NASHVILLE
HIP INSTITUTE
PRESERVATION, RECONSTRUCTION
& SPORTS MEDICINE

J. W. Thomas Byrd, M.D.
Tania A. Ferguson, M.D.

2004 Hayes Street, Suite 700
Nashville, TN 37203
615-284-5800
Fax 615-284-5819

PATIENT HEALTH HISTORY

Patient Name: _____ Preferred Name: _____

Sex: ☐ Male ☐ Female Date of Birth:_____Height:_____Weight:_____

Name of Primary Care Provider:_____Phone:_____

Pharmacy Preference: _____Phone:_____

Reason for appointment: _____

Please list any medications you are currently taking (prescription and over the counter):

Name	Dosage	Frequency	Route (oral, injection, etc.)

Are you allergic to any medications? ☐ No ☐ Yes

Drug Name	Reaction

Can you take anti-inflammatory medications? ☐ No ☐ Yes
Do you take any anti-inflammatories, blood thinners, aspirin products or vitamins containing Vitamin E? ☐ No ☐ Yes
Please list: _____

Past surgeries and dates: _____

_____

Have you ever had MRSA (staph infection)? ☐ No ☐ Yes
If so, when and where? _____

Hand dominance: ☐ Right ☐ Left Current occupation: _____

Female patients: Do you think you are pregnant? ☐ No ☐ Yes
Date of last menstrual period: _____

Name: _____

PAST MEDICAL HISTORY

Check if you currently suffer or have previously suffered from:

☐ Osteoporosis ☐ Arthritis ☐ Thyroid: ☐ Hyper ☐ Hypo

☐ Deep vein thrombosis ☐ Pulmonary embolism ☐ Alzheimer's/ Dementia

☐ High blood pressure ☐ Heart disease or heart attack ☐ Stroke

☐ Kidney disease ☐ Liver disease ☐ Seizures ☐ Anxiety ☐ Loose joints

☐ Diabetes ☐ Asthma ☐ Depression ☐ Gout ☐ Reflux disease (GERD)

☐ Gastric ulcers ☐ Gastritis ☐ COPD ☐ Tuberculosis ☐ Elevated cholesterol

☐ Polio ☐ Rheumatic fever ☐ Ulcerative colitis

Cancer (what kind and when: _____

Other: _____

_____

Please circle family history conditions:

☐ Blood Clots ☐ Diabetes ☐ Hypertension ☐ Rheumatoid Arthritis ☐ Anesthesia problems

☐ Cancer ☐ Heart Disease ☐ Osteoporosis ☐ Stroke ☐ Seizures

SOCIAL HISTORY

Tobacco Use: ☐ Never smoke ☐ Former smoker ☐ Everyday ☐ Some days

Alcohol Use (drinks per day): ☐ 0 ☐ 1 ☐ 2-3 ☐ 4-5 ☐ 6 or more

Recreational Drug Use? ☐ No ☐ Yes Frequency: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Anything else we may need to know: _____

_____

Name: _____

HISTORY OF YOUR HIP PAIN

Is the pain **CHRONIC**? ☐ No ☐ Yes If **YES**, how long?_____

Is the pain **NEW** as a result of a specific injury? ☐ No ☐ Yes

If **YES**, date of injury/accident: / /

Was it a ☐ Work injury or ☐ Motor Vehicle Accident? ☐ No

Briefly describe how the initial pain began and how it limits your current level of activity:

_____

_____

Have you seen another physician for this injury? ☐ No ☐ Yes

If **YES**, who? _____

What treatments have you tried? ☐ Nothing ☐ Physical therapy ☐ Exercise ☐ Acupuncture ☐ Chiropractic ☐ Bursa injections ☐ Joint injections ☐ Ice ☐ Decreased activity/rest ☐ Medications: _____

When was the first time you went to a doctor about it? _____

Who was the doctor? _____

What Medications have you taken for this problem?

Prescription: _____

Over-the-counter: _____

How long have you taken these medications? _____

Have you ever been told that you cannot take anti-inflammatories (NSAIDs)?

(Advil, Motrin, Celebrex, etc.)? ☐ No ☐ Yes

If **YES**, please explain: _____

Are you using any assistive devices? (for example: cane, crutches, etc.) ☐ No ☐ Yes

If **YES**, what kind? _____

Have you modified your activities because of your hip pain and/or a diagnosis of FAI including restriction of your athletic pursuits and/or avoidance of symptomatic movements? ☐ No ☐ Yes

If **YES**, how? _____

_____

_____

Patient signature: _____ Date: _____

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Personal Information

Today's Date: _____ Account #: _____ SSN: _____
First Name: _____ MI: _____ Last Name: _____
Address: _____ Apt./Suite: _____
Zip: _____ City: _____ State: _____
Date of Birth: _____ Age: _____ Marital Status: _____ Sex: _____
Home Phone: _____ Cell Phone: _____
May we leave info. on your voicemail? ☐Yes ☐No
Email Address: _____ May we email you? ☐Yes ☐No
Occupation: _____ Work phone: _____
Employer: _____ Full Time Student ☐Yes ☐No

In the event of an emergency, please contact:

Name: _____ Relationship: _____ Phone No: _____
Minor Patients: Name of Parent/Guardian _____
Who referred you? ☐Physician ☐Family ☐Friend ☐Internet ☐Insurance Co. ☐Other_____
Referring Physician's Name: _____ Phone No: _____
Address: _____

Insurance Information

Please present your insurance card(s) to the receptionist. Please give complete information.

Primary Insurance: _____ Insured's Name: _____
Patient's relationship to insured: ☐Self ☐Spouse ☐Child ☐Other
Policy #: _____ Group #: _____
Employer: _____ SSN: _____ DOB: _____
Secondary Insurance: _____ Insured's Name: _____
Patient's relationship to insured: ☐Self ☐Spouse ☐Child ☐Other
Policy #: _____ Group #: _____
Employer: _____ SSN: _____ DOB: _____

NOTICE REGARDING INSURANCE CLAIMS/PAYMENTS:

If we are filing insurance for your visit, we must have complete information and any required referral at the time of the visit. If you cannot provide the information, we will be unable to file your insurance, and payment in full will be required.

Payment of your charges cannot be determined until the claim is submitted to your insurance company. Payment will be based on your individual health plan, and the amount applied to your plan deductible and/or coinsurance will be your responsibility. Procedures that are excluded from coverage, based on your plan's determination of medical necessity, will also by your responsibility. Your office visit co-pay is due at the time of the visit and, in many cases, covers only the office visit charge. Any procedures performed will be considered surgery by your insurance company, and deductibles and coinsurance may apply.

For all other patients, payment is required at the time of service. We will provide you with the necessary documentation to file for reimbursement upon your request.

I have read the above information and understand that I am responsible for payment for services I receive.

Patient/Guardian Signature: _____ Date: _____

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PRESERVATION, RECONSTRUCTION & SPORTS MEDICINE

NASHVILLE SPORTS MEDICINE FOUNDATION
RESEARCH & EDUCATION

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Modified Harris Hip Score (mHHS)

Date_____

Patient Name_____ **Date of Birth** _____

Hip ☐Right ☐Left Have you had surgery on this hip by Dr. Byrd before? ☐YES ☐NO

If so, how long ago was the surgery? ☐3 months ☐1 yr ☐2 yrs ☐5 yrs ☐10 yrs ☐15 yrs ☐20 yrs ☐25 yrs

Are you glad you did the surgery? ☐YES ☐NO

Please think about how you feel on an average day and check one box under each heading.

PAIN:

☐None or it can be ignored (44)
☐Slight, occasional with no compromise in activities (40)
☐Mild pain, no effect on average activities, rarely moderate pain after unusual activities, uses aspirin (30)
☐Moderate pain, tolerable but makes concessions to pain. Some limitation to ordinary activity or work. May require occasional pain medicine stronger than aspirin (20)
☐Marked pain, serious limitation of activities (10)
☐Totally disabled, crippled, pain in bed, bedridden (0)

FUNCTION:

Limp:
☐None (11)
☐Slight (8)
☐Moderate (5)
☐Severe (0)
☐Unable to walk (0)

Distance Walked
☐Not limited (11)
☐Can walk 1 mile (8)
☐Can walk ½ mile (5)
☐Indoors only (2)
☐From bed to chair (0)

Support
☐None (11)
☐Cane for long walks (7)
☐Cane most of the time (5)
☐One crutch (4)
☐Two canes (2)
☐Two crutches (0)
☐Not able to walk (specify reason) _____ (0)

ACTIVITIES

Stairs
☐Normally without using a railing (4)
☐Normally using a railing (2)
☐In any manner (1)
☐Unable to do stairs (0)

Shoes and Socks
☐With ease (4)
☐With difficulty (2)
☐Unable(0)

Sitting
☐Comfortably on an ordinary chair for one hour (5)
☐On a high chair for 30 minutes (3)
☐Unable to sit comfortably in any chair (0)

Public Transportation
☐Able to enter public transportation (1)
☐Unable to enter public transportation (0)

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International Hip Outcome Tool (IHOT12)

Date _____

Patient Name_____ Date of Birth _____

Hip ☐ **Right** ☐ **Left** **Have you had surgery on this hip by Dr Byrd before?** ☐ **YES** ☐ **NO**

If so, how long ago was the surgery? ☐ 3 months ☐ 1 yr ☐ 2 yrs ☐ 5 yrs ☐ 10 yrs ☐ 15 yrs ☐ 20 yrs

Are you glad you did the surgery? ☐ YES ☐ NO

Simply place a vertical line at the position on the line below that corresponds accurately with your perception of your answer to the question. Please ensure that your line crosses the horizontal line, inside the shaded area. Please answer all the questions.

1. Overall, how much pain do you have in your hip/groin?

Extreme pain _____ No pain at all

2. How difficult is it for you to get up and down off the floor/ground?

Extremely difficult _____ Not difficult at all

3. How difficult is it for you to walk long distances?

Extremely difficult _____ Not difficult at all

4. How much trouble do you have with grinding, catching or clicking in your hip?

Severe trouble _____ No trouble at all

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Patient Name_____ **Date of Birth** _____

5. How much trouble do you have pushing, pulling, lifting or carrying heavy objects?

Severe trouble _____ No trouble at all

6. How concerned are you about cutting/changing directions during your sport or recreational activities?

Extremely concerned _____ Not concerned at all

7. How much pain do you experience in your hip after activity?

Extreme pain _____ No pain at all

8. How concerned are you about picking up or carrying children because of your hip?

Extremely concerned _____ Not concerned at all

9. How much trouble do you have with sexual activity because of your hip?

This is not relevant to me

Severe trouble _____ No trouble at all

10. How much of the time are you aware of the disability in your hip?

Constantly aware _____ Not aware at all

11. How concerned are you about your ability to maintain your desired fitness level?

Extremely concerned _____ Not concerned at all

12. How much of a distraction is your hip problem?

Extreme distraction _____ No distraction at all

(End of survey- Thank you for taking the time to complete!)

Nashvillehip.org

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PATIENT FINANCIAL POLICY

Patient Name:_____ **DOB:** _____

Thank you for choosing Nashville Hip Institute for your medical care! We are committed to the success of your medical treatment and care. Please understand that a mutual financial understanding is part of our relationship.

We sincerely hope that by sharing our financial expectations that we will strengthen the practice-patient relationship and keep the lines of communication open. This financial policy helps the practice provide quality care to our valued patients. If you have any questions or need clarification of any of the policies listed below, please feel free to contact our billing department at 615-284-5800.

Payment is Due at the Time of Service

- We accept cash, checks, debit and credit cards, and Care Credit.
- All co-payments, deductibles, and non-covered services are due at the time of service unless you have made payment arrangements in advance of your appointment.
- Insurance required co-payments are due when you check in for your appointment.
- If your co-payment is based on a percentage (example: 20% of the allowed payment) and you do not have a secondary policy, please be prepared to pay $100.00 on the date of service.
- Patient-responsible balances are due when you check in for your appointment. Our billing staff will assist you in making payment arrangements.
- In the event you need surgery, we will provide you an estimate of your insurance required deductible and co-insurance amounts. This amount will due at the time of scheduling your procedure.
- We request that at least **24 hour** advance notice be given to the office if you will be unable to keep your scheduled appointment. This allows us to release your appointment time to another patient.

Proof of Insurance

- Please bring your insurance card(s) and a valid photo ID with you to each appointment.
- It is your responsibility to notify the practice of changes in your health insurance.

Self-Pay Accounts

We designate accounts to be, **Self-Pay** under the following circumstances: (1) patient does not have health insurance coverage, (2) patient does not have a current, valid insurance card on file, or (3) patient does not have a valid insurance referral on file.

Referrals

- If you have an HMO plan we are contracted with, you need a referral authorization from your primary care physician. If we have not received an authorization prior to your arrival at the office, call your primary care physician to obtain it. Without an insurance required referral, the insurance company will deny payment for services. As such, If you are unable to obtain the referral at that time, you will be rescheduled or asked to pay for the visit in advance.

Financial Assistance

- Our practice treats patients regardless of financial status. We offer assistance in the form of a sliding scale discount of charges based on verifiable household income.

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Divorce and Child Custody Cases

- In cases of divorce, the individual who receives care is responsible for payment of co-payments, coinsurance, deductibles, and nonparticipating insurance balances at the time of service. We will not bill a divorced spouse for the patient's services.
- The parent who brings the child to the office for care is responsible for payment at the time of service no matter if the account is self-pay, participating insurance, or nonparticipating insurance. The practice does not honor divorce specifics (*e.g., percentage of financial responsibility).*
- If the child has coverage with a participating insurance plan and the proper insurance identification is present at the time of service, the practice will bill that insurance company. Applicable co-payments, coinsurance, and/or deductibles are due at the time of service unless arrangements have been made with the office prior to arrival.

Billing, Payments and Refunds

- All balances are due in full within 14 days of the statement date.
- If you cannot pay the balance in full within 14 days, please contact our billing department to see if you qualify for special payment options.
- It is your responsibility to notify the office of any change in address, phone, employment, or insurance coverage.
- If you make an overpayment on your account, we will issue a refund if there are no other outstanding balances on other accounts with the same guarantor or financially responsible party.
- We reserve the right to report delinquent accounts to credit bureaus, assess a collection fee, or take other collection action.

☐ I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility.

☐ I authorize my insurance benefits be paid directly to Nashville Hip Institute.

☐ I authorize Nashville Hip Institute, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

☐ I authorize Nashville Hip Institute to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

☐ I authorize Nashville Hip Institute to contact and discuss my personal health information with:

Name:_____ Relationship _____

Name:_____ Relationship_____

X Patient/Guarantor Signature_____Date_____

Acknowledgement of Nashville Hip Institute Notice of Privacy Practices

I hereby acknowledge that I have reviewed, received, or have been given the opportunity to receive a copy of Nashville Hip Institute Notice of Privacy Practices.

X Patient Signature_____Date_____

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FINANCIAL ASSISTANCE POLICY

Nashville Hip Institute is committed to providing quality healthcare to all of our patients in the most cost-effective manner. We are sensitive to the needs of our uninsured patients as well as our patients who are experiencing financial hardships. As such, we are pleased to announce the following options:

CareCredit

Patients who will be undergoing surgery, or who have balances over $300, are encouraged to apply for financing through CareCredit. CareCredit offers no interest payment terms (up to 18 months) or competitive interest rates for extended payment terms (6 or 12 months interest free, or 24 months competitive interest rate) to help finance your surgery or large balance. For the easy application process, follow the link on our website, **nashvillehip.org**, under the "For Patients" tab, then click the "Insurance & Payment Options" option.

Self-pay discounts

For our uninsured patients, we are pleased to offer a 25% discount for full payment at the time of service. However, if you are unable to pay your balance in full, we encourage you to apply for CareCredit.

Payment plans

Payment plans may be offered to those patients who do not qualify for CareCredit or who have a balance under $300. Payment plans are intended for our patients who may need to pay their balance over several months, whether you are uninsured, have a high deductible, or have high co-insurance. Please note that co-payments are due at the time of service. We ask for a minimum $100 good faith payment at the time of the visit and then we will work with each patient individually to develop a payment plan that meets your needs and keep's your balance current. We offer recurring billing – whereby your credit card is charged or your checking account is debited on an agreed date and amount. This saves you the hassle of writing a monthly check and allows us to keep costs down.