TUSCALOOSA ORTHOPEDIC & JOINT INSTITUTE

Patients will not be seen until all required forms are completed in full. Incomplete paperwork may result in delayed care and extended wait times. This applies to new and established patients, and forms must be updated annually to ensure optimal treatment.

PATIENT INFORMATION

LAST: _____ FIRST: _____ MIDDLE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

CELL PHONE: (_____) _____-_____ HOME PHONE: (_____) _____-_____ WORK PHONE: (_____) _____-_____

EMAIL ADDRESS: _____ RACE: _____ ETHNICITY: ☐ HISPANIC ☐ NOT HISPANIC

DATE OF BIRTH: _____ / _____ / _____ SOCIAL SECURITY #: _____-_____-_____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ OTHER SEX: ☐ FEMALE ☐ MALE

PRIMARY CARE PHYSICIAN: _____ REFERRED BY: _____

EMPLOYER NAME: _____ EMPLOYER CITY: _____

EMPLOYER PHONE: (_____) _____-_____

GUARANTOR

RELATIONSHIP TO RESPONSIBLE PARTY: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER _____

RESP. PARTY NAME: LAST: _____ FIRST: _____ MIDDLE: _____

ADDRESS: _____ DATE OF BIRTH: _____ / _____ / _____

SEX: ☐ FEMALE ☐ MALE SOCIAL SECURITY #: _____-_____-_____

CELL PHONE: (_____) _____-_____ EMAIL ADDRESS: _____

EMERGENCY CONTACT

NAME: _____ PHONE NUMBER: (_____) _____-_____

RELATIONSHIP: _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____

CONTRACT (ID#): _____ GROUP #: _____

SUBSCRIBER NAME: _____

SUBSCRIBER DATE OF BIRTH: _____ / _____ / _____ SOCIAL SECURITY #: _____-_____-_____

RELATIONSHIP TO SUBSCRIBER: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

Medical Information Release Form

Name: _____ **Date of Birth:** _____/_____/_____

Release of Information:

☐ I authorize the release of diagnosis, records, examination rendered to me and the claims information. This information may be released to:

OR

☐ INFORMATION IS NOT TO BE RELEASED TO ANYONE.

This Release of Information will remain in effect until terminated by me in writing.

PLEASE LIST NAMES DOWN BELOW:

☐ Spouse _____

☐ Child(ren) _____

☐ Other: _____

Messages

Please call: ☐ Call my home ☐ My cell number ☐ Other _____

Please select one in case we are unable to reach you:

☐ You may leave a detailed message

☐ Please leave a message asking me to return your call

Signed: _____ **Date:** _____/_____/_____

Witness: _____ **Date:** _____/_____/_____

Consent & Financial Responsibility

WE APPRECIATE THE OPPORTUNITY OF SERVING YOU.

I AUTHORIZE THE RELEASE AND DISCLOSURE OF ANY OR ALL OF MY MEDICAL AND TREATMENT RECORDS OR REPORTS TO ANY OTHER HEALTH CARE PROVIDER WHO MAY BE OF ASSISTANCE, IN THE OPINION OF *Tuscaloosa Orthopedic and Joint Institute, LLC*, AND/OR FOR ASSISTING IN ANY REIMBURSEMENT OR MEDICAL BENEFITS TO WHICH PATIENT MAY BE ENTITLED. I ALLOW FAX TRANSMITTAL OF MY MEDICAL RECORDS, IF NECESSARY. I FURTHER AUTHORIZE AND REQUEST THAT INSURANCE PAYMENTS BE MADE DIRECTLY TO *Tuscaloosa Orthopedic and Joint Institute, LLC*, MD, PC SHOULD THEY ELECT TO RECEIVE SUCH PAYMENT. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

I ACKNOWLEDGE FULL FINANCIAL RESPONSIBILITY FOR SERVICES RENDERED BY *Tuscaloosa Orthopedic and Joint Institute, LLC*, MD, PC. I UNDERSTAND THAT PAYMENT OF CHARGES INCURRED IS DUE AT THE TIME OF SERVICE UNLESS OTHER DEFINITE FINANCIAL ARRANGEMENTS HAVE BEEN MADE PRIOR TO TREATMENT. I AGREE TO PAY ALL REASONABLE ATTORNEY FEES AND COLLECTION COSTS IN THE EVENT OF DEFAULT OF PAYMENT OF MY CHARGES.

I AUTHORIZE TREATMENT BY *Tuscaloosa Orthopedic and Joint Institute, LLC*, MD, PC, PHYSICIANS AND PERSONNEL.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT FOR TREATMENT, FINANCIAL RESPONSIBILITY, RELEASE OF MEDICAL INFORMATION AND INSURANCE AUTHORIZATION. THIS AUTHORIZATION IS VALID FOR ONE YEAR.

I have read the above and accept financial responsibility in full of this account.

SIGNED: _____ **DATE:** _____

Patient, Parent, or Guardian

TUSCALOOSA ORTHOPEDIC & JOINT INSTITUTE, LLC

Authorization to Disclose Health Information

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

1. I authorize _____ to disclose the above named individual's health information as described below to Dr. Bryan King, Tuscaloosa Orthopedic & Joint Institute, LLC, 100 Rice Mine Road Loop, STE 205, Tuscaloosa, AL 35406 or by fax to: (205)354-2679.

2. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)
   ☐ Entire record ☐ X-ray and imaging reports ☐ Other: _____

3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
4. This information may be disclosed at the request of the individual.
5. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Latricia Bass, Privacy/Security Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____ If I fail to specify an expiration date, event or condition, this authorization will expire in six months.
6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CRF 164.524 of the Federal Register Rules and Regulations. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure or my health information, I can contact Latricia Bass, Privacy/Security Officer.

Signature of Patient or Legal Representative: _____ **Date:** _____

If signed by Legal Representative, Relationship to Patient: _____

Legal Representative Name: _____

For Healthcare Organization Use Only

Staff Member Processing Request and Date Released: _____

Date Received: _____

Patient General Consent Form

Consent for Treatment: I, the undersigned, consent to the care and treatment by the attending physicians, his/her associates or assistants of Tuscaloosa Orthopedic & Joint Institute, LLC.

Patient Name: _____

Signature of Patient: _____ **Date:** _____

Person other than patient: _____ **Relationship to Patient:** _____

Assignment of Benefits and Guarantee of Account:

In consideration of all services and supplies provided by Tuscaloosa Orthopedic & Joint Institute, LLC, I understand and agree that I have full responsibility to pay Tuscaloosa Orthopedic & Joint Institute, LLC. I understand that the charges not covered by my insurance remain my responsibility and assign insurance benefits to Tuscaloosa Orthopedic & Joint Institute, LLC. I accept full financial responsibility for the immediate payment of any charges not covered by my insurance. I accept the fees charged as a legal and lawful debt and agree to pay said fee. I agree to reimburse Tuscaloosa Orthopedic & Joint Institute, LLC the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

I agree, in order for Tuscaloosa Orthopedic & Joint Institute, LLC to coordinate my care, service my account or to collect monies I may owe, Tuscaloosa Orthopedic & Joint Institute, LLC and/or their agents may contact me by telephone at any telephone number associated with my account, including my wireless telephone numbers, which could result in charges. Tuscaloosa Orthopedic & Joint Institute, LLC may also contact me by sending text messages or emails, using any e-mail address I provide. Methods of contacting may include prerecorded or artificial voice messages and/or use of automatic dialing devices, as applicable.

Signature of Patient: _____ **Date:** _____

Person other than Patient: _____ **Relationship to Patient:** _____

Notice of Privacy Practices Receipt

I have received the Notice of Privacy Practices provided by Tuscaloosa Orthopedic & Joint Institute, LLC.

Signature of Patient: _____ **Date:** _____

Person other than Patient: _____ **Relationship to Patient:** _____

TUSCALOOSA ORTHOPEDIC & JOINT INSTITUTE

No Show/Late Cancellation Policy

Effective 09/01/2025

This policy has been established to help us serve you better.

It is necessary for us to make appointments in order to see our patients as efficiently as possible. No Shows and Late Cancellations cause problems that go beyond a financial impact on our practice. When an appointment is made, it takes an available time slot away from another patient. No Shows and Late Cancellations delays the delivery of healthcare to other patients, some who are quite ill.

A "No Show" is missing a scheduled appointment. A "Late Cancellation" is cancelling an appointment without calling us to cancel within 24 hours of an office appointment or 72 hours in advance of a procedure.

We understand that situations such as medical emergencies occasionally arise. These situations will be considered on a case by case basis.

- **A Charge of $50.00 will be assessed for each no show or late cancellation office visit appointment if less than 24 hours notice is given.**
- **A Charge of $200.00 will be assessed for each no show or late cancellation procedure appointment if less than 72 hours notice is given.**

Please understand that insurance companies consider this charge to be entirely the patient's responsibility.

To cancel or reschedule an appointment, please call Tuscaloosa Orthopedics and Joint at 205-391-4440 and speak with the Front Office Staff. This policy is in effect to ensure that all of our patients have the opportunity to be seen in a timely manner.

Signature of Patient: _____ **Date:** _____

100 Rice Mine Road Loop Suite 205

Tuscaloosa, Alabama 35406

Phone: 205.391.4440 Fax: 205.391.4441

TUSCALOOSA ORTHOPEDIC & JOINT INSTITUTE

PATIENT MEDICAL HISTORY FORM

Patient Name: _____ **Height:** _____ **Weight:** _____

Chief Complaint

Dominant Hand: ☐ Right ☐ Left ☐ Ambidextrous (BOTH)

SELECT ONLY ONE PRIMARY SYMPTOM AND ONE AFFECTED AREA

Primary Symptom: ☐ Pain ☐ Numbness/Tingling ☐ Fracture ☐ Stiffness ☐ Other: _____

Affected Area: ☐ Right ☐ Left ☐ Both (Bilateral)

☐ Shoulder ☐ Upper Arm ☐ Elbow ☐ Forearm ☐ Wrist ☐ Hand ☐ Finger(s) ☐ Pelvis ☐ Hip ☐ Thigh ☐ Knee ☐ Lower Leg ☐ Ankle ☐ Foot ☐ Toe(s) **Pain radiates from/to:** _____

History of Present Illness

1. **Is your problem the result of an injury or accident?** ☐ No Injury ☐ Injury ☐ Injury at Work ☐ Auto Accident ☐ Sport Injury ☐ Prior Surgery
   How long have the symptoms been present? _____
   Describe the onset: ☐ Acute (sudden) ☐ Chronic condition (>3 months) **Onset Date:** _____/_____/_____
2. **Are you represented by an attorney?** ☐ Yes ☐ No **Are legal actions expected?** ☐ Yes ☐ No
   Attorney Name: _____
3. **Have you had a problem like this before?** ☐ Yes ☐ No
   Describe: _____
4. **Have you been seen in an ER for this problem?** ☐ Yes ☐ No
   Treating ER: _____ Date: _____/_____/_____
5. **Rate the pain (0–10):** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
6. **Do the symptoms wake you from sleep?** ☐ Yes ☐ No
7. **Please describe the symptoms:** ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning ☐ Shooting
8. **Timing of symptoms:** ☐ Constant ☐ Intermittent (Comes and goes)
9. **Is the problem:** ☐ Getting better ☐ Getting worse ☐ Unchanged
10. **What makes the symptoms worse?** ☐ None

    ☐ Squatting ☐ Kneeling ☐ Sitting ☐ Bending ☐ Stairs ☐ Twisting ☐ Moving ☐ Lying in bed ☐ Running ☐ Walking ☐ Athletics ☐ Reaching Overhead ☐ Standing ☐ Gripping ☐ Lifting
11. **Associated symptoms:** ☐ None

    ☐ Redness ☐ Bruising ☐ Swelling ☐ Numbness ☐ Stiffness ☐ Limping ☐ Clicking ☐ Locking ☐ Popping ☐ Tingling ☐ Weakness ☐ Giving way

Prior Testing / Treatment

Have you had any prior tests for this problem? ☐ None ☐ X-rays ☐ MRI ☐ CT Scan ☐ Nerve Test (EMG/NCV) ☐ Bone Scan

Have you had any prior treatment for this problem? ☐ Yes ☐ No

If yes, please check all treatments received and indicate the result:

Ice ☐ Improved ☐ Worsened ☐ Unchanged Heat ☐ Improved ☐ Worsened ☐ Unchanged

Rest ☐ Improved ☐ Worsened ☐ Unchanged NSAIDS ☐ Improved ☐ Worsened ☐ Unchanged

Muscle Relaxers ☐ Improved ☐ Worsened ☐ Unchanged Physical Therapy ☐ Improved ☐ Worsened ☐ Unchanged

Bracing ☐ Improved ☐ Worsened ☐ Unchanged Surgery ☐ Improved ☐ Worsened ☐ Unchanged

Injections ☐ Improved ☐ Worsened ☐ Unchanged Home Exercise Program ☐ Improved ☐ Worsened ☐ Unchanged

Other/Comments:_____

_____

Previous Hospitalizations / Surgeries

Check all that apply if applicable: ☐ None

☐ Aneurysm (Brain) Surgery ☐ Aortic Bypass / Vascular Surgery ☐ Appendectomy ☐ Cataract (Eye) Surgery

☐ Cholecystectomy (Gallbladder) ☐ Heart Surgery ☐ Hernia Repair ☐ Hysterectomy ☐ Cancer ☐ Stents

☐Lumpectomy ☐ Mastectomy ☐ LAP Band/Gastric Bypass Surgery

☐ Other Surgery: _____

Orthopedic Surgery

Check all that apply if applicable: ☐ None

☐ Arthroscopy: Knee Side: ☐ Right ☐ Left

☐ Arthroscopy: Shoulder Side: ☐ Right ☐ Left

☐ Carpal Tunnel Release Side: ☐ Right ☐ Left

☐ Rotator Cuff Repair Side: ☐ Right ☐ Left

☐ Total Hip Replacement Side: ☐ Right ☐ Left

☐ Total Knee Replacement Side: ☐ Right ☐ Left

☐ Total Shoulder Replacement Side: ☐ Right ☐ Left

☐ Spinal Surgery

☐ Other Surgery: _____

Family History

Father: ☐ None ☐ Diabetes ☐ Heart Disease ☐ Hypertension ☐ Bleeding Problems ☐ Epilepsy ☐ Stroke
☐ Osteoporosis ☐ Connective Tissue ☐ Rheumatoid Arthritis ☐ Muscular Dystrophy ☐ Cancer

Mother: ☐ None ☐ Diabetes ☐ Heart Disease ☐ Hypertension ☐ Bleeding Problems ☐ Epilepsy ☐ Stroke
☐ Osteoporosis ☐ Connective Tissue ☐ Rheumatoid Arthritis ☐ Muscular Dystrophy ☐ Cancer

Sibling: ☐ None ☐ Diabetes ☐ Heart Disease ☐ Hypertension ☐ Bleeding Problems ☐ Epilepsy ☐ Stroke
☐ Osteoporosis ☐ Connective Tissue ☐ Rheumatoid Arthritis ☐ Muscular Dystrophy ☐ Cancer

Social History

Do you smoke tobacco? ☐ Never ☐ Current, every day smoker ☐ Current, some day smoker ☐ Former smoker
☐ Heavy tobacco smoker ☐ Light tobacco smoker

Caffeine Use? ☐ Daily ☐ Occasionally ☐ Rarely ☐ Never

Do you drink alcohol? ☐ Daily ☐ Occasionally ☐ Rarely ☐ Never

Non-prescribed substance use? ☐ Daily ☐ Occasionally ☐ Rarely ☐ Never

Are you currently working? ☐ Yes ☐ No ☐ Retired ☐ Disabled **Are you a student?** ☐ Yes ☐ No

If not, what date did you last work?_____/_____/_____**Work restrictions, if any:**_____

_____

Medical Questions

Mark all that currently apply: ☐ None ☐ Metal in body ☐ Claustrophobic ☐ Pregnant ☐ Sleep Apnea
☐ Uses a CPAP ☐ Snores

Personal Medical History

Check all that apply and provide details where indicated: ☐ None

☐ Aneurysm ☐ Angina (Chest Pain) ☐ Arthritis ☐ Asthma ☐ Bone or Joint Infections ☐ Cancer
☐ Chemotherapy ☐ Radiation ☐ COPD ☐ Congestive Heart Failure ☐ Diabetes ☐ Emphysema ☐ Epilepsy
☐ Heart Attack ☐ Hepatitis ☐ High Cholesterol ☐ HIV / AIDS ☐ Hyperthyroidism ☐ Hypothyroidism
☐ Kidney Disease ☐ MRSA ☐ Pacemaker ☐Blood Clots ☐ Pulmonary Embolism ☐ Reaction to Anesthesia
☐ Seizures ☐ Stroke ☐ Stomach Ulcers ☐ Tuberculosis

Other conditions or details: _____

_____

Allergies

Do you have any allergies? ☐ Yes ☐ No **If Yes, please list below: Medication, Relevant Food, or "Seasonal"**
Latex allergy? ☐ Yes ☐ No

_____ **Reaction:** _____

_____ **Reaction:** _____

_____ **Reaction:** _____

_____ **Reaction:** _____

_____ **Reaction:** _____

_____ **Reaction:** _____

Medications

Preferred Pharmacy: _____

Please list all medications you take on a regular basis: ☐ **None** **Are you taking blood thinners?** ☐ Yes ☐ No

_____

_____

_____

_____

_____

_____

_____

Signature: _____ **Date:** _____/_____/_____