James J. Lohse, MD FAAFP CAQSM
Jay Cleveland, MD

1646 Westgate Circle, Suite 106
Brentwood, TN 37027
Tel: 615-850-5290
Fax: 615-777-3702
www.nextlevelhealthtn.com

Patient Information:

Patient Name: _____ DOB: _____

Social Security #: _____ Sex: Male or Female

Marital Status(circle): Single Married Divorced Widowed

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone (if under 18, parent): _____Work Phone: _____

Email: _____

Employer (if under 18, parent): _____

Insurance: Policy Holder Information *OR* Guarantor Information for patients younger than 18

Name: _____ DOB: _____

Social Security #_____ Sex: Male or Female

Marital Status(circle): Single Married Divorced Widowed

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Work Phone: _____

Email:_____

Employer:_____

Emergency Contact: _____

AUTHORIZATION TO LEAVE PATIENT MESSAGES

The HIPPA Privacy Rule permits health care providers to communicate with patients regarding their healthcare. This includes communicating with patients at their homes, whether through the mail, by phone, or in some other manner. In addition, the rule does not prohibit covered entities from leaving messages for patients on their answering machines. However, to reasonably safeguard the individual's privacy, covered entities should take care to limit the amount of information disclosed on the answering machine. For example, a covered entity might want to consider leaving only its name and number and other information necessary to confirm an appointment or ask the individual to call back.

A covered entity also may leave a message with a family member or other person who answers the phone when the patient is not home. The Privacy Rule permits covered entities to disclose limited information to family members, friends, or other persons regarding an individual's care, even when the individual is not present; however, professional judgement should be exercised.

The HIPPA Privacy Rule also prohibits the practice from using or disclosing patient protected health information (PHI) outside the Notice of Privacy Practice without the authorization of the patient. Messages that contain patient PHI require the patient to sign an authorization form to receive messages by phone, fax, email, voicemail, or any other means by which someone other than the patient might reasonably have access to the message, thereby potentially violating the patient's privacy rights under HIPPA. For example, messages that contain PHI would be test results, medication information, payment information, treatment plans, patient condition information, and anything else that is considered patient condition, treatment, or payment related.

You may elect to have your PHI provided to you by message from the physician's office by signing this form in the space provided below. Once you have signed the form, future communication with you concerning PHI may be provided to the designated relative or friend, sent by email, fax, or left on your voicemail at the number you provide to this office.

I understand my HIPPA rights and I request that this office leave messages, including those containing PHI, for me with either of the two individuals listed below or by email, fax, or voicemail at the numbers noted below. I understand that it is my responsibility to keep the practice informed of any changed to this information.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Patient Signature: _____ Date: _____

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Please Review ALL of the Following Information:

Financial Statement to Patients

I hereby authorize James J. Lohse MD and/or The Next Level Sports Medicine to furnish my insurance company any/all information, which said insurance company(s), may request.

I hereby assign James J. Lohse MD and/or The Next Level Sports Medicine all money to which I am entitled for Medical and/or Procedural expenses relative to the service rendered.

I understand that I am financially responsible to James J. Lohse MD, Jay Cleveland MD, and/or Next Level Health for charges NOT covered by this assignment, meaning services NOT covered by my insurance company. I understand that if I cannot pay my balance in full, I can set up a payment plan or apply for Care Credit.

I agree to pay all collection fees, court costs and reasonable attorney fees if I fail to promptly pay this account when due and unpaid balance is turned to the collection service.

Please be aware that we review past due accounts frequently and at every statement cycle. Your communication and involvement to ensure your balance is paid timely is important to us. It is imperative that you maintain communications and fulfill your financial agreement and arrangements to keep your account active and in good standing.

If your account becomes sixty (60) days past due, further steps to collect this debt may be taken. If we have to refer your account to a collection agency, you agree to pay all of the collection costs, which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer fees, which we incur, plus all court costs. In case of suit, you agree the venue shall be Davidson County, Tennessee. In addition, we reserve the right to deny future non-emergency treatment for any and all debtor-related unpaid account balances.

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected, health information as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary Information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements:

Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Use and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken on action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published, and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

General Consent for Treatment

- As the patient, you have the right to be informed about your conditions and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify appropriate treatment and/or procedure for any identified condition(s).
- I request and authorize **Dr. James Lohse** or **Dr. Jay Cleveland** as my provider, his assistant, or designees (collectively called "the providers") to perform any treatment/care/services they may deem necessary or advisable. This care may include, but is not limited to, routine diagnostics, radiology and laboratory procedures, administration of routine drugs, biological and other therapeutics, and routine medical and nursing care. I authorize my provider(s) to perform other additional or extended services in emergency situations if it may be necessary or advisable to preserve my life or health. I understand that my (the patient) care is directed by my provider(s) and that other personnel render care and services to me (the patient) according to the provider(s) instructions.
- I understand that I have the right and the opportunity to discuss alternative plans of treatment with my provider and to ask and have answered to my satisfaction any questions or concerns.
- In the event that a healthcare worker is exposed to my blood or bodily fluid in a way which may transmit HIV (human immunodeficiency virus), hepatitis B virus or hepatitis C, I consent to the testing of my blood and/or bodily fluids for these infections and the reporting of my test results to the healthcare worker who has been exposed. _____ **(initial)**

I HAVE READ OR HAD READ TO ME AND FULLY UNDERSTAND THIS CONSENT; I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS AND HAD THESE QUESTIONS ADDRESSED.

Name of Patient:

_____

Signature of Patient, Legal Guardian, Patient Advocate, Nearest Relative or Other:

_____Date: _____

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