

First Name _____ Last 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 _____
Home phone _____ Cell phone _____

Primary Insurance Company _____
Policyholder _____ Social Security # _____ Date of Birth _____
Relationship of Policyholder to patient _____
Address (if different than above) _____
City _____ State _____ Zip _____
Home phone _____
ID/Policy # _____ Group # _____ Employer _____

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 _____

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 _____



Consent to Disclose Health Care Information

It is important for you to know how your rights concerning your records and how your Personal Health Information (PHI) is used in our office. Before we begin any health care operations, we must require you read and sign this consent form stating you understand and agree with how your records will be used.

1. I understand and agree to allow Tennessee Family Medicine, PLLC to use my Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care.
2. 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.
3. 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.
4. 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.
5. 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.
6. I understand that if I cancel this consent, Tennessee Family Medicine, PLLC does not have to provide further healthcare services to me.
7. I grant Tennessee Family Medicine permission to view my prescription history from external sources.

I have read and understand how my Patient Health Information (PHI) will be used and I agree to these policies and procedures.

Patient Signature

Date

Printed Name

Patient name _____

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

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.

Patient Signature

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:

1. I understand my co-pay, deductible or non-covered service fee is due and payable at my appointment or I will need to reschedule my appointment.
2. I understand that I am financially responsible for all charges, even if they are not covered by insurance.
3. If my insurance does not pay, I understand that I am responsible for those charges.
4. In the event that I do not pay in accordance with the above policy and my account is sent to a collection agency, I agree to pay all costs of collection, including attorney fees.
5. If my account is sent to collection, I understand I will be dismissed from this practice.
6. I understand if I fail to show up for a scheduled appointment, I will receive one courtesy notice. For a second no show appointment, I understand I will receive a bill for the missed appointment. I understand a third missed appointment is grounds for dismissal from the practice.

I, the patient or guarantor/guardian 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 _____

Almost done... We need this information to provide the best care:

Please list your **current medications**: We need the Name, Dose, How often taken and who started the medication:

To avoid dangerous interactions, please list any **supplements, vitamins or over the counter** products you use regularly:

Any **Allergies** to medications or other?

Last **Colonoscopy** (Colon Cancer Screening)?
Doctor that performed?

Last **Pap** and **Breast Exam**?

Last **Tetanus** booster?

Last **Pneumonia** Vaccine?

Please list any **Operations** or **Hospitalizations**?

Anything else we need to know?

