BAPTIST HOSPITAL, INC. – CONSENT FOR TREATMENT AND CONDITIONS OF ADMISSION

1. Medical and Surgical Consent.

   a. I recognize that I have a condition requiring medical care, and I hereby consent to such medical care and treatment and such diagnostic tests at Baptist Hospital, Inc. (the "Hospital"), as the physicians and staff at the Hospital may deem necessary or advisable. I hereby consent to photographs, videos, digital images that may be recorded to document my care, any x-ray examination, laboratory procedures, urine drug screen, blood drug screen, anesthesia, medical, surgical or dental treatment or Hospital services rendered to me under the general and special instructions of the physician/dentist.

   b. I understand that if I am pregnant, my physician may determine that it is necessary to take urine or blood samples to perform drug screens, and I consent to both the taking of the samples and the performance of the screens.

   c. I understand and acknowledge that this facility participates in the education of health care personnel and that students may be involved in the care I receive.

   d. I understand that an explanation of the risks, benefits and alternatives of any medical or surgical procedure performed by my physician will be explained to me by my physician except in an emergency situation.

   e. I UNDERSTAND AND AGREE THAT, AS A PATIENT, MY ATTENDING PHYSICIAN IS DIRECTING MY CARE, AND I RECOGNIZE THAT NONE OF THE PHYSICIANS PROVIDING CARE TO ME INCLUDING, BUT NOT LIMITED TO, EMERGENCY ROOM PHYSICIANS, SURGEONS, RADIOLOGISTS, PATHOLOGISTS AND ANESTHESIOLOGISTS, ARE EMPLOYED BY THE HOSPITAL. PHYSICIANS HAVE PERMISSION TO USE THE HOSPITAL FACILITIES AND MAY TAKE EMERGENCY CALLS FOR THE HOSPITAL BUT ARE INDEPENDENT CONTRACTORS AND NOT AGENTS OR EMPLOYEES OF THE HOSPITAL EVEN THOUGH THEY MAY WEAR GARMENTS OR IDENTIFICATION THAT INCLUDE THE HOSPITAL'S NAME OR LOGO. **I EXPRESSLY AGREE TO RELEASE AND DISCHARGE THE DUTY OF THE HOSPITAL AS TO SERVICES THAT MAY BE PERFORMED BY PHYSICIANS WHO ARE INDEPENDENT CONTRACTORS, BUT NOT EMPLOYEES, OF THE HOSPITAL. I UNDERSTAND THAT BY RELEASING AND DISCHARGING THE HOSPITAL OF ITS DUTY AS TO THESE SERVICES, I AM GIVING UP THE RIGHT TO HOLD THE HOSPITAL LIABLE FOR THE POTENTIAL NEGLIGENCE OF THE PHYSICIANS.**

2. Release of Information. I authorize the Hospital to disclose all or any part of my record, including my medical records, to any person or entity that may be liable to the Hospital or me for all or part of the Hospital's charges, including, but not limited to: a) hospital or medical service companies; b) insurance companies; c) workers' compensation carriers; d) welfare or social services agencies; e) my employer; f) any entity that provides pharmaceutical products or services to the Hospital for my benefit and that offers reimbursement to the Hospital for the provision of those products and services. All such disclosures will be conducted in accordance with applicable laws. I further agree to release the Hospital, its employees, agents and assigns, and representatives from any and all liability arising out of the release of my records pursuant to this paragraph.

3. Consent for Testing and Sharing of Test Results. If, in the course of my medical care, a health care worker is exposed to my blood or other bodily fluids, I give consent for a sample of my blood to be tested for HIV or Hepatitis B antibodies. I understand and acknowledge that the health care worker will be notified of the results for purposes of his or her treatment. I will also be notified of the results.

4. Personal Valuables. I understand the Hospital is not responsible for the safekeeping of my personal belongings such as money, jewelry, dentures, hearing aids, eyeglasses, watches, credit cards, or phones.

5. Assignment of Insurance Benefits. I assign payment of all applicable insurance payments directly to the Hospital and agree that the Hospital may receive any such payment, and I further understand and agree that I will be responsible for charges

6. Medicare-Medicaid Patients Certification. I certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act is correct. I authorize the release of all records, including but not limited to medical records. required to act on this request and that payment of authorized benefits be made directly to the Hospital and the physicians involved in my care for any services furnished me by the Hospital and said physicians.

7. Indigent Drug Program. If I qualify and accept assistance, I agree to comply with the policies of the Hospital's drug program for indigents, which may provide me with replacement of certain medications.

8. Patient Information Packet. I acknowledge that I have been offered Hospital's Patient Admission Packet, which includes the notice of patients' rights and the Notice of Privacy Practices.

9. Emergency Care. I understand that if I come to the Hospital's dedicated emergency department seeking care, I will be screened for an emergency medical condition and, if I have an emergency medical condition, the Hospital will provide stabilizing treatment, admit me to the Hospital as an inpatient, or transfer me if medically needed. The screening and the stabilization will be provided **regardless of my ability to pay.** I certify that the Hospital has not withheld, delayed, or conditioned screening or stabilizing care based upon my signing or refusing to sign this paragraph or based upon any payment related concerns.

10. Obligation to Pay My Hospital Bill. I acknowledge that I am financially responsible for my Hospital bills (or, if signed by a guarantor, the guarantor is responsible) which are not paid for by my health insurance, and I agree to pay them promptly. If my insurance does not pay my claim after reasonable attempts by the Hospital, I may be responsible for paying my entire bill to the Hospital.

11. Financial Assistance. **I understand the Hospital has financial assistance programs available to those individuals who are unable to pay for their care, based upon a determination of financial need.** By signing below, I acknowledge that the Hospital's financial assistance policy is available to me on the Hospital's webpage or, will be made available to me upon request from the person who provided me this form. I understand I may be asked to provide my personal financial information and/or submit to a credit check in order to qualify for the financial assistance program. If I do not qualify for a financial assistance program, I understand that I may be able to enter into a payment plan with the Hospital.

12. Patient Contact. I authorize the Hospital, its service providers (including service providers contacting me about obtaining potential financial assistance for my account(s) and/or for collection services) and their successors, assigns, affiliates, or agents to contact me at any telephone number associated with my account(s), including wireless telephone numbers or other numbers that result in charges to me, whether provided in the past, present or future. I agree that methods of contact may include using prerecorded or artificial voice messages and/or an automatic telephone dialing system, as applicable.

_____

Patient or Patient's Representative (if patient is minor or unable to sign) Relationship to Patient Date and Time

_____

Witness

If patient is a minor, the parent must also complete the following:

The undersigned guarantees and agrees to pay to the Hospital on demand for any and all indebtedness of the patient to the Hospital relating to services provided pursuant to this consent form.

_____

Guarantor Date and Time

_____

Guarantor (Print Name)

Revised 6/2019

Andrews Institute Orthopaedics & Sports Medicine

Patient Consent and Responsibility Agreement

Welcome to Baptist Physician Group, LLC ("BPG"). We understand you have many choices when it comes to health care and we are glad you chose our medical group. We look forward to providing you with quality health care that is accessible, comprehensive, team-based, coordinated, and focused on your health and safety. Please review the following patient responsibilities, sign and return.

CONSENT FOR TREATMENT. I consent to all services as ordered or performed by my BPG physician, advanced practice provider, or their assistants and designees. This care may include, but is not limited to, medical examination and treatment, administration of drugs or vaccines, nursing care, laboratory, and x-ray procedures. I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees or promises have been made to me about the results of any treatment.

OBLIGATION TO PAY MY BPG BILL: I understand that all charges for services rendered are due and payable at the time of service. If I have health care insurance, I agree to pay for any deductibles, co-payments and the patient responsibility portion of the fee at the time of service. I acknowledge that I am financially responsible for my provider bills (or, if signed by a guarantor, the guarantor is responsible) which are not paid for by a third party payor, and I agree to pay the bill promptly.

MEDICAL INSURANCE: I authorize BPG to bill my health plan or other applicable insurer or third party payor and I assign to BPG all of my rights and claims for reimbursement by a third party payor. I authorize BPG to release to all third party payors any medical information that is required in order for BPG to receive payment for its services to me. I will inform my provider of any changes in address or phone number for myself and/or responsible party, present my photo ID and all insurance identification cards upon request. I understand I may be responsible for the entire provider bill if my third party payor refuses to pay after reasonable attempts to collect from the third party payor.

APPOINTMENTS: I agree to bring a list of all medications I am currently taking to each appointment. I agree to check in on time for my appointment. I understand that if I am late for my appointment, I will be rescheduled for the next available appointment time and understand there may not be an appointment available the same day. I agree to notify the office at least 24 hours in advance of my appointment if I find I must cancel my appointment. I understand that failure to notify the office 24 hours in advance may result in a $25.00 missed appointment fee, which cannot be billed to insurance. I understand my patient/physician relationship may be terminated if I miss more than three appointments.

AUTHORIZATIONS AND REFERRALS: I understand that I am responsible for notifying the practice if my third party payor requires pre-authorizations for tests or for referrals to specialists. I understand the BPG office staff may assist me with scheduling referrals or diagnostic testing, but failure to obtain necessary authorizations before the scheduled appointment may result in the visit/test needing to be rescheduled and/or charges being billed directly to me.

FINANCIAL ASSISTANCE: I understand there are financial assistance programs available for patients who are unable to pay for their care based upon a determination of financial need in accordance with Baptist Health Care's Financial Assistance Policy. I understand it is my responsibility to contact a Patient Account Specialist at BPG's business office at (850) 469-2000 to request financial assistance or access the policy and application at https://ebaptisthealthcare.org/PatientFinancialResources. I agree to provide my personal financial information and/or submit to a credit check to determine if I qualify for financial assistance. If I do not qualify for financial assistance and do not have insurance third party payor, I understand and agree that I will pay in full for all services at the time of service. If I do not have insurance, I may be eligible for a discount when full payment is made at time of service.

RETURN CHECK POLICY: I understand I will be responsible for all service charges and collection fees associated with collecting any bad check I write, and will pay these fees upon notice.

BUSINESS HOURS: I understand unusual circumstances will sometimes require the office hours to be changed without notice. I understand the pre-recorded telephone message will let me know when to call back for routine requests and what to do in case of an urgent medical need (one that does not require emergency treatment). I understand that I should call 911 in the event of a medical emergency or proceed to the closest emergency room for treatment.

PRESCRIPTIONS AND/OR REFILLS: I understand that requests for new medication and/or refills should be made during my visit with my provider. If I need a prescription refill between visits, I agree to contact the practice or my pharmacy and allow 48 to 72 business hours to process. I understand refill requests will only be processed during office hours. I understand that narcotic prescriptions are highly regulated and may require a signed narcotics agreement between me and my provider.

PATIENT FORMS COMPLETION: I understand that an office visit may be necessary if I request the provider complete certain forms for me. There may also be a nominal fee, payable in advance, for the completion of these forms. I understand these requests may take up to 14 days for processing.

PATIENT PORTAL: I understand this practice may have a patient portal to offer me a secure online website for convenient 24-hour access to my personal health information. This is an optional program using a secure username and password. Recent doctor visit notes, medications, contact information and health records can be viewed and printed. The office staff can provide more information regarding the patient portal which may be accessed at: https://ebaptisthealthcare.org/PatientPortal.

WIRELESS COMMUNICATION: By providing a wireless or mobile telephone number, I give permission to my provider to use this number for contact. Contact includes receiving calls and messages, including pre-recorded messages and calls via an automatic telephone dialer from the practice and its authorized agents.

NOTICE OF PRIVACY PRACTICES: I understand that Baptist Health Care's Notice of Privacy Practices provides information about how my health information may be used and disclosed. I have been offered and (if requested by me) received a copy of the Notice of Privacy Practices.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND AND CONSENT TO TREATMENT BY BPG AND I AGREE TO ABIDE BY THE ABOVE PATIENT RESPONSIBILITIES.

Patient/Personal Representative Signature	**Date**
Print Patient/Personal Representative Name	**Personal Representative's relationship to patient:**

Huaiyu Tan, M.D., Ph.D.

1040 Gulf Breeze Pkwy, Suite 210
Gulf Breeze, FL. 32561
Phone: 850.916.8697
Fax: 850.916.8666

Marisa Terry, M.D.

1717 N. E Street, Tower 3, Suite 530
Pensacola, FL. 32501
Phone: 850.437.8670
Fax: 850.438.8679

Adam Mullan, M.D.

9400 University Parkway, Suite 101B
Pensacola, FL. 32514
Phone: 850.916.8697
Fax: 850.916.8666

We are happy to schedule you as a new patient with one of our physicians.

In anticipation of your upcoming appointment, we would appreciate your attention to the following information:

- Please complete the enclosed paperwork in its entirety to ensure the most accurate records for our physicians. This includes an up-to-date medication list.
- Please arrive at least 30 minutes early so that we may verify your insurance, scan your cards, and have you ready to see the provider at your appointment time. Please make travel arrangements to be *early* to your appointment.
- If you are late to your appointment, we reserve the right to reschedule your appointment. This policy helps ensure a timely schedule for both the physician and our patients.
- It is the patient's responsibility to verify that the physician you are seeing is in-network with the insurance plan you have. You can call the customer service number located on the back of your card to verify this.
- If you are to be treated for injuries sustained during a motor vehicle accident, please bring your automobile insurance card as well as your health insurance cards.
- Please provide our office with any pertinent medical records, X-ray, MRI, or CT reports. This is immensely helpful to the productivity of your appointment. If the imaging was done outside of the Baptist Health Care System, please bring a CD with images that we can view at your appointment.
- Please keep in mind that our office does not take over prescribing controlled substances (i.e. opioids or narcotics).
- Please **DO NOT** mail your paperwork back to us, bring the completed paperwork with you to the appointment.

We look forward to meeting you at your upcoming appointment. Thank you for choosing Andrews Institute Physical Medicine and Rehabilitation.

APPOINTMENT DATE: ___/___/___ TIME: __:___AM/PM

Rm#:

BP: _____ HR: _____ R: _____

Ht: _____ Wt: _____

NEW PATIENT HISTORY AND PHYSICAL FORM
Dr. Adam Mullan, Dr. Huaiyu Tan, Dr. Marisa Terry

Patient's Name: _____ Date of Birth: ____/____/____ Age: ____

Body part being seen for: _____ Side of Body (circle): Right Left Both

Date symptoms began: _____ Was there an *injury*? (check) ☐Yes ☐No
If so, how did it happen?: _____

Does the pain *spread/radiate* anywhere (ex. arms, legs)? _____

Associated symptoms (ex. Numbness/tingling or muscle weakness)? _____

How *severe* is the pain: zero being no pain and 10 being the worst pain imaginable?

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

Quality: What does the pain feel like? ☐Constant - or - ☐ Intermittent
☐Aching ☐Burning ☐Sharp ☐Stabbing ☐Pressure ☐Other: _____

What makes the pain *worse*? _____
What makes the pain *better*? _____

Have you had any of the following symptoms (circle):
Fall within the past month
Bowel/Bladder Incontinence or Severe Constipation
Lack of sensation in the saddle region
Fever, Night sweats, or severe chills

Does the pain affect your enjoyment of life (please explain): _____
Does the pain limit your general activity level (please explain): _____

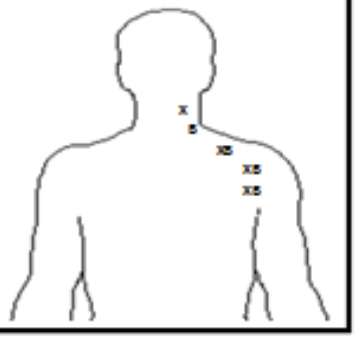
Current or Prior Pain Treatment/Therapies (please state if helpful or not helpful):
☐Heating pad or hot tub
☐Ice pack
☐Braces
☐Chiropractic Care: _____
☐Acupuncture or Massage
☐Physical Therapy: _____
☐Medication(s): _____
☐Injection(s) / Procedure (s): _____

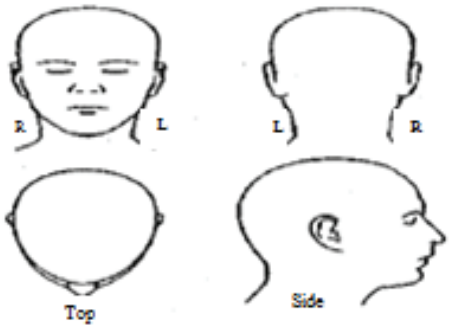
Please use the following symbols to indicate the type and location of your pain on the drawings below.

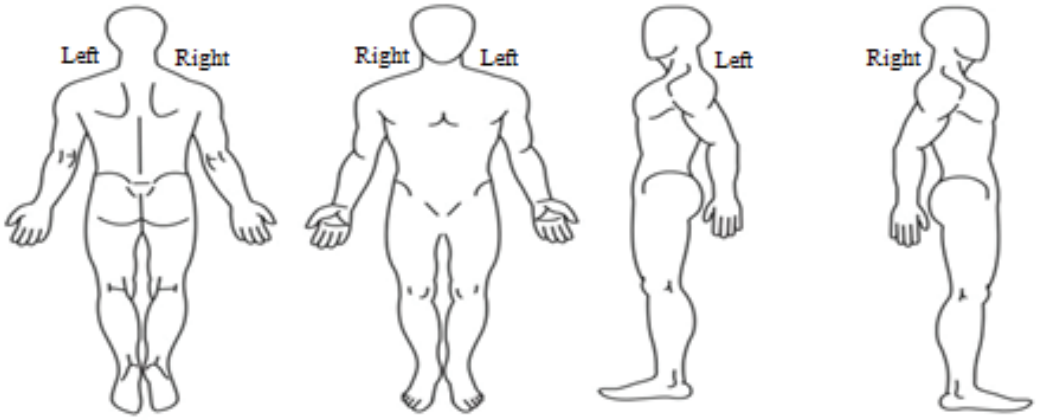
TYPE OF PAIN	SYMBOL
Sharp	X
Shooting	→
Burning	B
Aching	A
Spasming	S
Tingling	T
Numbness	N

EXAMPLE:
Types of pain:
Sharp and burning

Location of pain:
back of neck down
to right shoulder blade







GENERAL MEDICAL INFORMATION

Who is your primary care doctor?_____ Date of last visit: _____

Do you take a blood thinning medication (check): ☐ Yes, name: _____ ☐No

Are you pregnant or attempting to get pregnant? ☐Yes ☐No

List **ALL** current medications (Including vitamins and supplements):

Name:	Dosage:	How Often:	Name:	Dosage:	How Often:
_____			_____		
_____			_____		
_____			_____		
_____			_____		
_____			_____		

Preferred Pharmacy (Name and location): _____

ALLERGIES

List medications and food allergies and type of reaction:

_____

_____

PAST MEDICAL HISTORY

CHECK ANY PROBLEM YOU HAVE BEEN TREATED FOR AND THE DATE OF TREATMENT

☐Arthritis
☐Lupus
☐Rheumatoid Arthritis
☐Osteoporosis
☐Brittle bones
☐Ruptured disc
☐Sciatica
☐Diabetes
☐Stomach ulcers
☐Hypertension
☐Heart attack
☐Heart failure
☐Heart murmur
☐Irregular heartbeat
☐Peripheral vascular disease
☐ Stroke
☐Blood clot
☐Varicose veins
☐Kidney disease
☐Bladder infections
☐Thyroid problems
☐Sickle cell anemia
☐Hepatitis A/B/C
☐Cirrhosis
☐Gallstones
☐HIV/AIDS
☐Tuberculosis
☐Polio
☐Venereal disease
☐Asthma
☐Emphysema
☐COPD
☐GERD
☐Cancer: Type: _____
☐Hereditary defects
☐Glaucoma
☐Depression
☐Drug dependence/ Alcoholism
☐Head injury
☐Convulsion/Seizures
☐Fainting spells
☐Insomnia
☐Gout
☐High Cholesterol/ Triglycerides

PAST SURGERY AND MAJOR ILLNESS/HOSPITALIZATIONS

TYPE OF SURGERY/ILLESS:	DATE OF SURGERY/ILLESS:

SOCIAL HISTORY

Marital Status: ☐SINGLE ☐MARRIED ☐WIDOWED ☐DIVORCED ☐SEPARATED

OCCUPATION: _____ Are you working now? ☐YES ☐NO
If not working, when did you last work? _____

Place of Birth: _____School Grade completed: _____

I live in a: ☐House ☐Apartment ☐Condominium ☐Other _____

My Home is a: ☐Single level ☐Multi-Level

I live: ☐Alone ☐With spouse ☐With parent ☐With children ☐Other: _____

Current **Alcohol** Use: ☐Yes (_____ # drinks per day/ week) ☐None ☐ Quit (how long ago: _____)

Current **Tobacco** Use: ☐Yes (_____ # times per day and for ____ years) ☐None ☐ Quit (how long ago: _____)

Current **Caffiene** Use: ☐Yes (____ # drinks per day) ☐None

FAMILY HISTORY

Mother living: Yes☐ (Age: _____) No☐ (cause of death and age at death:_____)

Father living: Yes☐ (Age: _____) No☐ (cause of death and age at death:_____)

Please check all boxes that apply OR ☐ **No significant family history is known**

Diagnosis	Mother	Father	Paternal Grandparent	Maternal Grandparent	Siblings	Children
CANCER (Type)						
HEART DISEASE						
HYPERTENSION						
DIABETES						
RHEUMATOID ARTHRITIS						
OSTEOARTHRITIS						
SEIZURES						
KIDNEY DISEASE						
FIBROMYALGIA						
STOMACH ULCERS						
MENTAL ILLNESS						
STROKE						
REACTION TO ANESTHESIA						

PLEASE LIST OTHER PERTINENT INFORMATION YOUR PHYSICIAN SHOULD KNOW:

_____

_____

I hereby attest that I personally completed this form and all the information is true and correct:

_____ _____

Signature of Patient or Guardian completed form: **Date:**

HISTORY FORM REVIEWED BY:_____Date:_____

Physician's or Physician Assistant's Signature

Review Of Systems Report

Patient Name: _____ Date of Birth: _____

Please look at the following symptoms and mark any issues you have had ***within the last month:***

Constitutional
[ ] Anorexia (no appetite)
[ ] Chills
[ ] Fever
[ ] Malaise (Fatigue)
[ ] Weight loss
[ ] _____

Mouth / Throat / Teeth
[ ] Gum bleeding
[ ] Hoarseness
[ ] Lesions (mouth sores)
[ ] Toothache
[ ] Tooth caries (cavity)
[ ] Tooth trauma
[ ] Throat pain
[ ] Dentures

Gastrointestinal
[ ] Abdominal pain
[ ] Constipation
[ ] Diarrhea
[ ] Nausea
[ ] Melena (dark stool)
[ ] Stool incontinence
[ ] Vomiting

Neurological
[ ] Dizziness
[ ] Headache
[ ] Loss of function
[ ] Lower extremity (legs or feet) numbness
[ ] Memory impairment
[ ] Neck stiffness
[ ] Sensory deficits (less feeling / numbness)
[ ] Tremors
[ ] Upper extremity (arms or hands) numbness
[ ] Vertigo (dizziness)
[ ] _____

Eye
[ ] Absent lacrimation (dry eyes)
[ ] Itching
[ ] Lacrimation (watery eyes)
[ ] Lid swelling
[ ] Pain
[ ] Photophobia (light sensitivity)
[ ] Redness
[ ] Vision changes

Neck
[ ] Lumps
[ ] Pain
[ ] Stiffness
[ ] Swollen glands

Genitourinary
[ ] Dysuria (painful urination)
[ ] Frequency (too often)
[ ] Hematuria (bloody urine)
[ ] Urgency
[ ] Urine output decreased

Psychiatric
[ ] Anxiety
[ ] Depression
[ ] Insomnia
[ ] Psychiatric disorder
[ ] _____

Allergic / Immunologic
[ ] Dermatitis
[ ] Environment allergies
[ ] Food allergies
[ ] Hay fever
[ ] HIV
[ ] Immunologic disorder
[ ] Latex allergy
[ ] _____

Ear
[ ] Discharge
[ ] Hearing loss
[ ] Pain
[ ] Tinnitus (ringing in the ear)

Cardiovascular / Heart
[ ] Bradycardia (slow heart beat)
[ ] Chest pain
[ ] Edema (swelling)
[ ] Irregular rhythm
[ ] Orthopnea (shortness of breath laying down)
[ ] Palpitation (fluttering, pounding, or skip a beat)
[ ] Tachycardia (fast heart beat)
[ ] _____

****Musculoskeletal****
[ ] Back pain
[ ] Gout
[ ] Joint pain
[ ] Neck pain
[ ] Pain
[ ] Sensory deficits (less feeling / numbness)
[ ] Stiffness
[ ] Swelling
[ ] Weakness
[ ] _____

Endocrine
[ ] Cold / heat tolerance
[ ] Diabetes
[ ] Hot flashes
[ ] Polydipsia (excessive thirst)
[ ] Polyuria (frequent urination)
[ ] Thyroid trouble

Nose
[ ] Congestion
[ ] Discharge
[ ] Nose bleeds
[ ] Sneezing

Respiratory / Breathing
[ ] Cough
[ ] Dyspnea (shortness of breath)
[ ] Hemoptysis (coughing up blood)
[ ] Stridor (whistling)
[ ] Wheezing
[ ] _____

Integumentary / Skin
[ ] Abrasions (scrapes)
[ ] Hives
[ ] Jaundice (yellow skin)
[ ] Lesions (cuts)
[ ] Pruritus (chronic itchy skin)
[ ] Rash
[ ] Thin skin
[ ] _____

Heme/Lymph
[ ] Anemia
[ ] Easy bleeding
[ ] Easy bruising
[ ] Night sweats
[ ] Past transfusion
[ ] Swollen lymph nodes
[ ] Transfusion reaction
[ ] _____

*****ANY HISTORY OF:*****

MRSA	[ ] Y [ ] N
Sleep Apnea	[ ] Y [ ] N
Blood Clot	[ ] Y [ ] N
Latex Allergy	[ ] Y [ ] N

_____ _____
Patient Signature Date

PROMIS–29 Profile v1.0

Please respond to each question or statement by marking one box per row.

	Physical Function	**Without any difficulty**	**With a little difficulty**	**With some difficulty**	**With much difficulty**	**Unable to do**
1	Are you able to do chores such as vacuuming or yard work?	☐	☐	☐	☐	☐
2	Are you able to go up and down stairs at a normal pace?	☐	☐	☐	☐	☐
3	Are you able to go for a walk of at least 15 minutes?	☐	☐	☐	☐	☐
4	Are you able to run errands and shop?	☐	☐	☐	☐	☐
	Anxiety **In the past 7 days…**	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
5	I felt fearful	☐	☐	☐	☐	☐
6	I found it hard to focus on anything other than my anxiety	☐	☐	☐	☐	☐
7	My worries overwhelmed me	☐	☐	☐	☐	☐
8	I felt uneasy	☐	☐	☐	☐	☐
	Depression **In the past 7 days...**	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
9	I felt worthless	☐	☐	☐	☐	☐
10	I felt helpless	☐	☐	☐	☐	☐
11	I felt depressed	☐	☐	☐	☐	☐
12	I felt hopeless	☐	☐	☐	☐	☐
	Fatigue **During the past 7 days…**	**Not at all**	**A little bit**	**Somewhat**	**Quite a bit**	**Very much**
13	I feel fatigued	☐	☐	☐	☐	☐
14	I have trouble starting things because I am tired	☐	☐	☐	☐	☐
	In the past 7 days…					
15	How run-down did you feel on average?	☐	☐	☐	☐	☐
	In the past 7 days…	**Not at all**	**A little bit**	**Somewhat**	**Quite a bit**	**Very much**
16	How fatigued were you on average?	☐	☐	☐	☐	☐

PROMIS–29 Profile v1.0

Sleep Disturbance

	In the past 7 days…	Very poor	Poor	Fair	Good	Very good
17	My sleep quality was.....	☐	☐	☐	☐	☐

	In the past 7 days…	Not at all	A little bit	Somewhat	Quite a bit	Very much
18	My sleep was refreshing.....	☐	☐	☐	☐	☐
19	I had a problem with my sleep	☐	☐	☐	☐	☐
20	I had difficulty falling asleep	☐	☐	☐	☐	☐

Satisfaction with Social Role

	In the past 7 days…	Not at all	A little bit	Somewhat	Quite a bit	Very much
21	I am satisfied with how much work I can do (include work at home)	☐	☐	☐	☐	☐
22	I am satisfied with my ability to work (include work at home)……	☐	☐	☐	☐	☐
23	I am satisfied with my ability to do regular personal and household responsibilities	☐	☐	☐	☐	☐
24	I am satisfied with my ability to perform my daily routines.....	☐	☐	☐	☐	☐

Pain Interference

	In the past 7 days…	Not at all	A little bit	Somewhat	Quite a bit	Very much
25	How much did pain interfere with your day to day activities?.....	☐	☐	☐	☐	☐
26	How much did pain interfere with work around the home?	☐	☐	☐	☐	☐
27	How much did pain interfere with your ability to participate in social activities?	☐	☐	☐	☐	☐
28	How much did pain interfere with your household chores?	☐	☐	☐	☐	☐

Pain Intensity

In the past 7 days…

29 How would you rate your pain on average?.....

☐ 0 **No pain** ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 **Worst imaginable pain**

Patient Demographics:

Patient Name: _____ _____

First MI Last Preferred Name

SSN#: _____ Birth Date: _____ Sex: Male Female

Address: _____ _____ _____ _____

Street Address City State Zip Code

Home #: _____ Cell #:_____ Work #: _____

Marital Status: Married Single Divorced Widowed

Race: African American Asian White Hispanic Other

Ethnicity: Hispanic or Latino Non-Hispanic or Latino

Email Address: _____

How were you referred to our practice? (Circle)

Friend/Relative: _____ Physician Newspaper Radio Healthsource

Guardian Information: (If Patient is a Minor)

Name: _____ Relationship to Patient: _____

SSN#: _____ Birth date: _____ Sex: Male Female

Address: _____ _____ _____ _____

Street Address City State Zip Code

Home #: _____ Cell #: _____ Work: _____

Payment Information:

Form of Payment: Health Insurance Auto Insurance Worker's Compensation Self Pay

Primary Insurance

Primary Insurance Company: _____ Insured's Name _____

Policy #: _____ Group #: _____ Insured's Date of Birth: _____

Secondary Insurance

Secondary Insurance Company: _____ Insured's Name _____

Policy #: _____ Group #: _____ Insured's Date of Birth: _____

Self-Pay Agreement

I agree to pay for medical services rendered at Andrews Orthopaedic and Sports Medicine facilities. I understand that there are payment plans available at my request.

X _____ Date: _____

Release of Information: I authorize Andrews Orthopedic and Sports Medicine Center to release medical information requested by my health insurance, Medicare, or third- party payers in order to assist in the payment of claims.

X _____ Date: _____

Disclosure to Release Information to Families/ Emergency Contacts and Physicians

I authorize Baptist Physicians Group to disclose my health care information and to discuss my health care needs with those that I designate. I further authorize the release of my billing information to the following individuals and give them the ability to pick up prescriptions and/or forms, etc., on my behalf. A photo ID is required for any pick up. These individuals will be considered my emergency contacts. Without authorization, no information may be shared.

Important Note: If you may want or need any healthcare information or scheduling information released to any individuals they need to be specifically listed below. This includes individuals such as: a parent or child of a patient over 18 years of age, your primary care physician, your insurance policy holder, and/or sport coaches etc.

I authorize Baptist Physicians Group and his staff to disclose my personal health information to the following people:

Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

Consent to Treatment

I hereby grant authorization and consent for medical treatment and /or procedures for myself or for the patient for whom I am the parent or legally authorized guardian, and I understand that no guarantees or assurance has been made as to the results for which may be obtained.