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

State of Franklin
HEALTHCARE ASSOCIATES™
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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

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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: _____

State of Franklin HEALTHCARE ASSOCIATES™

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Past Medical History (Check all that Apply)

- ☐ Acne
- ☐ Allergies
- ☐ Alzheimer's Disease
- ☐ Anemia, Type_____
- ☐ Anxiety
- ☐ Arrhythmia
- ☐ Arthritis, Site _____
- ☐ Asthma
- ☐ ADD
- ☐ B12 Deficiency
- ☐ Bipolar Disease
- ☐ BPH (Enlarges Prostate)
- ☐ Breast Cancer
- ☐ Bronchitis (chronic)
- ☐ Heart Disease (CAD)
- ☐ Cancer, Type? _____
- ☐ Carpal Tunnel Syndrome
- ☐ Cataracts
- ☐ Cervical Cancer
- ☐ Chicken Pox
- ☐ Colitis
- ☐ Colon Cancer
- ☐ Colon Polyp (benign)
- ☐ Congestive Heart Failure
- ☐ Constipation
- ☐ COPD (Emphysema)
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Diabetes Type I, controlled? _____
- ☐ Diabetes Type II (Adult Onset), controlled? ___
- ☐ Eczema
- ☐ Epilepsy (Seizure Disorder)
- ☐ Erectile Dysfunction
- ☐ Fatigue
- ☐ Fibromyalgia
- ☐ Bone Fracture, Sites? _____
- ☐ Gallbladder Disease
- ☐ GERD (Heartburn)
- ☐ Gestational Diabetes (Diabetes during preg)
- ☐ Glucose Intolerance
- ☐ Gout
- ☐ Headaches (chronic), Type? _____
- ☐ Hearing Loss
- ☐ Heart Attack (year) _____
- ☐ Heart Murmur
- ☐ Hemorrhoids
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives
- ☐ Hyperthyroidism
- ☐ Hypothyroid
- ☐ Hypoglycemia
- ☐ Thyroid Nodule
- ☐ Irritable Bowel
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Low Back Pain (chronic)
- ☐ Liver Disease, Type? _____
- ☐ Lupus
- ☐ Neck Pain (chronic)
- ☐ Melanoma
- ☐ Menstrual Problems, Type? _____
- ☐ Mental Retardation
- ☐ MRSA (skin infection)
- ☐ Obesity
- ☐ Osteopenia
- ☐ Ear Infections (chronic)
- ☐ Ovarian Cysts
- ☐ Panic Attacks
- ☐ Ulcer (stomach)
- ☐ Palpitations
- ☐ Pneumonia
- ☐ Polycystic Ovaries
- ☐ Prostate Infection
- ☐ Restless Leg Syndrome
- ☐ Rheumatoid Arthritis
- ☐ Rosacea
- ☐ Scoliosis
- ☐ Sexually Transmitted Disease, Type? _____
- ☐ Shingles
- ☐ Sinusitis (chronic)
- ☐ Skin Cancer, Type? _____
- ☐ Sleep Apnea
- ☐ Sleep Problems
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Blood Clots, site? _____
- ☐ TMJ
- ☐ Urinary Incontinence
- ☐ Vertigo (chronic)
- ☐ Cancer, other _____
- ☐ Other diseases not listed _____
- ☐ _____
- ☐ _____

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SOCIAL HISTORY:

Occupation _____ Employer _____
Marital Status_____ Living Situation_____
Church/Religious Affiliation_____ Hobbies/Interests _____
Level of Education _____

HABITS: (Check those that apply to you)
( ) Smoke Cigarettes: How many packs per day? _____ How many years? _____
( ) Smokeless tobacco (Chewing, snuff) How many years? _____
( ) Alcohol: How many drinks per day? _____Per week? _____
Are you currently using or taking illegal drugs? Yes (____) No (____)
Do you wear seatbelts? Yes (____) No (____)
Do you exercise regularly? Yes (____) No (____) How many times per week? _____

ADVANCED DIRECTIVES:

Do you have a living will or durable power of attorney for health care? _____
If not, let us know and we will provider this for you. If you have one, please bring a copy with you.

ALLERGIES AND REACTIONS: (Please describe reactions)
Medication Allergies _____
Food or Environmental Allergies _____

IMMUNIZATIONS: PLEASE BRING A COPY OF SHOT RECORDS.
Last Tetanus? _____ (year) Last Pneumococcal (pneumonia) Shot? _____
Last Flu Shot? _____ TB skin test? Year_____ Positive____Negative___

WOMEN'S HEALTH

Number of Pregnancies_____ Any Abnormal pap smears?_____Date?_____
Number of children born_____ Have you had a hysterectomy?_____
Last menstrual period, date_____ Was it Vaginal hysterectomy?_____
Method of birth control?_____ Abdominal hysterectomy?_____
Age of menopause_____ Was it a total hysterectomy?_____ Or Partial (uterus only)_____
Hormone therapy?_____ Date of last mammogram_____
Date of last Pap smear, pelvic exam_____ Date of last bone densty test_____

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Symptoms (Circle 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, or 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
Poor circulation
Rapid heart rate
Swelling of ankles

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

Eyes, Ears, 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

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: _____
_____

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MEDICATION

Please list any Medications you are taking INCULDING over-the-counter medicines.

	Medications	Dosage/Strength	Directions
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

FAMILY HISTORY (Please list any diseases)	**Healthy?**	**Deceased?**	**Age**
Mother's History: _____	Yes / No	Yes / No	_____
Father's History: _____	Yes / No	Yes / No	_____
Grandmother (Mother's side): _____	Yes / No	Yes / No	_____
Grandfather (Mother's side): _____	Yes / No	Yes / No	_____
Grandmother (Father's side): _____	Yes / No	Yes / No	_____
Grandfather (Father's side): _____	Yes / No	Yes / No	_____
Brothers: _____	Yes / No	Yes / No	_____
Sisters: _____	Yes / No	Yes / No	_____
Family members in general: _____	Yes / No	Yes / No	**N/A**

PAST SURGICAL HISTORY (Please list all past surgeries, including COLONOSCOPY)

	Surgery	Date
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

State of Franklin HEALTHCARE ASSOCIATES™

Your Health, Our Focus

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: _____