State of Franklin
HEALTHCARE ASSOCIATES™
Your Health, Our Focus

Johnson City Internal Medicine
Patient Registration (Please Print)

Patient Information

First Name | M.I | Last Name

Birthdate | Age | Social Security Number

Address | City, State, Zip

( ) Home Telephone Number | ( ) Work Telephone Number

Employer's Name and Address

Name of Spouse or Parent | Employer of Spouse or Parent

In case of Emergency Notify | ( ) Telephone Number

Insurance Information

Primary Insurance | Identification Number | Group Number

Secondary Insurance | Identification Number | Group Number

Ethnic origin (check □ only one):

- □ White not Hispanic
- □ Black not Hispanic
- □ Hispanic
- □ Asian or Pacific Islander
- □ Filipino
- □ American Indian/Alaskan Native
- □ Decline
- □ Other: ___________________________

Authorization

I hereby authorize Johnson City Internal Medicine to release to the above companies (or their representatives) any information including the diagnosis, and the records of any treatment or examination render to me. I authorize and request the above names companies to pay directly to Johnson City Internal Medicine any benefits due for their medical or surgical services rendered to me. I permit a copy of these authorizations to be used in place of the original. I understand that I am responsible for payment of any and all changes incurred by me.

_____________________ X____

Date Signature of Patient or Responsible Party

Teaching Physicians

You will be seen by a physician who is a member of the facility of James H. Quillen College of Medicine. The teaching physicians who work in this office are responsible for teaching residents (postgraduate trainees). Not only will you be seen by your own physician here, but you may also be seen by one or more residents. We believe this adds to the depth and level of care the patient receives since patients are seen by one or more physicians and discussed in detail. We are pleased with your willingness to participate in our teaching program. Your care will encompass a team approach to health care with the involvement of your physician and residents.

_________________________ X____

Date Signature of Patient or Responsible Party

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Registration, Billing and Collection
Payment Policy

We are participating with Medicare, Tennessee Medicaid, and most Managed Care plans in the area. We will file these claims for you. Patients are expected to pay any deductibles, coinsurance or copay amounts owed at the time of service.

If you are a Medicare patient and do not have a supplemental plan or a Medicare Advantage plan, you are responsible for payment of the annual deductible, co-insurance and non-covered services at the time of service.

Patients with a third party coverage with whom we do not contract are responsible for payment in full at the time of service. As a courtesy, we will file your charges with this third party payer upon receipt of payment in full. Otherwise, we will provide you with a completed third party payer claim form to use in filing your insurance.

Patients with a High Deductible Health Plan that have not met their annual deductible amount on the date of service will be asked to pay $50.00 at the time of service for primary care providers and a percent of the charge amount for specialists. You will be billed for any additional deductible amounts after the insurance processes the claim.

Patients without verifiable insurance will be responsible for payment of all services rendered at the time of service. We accept cash, check, Visa, MasterCard, Discover and American Express.

Please realize, however, that:

1. Your insurance is a contract between you and your insurance company. We are not a party to that contract.
2. Depending on the specifics of the agreement we have with your insurance company, any portion of our fees not covered may be the responsibility of the patient.
3. Not all services are a covered benefit in all counts. Some insurance companies arbitrarily select certain services they will not cover. Any service not covered is the responsibility of the patient.

Regardless of insurance payment the patient and/or guardian remains responsible for all financial obligations incurred at the time of service. We realize that some balances may not be able to be paid in full at time of service and we will be happy to assist you in making satisfactory payment arrangements.

By signing this financial policy acknowledgement of the financial responsibility is accepted. This will remain in effect until revoked in writing.

______________________________	______________________
Patient Name Patient	Date of Birth
______________________________	______________________
Patient or Guardian Signature	Date

State of Franklin
HEALTHCARE ASSOCIATES™

Your Health, Our Focus

Acknowledgement of Notice of Privacy Practices

I have been given the opportunity to review the Notice of Privacy Practices and understand that the Notice describes how my protected medical information may be used and disclosed and how I may get access to this information. I have also been given the opportunity to take a copy of the Notice of Privacy Practices for further review.

If for some reason the facility needs to relay my protected medical information, i.e. lab results or billing issues, you can either leave or discuss the information with the following individual(s):

1. ____
2. ____
3. ____
4. ____
5. ____

Emergency Contact Number other than your home phone number

Name and Phone Number ____

Relationship ______________________________

By Signing below, I agree to the fore mentioned statements.

______________________________ ________ ______________
Patient or Guardian Date Cell Number

______________________________ ______________________
Practice Representative Date

______________________________ ______________________
Patient Name Date of Birth

______________________________ ______________________
Account Number Email Address

ACCESS YOUR MEDICAL INFORMATION ONLINE, *24/7 ANYWHERE, ANYTIME*

Yes! I would like to enjoy the benefits of accessing my personal health information through Follow my Health.

Patient's Name (please print): ______________________________Patient's DOB: ____________
Guarantor's Name: ____
E-mail Address: ____

HEALTH HISTORY

Today's Date: ____________

Name ____________ Age ____________ Date of Birth ____________

Education (highest level attained) ____________

Where and when have you lived or traveled outside the U.S. and Canada? ____________

Occupation ____________

Reason for visiting your physician today ____________

SYMPTOMS Check symptoms you currently have.

General
- [ ] Chills
- [ ] Depression
- [ ] Fainting
- [ ] Fever
- [ ] Forgetfulness
- [ ] Headache
- [ ] Loss of Sleep
- [ ] Loss of weight
- [ ] Nervousness
- [ ] Numbness
- [ ] Sweats

Muscle/Joint/Bone
Pain, weakness, numbness in
- [ ] Arms
- [ ] Hips
- [ ] Back
- [ ] Legs
- [ ] Feet
- [ ] Neck
- [ ] Hands
- [ ] Shoulders

Genito-Urinary
- [ ] Blood in urine
- [ ] Frequent urination
- [ ] Lack of bladder control
- [ ] Painful urination

Gastrointestinal
- [ ] Poor appetite
- [ ] Bloating
- [ ] Bowel Changes
- [ ] Constipation
- [ ] Diarrhea
- [ ] Excessive hunger
- [ ] Excessive thirst
- [ ] Gas
- [ ] Hemorrhoids
- [ ] Indigestion
- [ ] Nausea
- [ ] Rectal bleeding
- [ ] Stomach Pain
- [ ] Vomiting
- [ ] Vomiting blood

Cardiovascular
- [ ] Chest pain
- [ ] High blood pressure
- [ ] Irregular heart beat
- [ ] Low blood pressure
- [ ] Poor circulation
- [ ] Rapid heart rate
- [ ] Swelling of ankles
- [ ] Varicose veins

Eyes, Ear, Nose, Throat
- [ ] Bleeding gums
- [ ] Blurred vision
- [ ] Crossed eyes
- [ ] Difficulty swallowing
- [ ] Double vision
- [ ] Earache
- [ ] Ear discharge
- [ ] Hay fever
- [ ] Hoarseness
- [ ] Loss of hearing
- [ ] Nosebleeds
- [ ] Persistent cough
- [ ] Ringing in ears
- [ ] Sinus problems
- [ ] Poor vision

Skin
- [ ] Bruise easily
- [ ] Hives
- [ ] Itching
- [ ] Change in moles
- [ ] Rash
- [ ] Scars
- [ ] Sore that won't heal

MEN only
- [ ] Breast lump
- [ ] Erection difficulties
- [ ] Lump in testicles
- [ ] Penis discharge
- [ ] Sore on penis
- [ ] Other

WOMEN only
- [ ] Abnormal Pap smear
- [ ] Bleeding between periods
- [ ] Breast lump
- [ ] Extreme menstrual pain
- [ ] Hot flashes
- [ ] Nipple discharge
- [ ] Painful intercourse
- [ ] Vaginal discharge
- [ ] Other

Date of last menstrual period: ____________

Date of last Pap smear: ____________

Date of last mammogram: ____________

Are you pregnant?

CONDITIONS Check conditions you currently have or have had in the past.

- [ ] AIDS
- [ ] Alcoholism
- [ ] Anemia
- [ ] Anorexia
- [ ] Appendicitis
- [ ] Arthritis
- [ ] Asthma
- [ ] Bleeding Disorders
- [ ] Breast Lump
- [ ] Bronchitis
- [ ] Bulimia
- [ ] Cancer
- [ ] Cataracts
- [ ] Chemical Dependency
- [ ] Chicken Pox
- [ ] Diabetes
- [ ] Emphysema
- [ ] Epilepsy
- [ ] Glaucoma
- [ ] Goiter
- [ ] Gonorrhea
- [ ] Gout
- [ ] Heart Disease
- [ ] Hepatitis
- [ ] Hernia
- [ ] Herpes
- [ ] High Cholesterol
- [ ] HIV Positive
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Measles
- [ ] Migraine Headaches
- [ ] Miscarriage
- [ ] Mononucleosis
- [ ] Multiple Sclerosis
- [ ] Mumps
- [ ] Pacemaker
- [ ] Pneumonia
- [ ] Polio
- [ ] Prostate Problem
- [ ] Psychiatric Care
- [ ] Rheumatic Fever
- [ ] Scarlet Fever
- [ ] Stroke
- [ ] Suicide Attempt
- [ ] Thyroid Problems
- [ ] Tonsillitis
- [ ] Tuberculosis
- [ ] Typhoid Fever
- [ ] Ulcers
- [ ] Vaginal Infections
- [ ] Venereal Disease

MEDICATIONS List Medications your are currently taking	**ALLERGIES** To medications or substances

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FAMILY HISTORY Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check if your blood relatives have had the following:

X	Disease	Relationship to you
	Diabetes	
	Cancer	
	Bleeding tendency	
	Kidney disease	
	Tuberculosis	
	Heart disease	
	Stroke	
	High blood pressure	
	Nervous illness	
	Allergies	

HOSPITALIZATIONS

Year	Hospital	Reason for hospitalization

NAME & ADDRESS OF LAST TREATING PHYSICIAN

Have you ever had a blood transfusion? ☐ No ☐ Yes

Do you have an advance directive (living will)? ☐ No ☐ Yes

SERIOUS ILLNESSES/INJURIES

Illness or injury	Date	Outcome

PREGNANCY HISTORY

Year of Birth	Sex of Birth	Complications, if any

HEALTH HABITS Check if used

X	Type and daily amount	
	Caffeine	
	Tobacco	
	Drugs	
	Alcohol	
	Other	

Adult Vaccinations

Date Received	Vaccine
	Tetanus
	Pneumonia
	MMR
	Hepatitis

Today's Date: ____________________ Patient Signature: ____________________

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HEALTHCARE ASSOCIATES™

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State of Franklin Healthcare strives to provide excellent, quality care to each and every patient in a timely manner. In an effort to provide care when you need it, we have updated our policies on missed or canceled appointments and patient discharges.

We try to be good stewards of your time and ours. So, when at all possible, **please notify us as soon as possible and at least 24 hours in advance when you are unable to keep your appointment**. We will assist you in selecting another time better for you and will still be able to allow someone else to be seen.

In addition, we need time to greet you and complete registration for your appointment. Therefore, we ask that you **always arrive at least 15 minutes prior to your appointment**. Should you be running later than 15 minutes past your appointment time, we may consider this a "no show" but will make an effort to see you.

We realize things happen and you may miss an appointment. We do track missed appointments and will notify you if this happens. Your provider determines how often you need to be seen; so, to receive proper care, you need to keep or reschedule appointments within the time frame discussed at your visit.

We never want to say goodbye to a patient but sometimes circumstances cause us to determine our relationship isn't working the way it should. If you miss or "no show" an appointment three times, you are not receiving the frequency of care you need nor are we able to use that time for another patient in need. At that point, you may be asked to establish with another provider for your care.

We feel a good relationship consists of mutual respect. However, sometimes challenges arise that may cause us to discontinue the relationship. In addition to a trend of missed appointments, other issues that qualify for dismissal include failure to comply with a prescribed treatment plan, inappropriate/ abusive behavior to providers, staff or other patients or failure to pay outstanding balances.

Please let us know if you have any questions related to our policies. We are always available to answer your questions and thank you for the privilege to participate in your care.

Patient/ Guardian Initials: _______