

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Gender M F  
Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_ Marital Status S M W D  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work phone \_\_\_\_\_  
Confidential Email \_\_\_\_\_ Employer \_\_\_\_\_  
Employed (please circle one) Full-time Part-time Not Employed Student  
Pharmacy of Choice \_\_\_\_\_ Location of Pharmacy \_\_\_\_\_

Person Responsible for Bill (if different from Patient) \_\_\_\_\_  
Relationship \_\_\_\_\_ Social Security # \_\_\_\_\_ DOB \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Cell phone \_\_\_\_\_

**Primary Insurance Company** \_\_\_\_\_ Effective Date of policy \_\_\_\_\_  
Policyholder \_\_\_\_\_ Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Relationship of Policyholder to patient \_\_\_\_\_  
Address (if different than above) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
ID/Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Employer \_\_\_\_\_  
Is this a deductible policy? YES NO Has your deductible been met this year? YES NO

**Secondary Insurance Company** \_\_\_\_\_  
Policyholder \_\_\_\_\_ Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Relationship of Policyholder to patient \_\_\_\_\_  
Address (if different than above) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
ID/Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Employer \_\_\_\_\_  
Is this a deductible policy? YES NO Has your deductible been met this year? YES NO

**Self-pay (no insurance)** YES NO

I hereby authorize (a) payment of insurance benefits otherwise due to me to be made directly to Tennessee Family Medicine, PLLC, (b) release of information including protected health information to insurance companies as needed to file payment for services incurred, (c) Tennessee Family Medicine, PLLC to obtain records from other sources as may be necessary in the diagnosis or treatment, and (d) understand that I am financially responsible to Tennessee Family Medicine, PLLC for charges related to services provided or incurred by me or my dependents.

Signature (Responsible Party) \_\_\_\_\_ Date \_\_\_\_\_

Thank you for choosing Tennessee Family Medicine, PLLC.

It is our policy that all fees including co-pays, deductibles and non-covered services are due and payable on the date of service unless other payment arrangements have been made.

As a service to our patients, we will file a claim with your insurance company. The filing of insurance does NOT release the patient from responsibility for charges for services which have been provided. Please make sure we have a current copy of your insurance card. ***If we do not have the correct insurance information on the date of service and your claim is denied, you are responsible for payment.*** It is your responsibility to verify if our office is in network with your plan.

Accounts which are not paid within a reasonable period of time, and for which no special arrangements have been made, will be subject to placement with collection agencies following due notice.

Having read and understood the above statements, I agree to the terms set forth. I understand that I am financially responsible for all charges, even if they are not covered by insurance. If my insurance does not pay, I understand that I am responsible for those charges. In the event that I do not pay in accordance with the above policy and my account is sent to collections, I agree to pay all costs of collection, including attorney fees.

I, the patient or guarantor/guardian, certify that the information on this form is true to the best of my knowledge. I hereby authorize the release of all applicable medical information including, without limitation, copies of all records and test results produced to the designated attending, referral and/or follow-up physicians and such other healthcare practitioners or organizations which will be providing subsequent monitoring, care or treatment in connection with care provided by Tennessee Family Medicine, PLLC. I also authorize the release of information from my medical record in order to comply with applicable law, to facilitate the performance of utilization review and quality assurance activities and to facilitate third-party accreditation/certification activities. I accept responsibility for the medical charges incurred by the patient and agree to pay all bills at the time of service, unless other arrangements are made. I authorize physician and/or clinic to render medical treatment and to release information to process insurance claims and to determine Medicare benefits. I also authorize my insurance claim and/or authorized Medicare benefits to be paid directly to Tennessee Family Medicine, PLLC. I further agree that a photocopy of this document is to be considered as valid as an original.

Signature of Responsible Party \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_



## Consent to Disclose Health Care Information

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

I understand that my health information is private and confidential. I understand that the physician and staff of Tennessee Family Medicine, PLLC work very hard to protect my privacy and preserve the confidentiality of my personal health information.

I understand that signing this document means Tennessee Family Medicine, PLLC may use and disclose my personal health information to help provide my healthcare, to handle my billing and payment and to take care of other healthcare operations.

Tennessee Family Medicine, PLLC has a document called the "Notice of Privacy Practices" that contains more information about policies and practices used to protect our patients' privacy. I understand that I have the right to read the "Notice of Privacy Practices" before signing this agreement. The notice is posted in the office of Tennessee Family Medicine, PLLC. A written copy will be provided upon request. Tennessee Family Medicine, PLLC may update the "Notice of Privacy Practices" at any time. A copy of the most recent update is available upon request.

Under the terms of this consent, I can ask Tennessee Family Medicine, PLLC to restrict how my personal health information is used or disclosed to carry out treatment, payment or health care operations.

I understand that Tennessee Family Medicine, PLLC does not have to agree to my request. If Tennessee Family Medicine, PLLC does agree to my request, I understand that agreed limits would be followed.

I understand that I have the right to cancel this consent in writing to the Privacy Officer of Tennessee Family Medicine, PLLC. If I do cancel this consent, I understand that Tennessee Family Medicine, PLLC may have used or disclosed information about me and canceling this consent would not apply to information already used or disclosed.

I understand that if I cancel this consent, Tennessee Family Medicine, PLLC does not have to provide further healthcare services to me.

My signature below indicates that I have been given the opportunity to review a current copy of the Tennessee Family Medicine, PLLC "Notice of Privacy Practices."

Signature of Patient (or legally authorized person) \_\_\_\_\_

Relationship to Patient \_\_\_\_\_



Release of Information

Patient name \_\_\_\_\_ Date \_\_\_\_\_

I, \_\_\_\_\_ give permission to Tennessee Family Medicine to discuss my medical condition(s) , my treatment, and information regarding my appointments with the following individuals:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

May we leave a message on your answering machine? YES NO

OR

\_\_\_\_\_ Tennessee Family Medicine and their staff MAY NOT divulge information regarding my medical care or treatment to anyone other than me.

Consent to Treat

I, \_\_\_\_\_ hereby authorize Tennessee Family Medicine, PLLC and any of its physicians and/or staff to treat my medical condition(s). The risks, benefits and alternatives will be explained at the time of service. I have the right to question and/or refuse treatment. I hereby release Tennessee Family Medicine, PLLC and its physicians and/or staff from any liability.

Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to patient \_\_\_\_\_



353 New Shackle Island Road, Suite 128B  
Hendersonville, TN 37075

## Authorization for Release of Medical Records

Patient name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Phone \_\_\_\_\_ Social Security # \_\_\_\_\_

I hereby authorize the release of my **ENTIRE** medical record (including office notes, labs, xray, specialist notes, notes from previous doctors)

To: Tennessee Family Medicine  
353 New Shackle Island Road Suite 128-B  
Hendersonville, TN 37075  
(615)590-2020 ph (615)590-2027 fax

From: Name \_\_\_\_\_  
Address \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_

I understand that my medical record may also include information on diagnosis/treatment related to psychiatric or psychological conditions, drug and/or alcohol abuse, acquired immune deficiency syndrome (AIDS), and/or HIV status. I understand and agree that the information, if any, pertaining to any such diagnosis/treatment described above may be released.

Treatment, payment, enrollment or eligibility for benefits will not be conditional on signing this authorization. We may disclose your health care information to other healthcare Professionals or insurance companies for the purpose of treatment, payment or other healthcare operations. For further information, please see our Privacy Statement detailing our privacy policy.

Patient / Legal Representative \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

PLEASE NOTE: When your Personal Health Information (PHI) is released pursuant a valid authorization, you should be aware that the information released may be subject to re-disclosure by the recipient and may no longer be protected by the Privacy Rule. Treatment may not be withheld or conditioned on obtaining the authorization as is prohibited by the Privacy Rule.