TENNESSEE FAMILY MEDICINE

Patient Registration

First Name _____ Last Name _____ MI ____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Home phone _____ Cell phone _____ Work phone _____

May we leave a message on your Home phone Cell phone Work phone None

(please circle all that apply)

Best # to reach you _____ Confidential Email _____

*Race American Indian Asian Native Hawaiian African American White Hispanic Other

* Ethnicity Hispanic Not Hispanic Refuse to Answer *Preferred Language _____

*Government requires this information to protect patients against discrimination.

Pharmacy of Choice _____ Location of Pharmacy _____ Phone _____

Gender M F Marital Status S M W D SSN _____

Employer Name _____ Full-time Part-time Not Employed Student

Emergency Contact _____ Relationship _____ Phone _____

How did you hear about us? _____

Person responsible for bill _____ Relationship _____

SSN _____ DOB _____ Home # _____ Cell # _____

Address _____ City _____ State _____ Zip _____

Primary Insurance _____ ID # _____ Group # _____

Policyholder _____ Relationship to patient _____ DOB _____

Address _____ City _____State _____ Zip _____

Home phone _____ Cell phone _____ Employer _____

Secondary Insurance _____ ID # _____ Group # _____

Policyholder _____ Relationship to patient _____ DOB _____

Address _____ City _____State _____ Zip _____

Home phone _____ Cell phone _____ Employer _____

I hereby authorize (a) payment of insurance benefits 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 _____

TENNESSEE FAMILY MEDICINE

Release of Information

Patient Name _____ DOB _____

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

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

☐ NO, I do not give permission for Tennessee Family Medicine to discuss information regarding my medical care or treatment with anyone other than me.

Privacy Practices

Please note that our Patient Privacy Practice is posted in our waiting room for everyone to view. You may request a copy for your records. My signature below indicates I have been given the opportunity to review a current copy of the Tennessee Family Medicine, PLLC "***Notice of Privacy Practices***."

TennCare or Medicaid

I understand that Tennessee Family Medicine, PLLC does not take **TennCare** or any **Medicaid** policies. In signing this, I attest I do not have **TennCare** or **Medicaid**. I also understand if at any time I acquire one of these policies, I must disclose this information to Tennessee Family Medicine, PLLC before my next office visit. I understand if I have coverage under either plan and do not disclose this information, my actions will be considered fraudulent and I will be discharged from the practice.

No Show Policy

We require 24 hour notice of cancellation for appointments. No show appointments are visits that could have been given to other patients that need our services. You will receive a courtesy letter for your 1st no show. You will receive a $25 bill for your 2nd no show. If you have multiple no shows, you can be dismissed from the practice.

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.

_____ _____

Patient Signature or Responsible Party Date

TENNESSEE FAMILY MEDICINE

Financial Policy

Patient Name _____ DOB _____

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 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 those charges.
3. If my insurance does not pay, I understand 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 or give 24 hour cancellation notice, 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 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 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.

_____ _____

Patient Signature or Responsible Party Date

_____ _____

Printed Name Relationship to Patient

TENNESSEE FAMILY MEDICINE

Consent for Release of Prescription History

I authorize Tennessee Family Medicine to access my prescription history from outside sources to help keep my medical record as complete as possible. This includes many but not necessarily all medication used in the past.

yes _____ Initials

_____
Name Signature Date

no _____ Initials

Notice of Advanced Directives

I have formal advanced directives that dictate my preferences for medical management should I be incapacitated or unable to make decisions with good judgement.

yes _____ Initials

I have durable power of attorney for my health care and will provide copies to the clinic. A **durable power of attorney (DPA)** for health care is another kind of advance directive. A DPA states whom you have chosen to make health care decisions for you. It becomes active any time you are unconscious or unable to make medical decisions. A DPA is generally more useful than a living will. But a DPA may not be a good choice if you don't have another person you trust to make these decisions for you.

no _____ Initials

yes _____ Initials

I have a **living will** and will provide copies to the clinic. A living will is one type of advance directive. It is a written, legal document that describes the kind of medical treatments or life-sustaining treatments you would want if you were seriously or terminally ill. A living will doesn't let you select someone to make decisions for you.

no _____ Initials

yes _____ Initials

I have a **Do Not Resuscitate** order. A do not resuscitate (DNR) order is another kind of advance directive. A DNR is a request not to have cardiopulmonary resuscitation (CPR) if your heart stops or if you stop breathing. (Unless given other instructions, hospital staff will try to help all patients whose heart has stopped or who have stopped breathing.) You can use an advance directive form or tell your doctor that you don't want to be resuscitated. Forms available on our website.

no _____ Initials

Patient Name _____ DOB _____

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:

_____

_____

_____

_____

_____

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_____

_____

List any ***allergies*** to medications or other:

_____

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Last Colonoscopy _____ Doctor that performed _____
(Colon Cancer Screening)

Last Pap and Breast Exam _____

Last Tetanus booster _____

Last Pneumonia Vaccine _____

Please list any Operations or Hospitalizations _____

_____

_____

Anything else we need to know _____

_____

_____

_____