6._____

2._____ 7._____

3._____ 8._____

4._____ 9._____

5._____ 10._____

Blood Thinners: Aspirin Eliquis(Apixaban) Xarelto Coumadin Warfarin Plavix(Clopidogrel)

Who manages your blood thinner? _____

Do you have an advance directive or a living will? YES NO

If yes, who is your surrogate decision maker? _____

Please have office make a copy and put it in your chart if you have it with you.

MURFREESBORO VASCULAR & INTERVENTIONAL

BACK AND NECK PAIN CENTER

615-849-7490

APPOINTMENT CANCELLATION, NO SHOW, and LATE POLICY

Thank you for trusting your medical care to Murfreesboro Vascular and Interventional/Back and Neck Pain Center. When you schedule an appointment with our clinic, we set aside enough time to provide you with the highest quality care. If you need to cancel or reschedule an appointment, contact our office as soon as possible. This gives us time to schedule other patients who may be waiting for an appointment. If you are more than 15 minutes late, you will be asked to reschedule and will only be seen if time allows. Please see our full Policy below:

- Effective **May 1, 2023,** a patient scheduled with a new patient or follow up appointment who fails to show, cancel, reschedule, or is over 15 minutes late to an appointment and has not contacted our office with at least 48 hours' notice will be charged a $30.00 fee before being able to reschedule.

- Any new patient or follow up patient who fails to show, cancel, reschedule, or is over 15 minutes late to an appointment and has not contacted our office with at least 48 hours' notice a second time with be charged a $50.00 fee before being able to be rescheduled. Any time after that will result in dismissal.

- A patient scheduled for a procedure or insufficiency study that fails to show, cancel, reschedule, or is over 15 minutes late to an appointment and has not contacted our office with at least 48 hours' notice will be charged a $100.00 fee before being rescheduled.

- A patient scheduled for an Anesthesia procedure that fails to show, cancel, reschedule, or is over 15 minutes late for their procedure and has not contacted our office with at least a week's (7 days) notice will be charged a $575 fee before being rescheduled.

The fee is charged to the patient, not the insurance company. As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect.

If you need to cancel or reschedule an appointment and it is after regular business hours Monday through Friday, or a weekend, you may leave a message. Messages left are acceptable.

I have read and understand the Medical Appointment Cancellation, No Show, and late Policy and agree to its terms.

_____ _____

Signature (Patient or Guardian) Date

MURFREESBORO VASCULAR & INTERVENTIONAL

BACK AND NECK PAIN CENTER

Please sign below indicating you have received this notification of your Federal Health Care Privacy Rights. As a patient, you have the right to adequate notice of the use and disclosure of your protected health information. Under the Health Insurance Portability and Accessibility Act (HIPAA), MVI/Back & Neck Pain Center can use your protected health information for treatment, payment, and health care operations.

1. Treatment: We may use or disclose your health information to a physician or other health care provider providing treatment to you.
2. Payment: We may use and disclose your health information to obtain payment for services we provide you
3. Healthcare Operations: We may use or disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competency or qualifications of healthcare professionals, evaluating provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Most uses and disclosures that do not fall under treatment, payment, or healthcare operations will require your written authorization. Upon signing, you may revoke your authorization in writing through our practice at any time.

In the event of your incapacity or an emergency, we will disclose health information to a family member, or other person responsible for your car, using your professional judgement. We will only disclose health information that is directly relevant to the person's involvement with your healthcare.

We will not use your health information for marketing communications without your written consent.

We may use or disclose your health information when we are required to do so by law.

We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to you or other people's health and safety.

We may disclose the health information of armed forces personnel to military authorities under certain circumstances. We may disclose health information to authorized federal officials required for lawful intelligence, counterintelligence, and other national security activities. We may disclose health information of inmates or patients to the appropriate authorities under certain circumstances.

We may use or disclose your health information to provide you with appointment reminders via phone, text, email, or letter.

You have the right to restrict disclosure of your protected health information in writing. The request for restriction may be denied if the information is required for treatment, payment, or healthcare operations.

You have the right to:

- Receive confidential communications regarding your protected health information.
- Inspect a copy of your protected health information
- Amend your health information
- Receive an account of disclosures of your protected health information
- A paper copy of this notice of privacy practices.

If you have any complaints with the way your protected health information was handled, you may submit a complaint in writing to our office. You will not be retaliated against in any manner for complaints.

For further information about MVI/Back & Neck Pain Center's privacy policies, please contact our office at the following address or number.

Print Name: _____ Date: _____

Signature: _____

1840 Medical Center Parkway Ste. 200 Murfreesboro, TN 37129
Telephone: 615-849-7490

MURFREESBORO VASCULAR & INTERVENTIONAL

BACK AND NECK PAIN CENTER

Patient Financial Responsibility

Assignment of Benefits: I assign Murfreesboro Vascular and Interventional (MVI) my right to receive payment from third-party payers. Third-party payers include payers who provide coverage to me for care provided by MVI. Such payers are insurance carriers or social security administrators.

Responsibility for Payment: I understand that I am responsible for insurance co-payments and deductibles. I also understand that I am responsible for any services that are deemed not medically necessary by my insurance carrier.

Patient Name: _____ Date: _____

Signature: _____

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