Family Physicians of Johnson City 303 Med Tech Parkway, Suite 100 Johnson City, TN 37604

Patient Registration Form

Last Name	First Name	Middle Initial	Sex: M F	Date of Birth
Address		City	State	Zip Code
Social Security Number	Home Phone	Cell Phone		rital Status: rried, Single, Divorced, Widowed
			IVIa	med, Single, Divorced, Widowed
Employer Name		Employer Pho	one	
Employer Address				
_				,
SURGICAL PROCEDUR	RES: Please list all previo	ous surgical procedure	es (approximate date	es).
<u>Year</u> <u>S</u>	urgical Procedure & physic	ian providing care		Location of Hospital
ALLERGIES : Are you	allergic to: ☐ Pain pills			
	□ Otner			
MEDICATIONS : Pleas	e list medications taken	within the last six mon	iths:	
PAST MEDICAL HISTO	RY: Have you had any o	of the following condition	ons or illnesses?	
□ Asthma				
□ Diabetes				
□ Stroke				
☐ Heart Diseas	<u> </u>			
☐ Lung Disease				
☐ Liver Disease				
☐ High Blood P☐ Cancer	ICOOUIC			
	ndico			
☐ Hepatitis/Jau☐ Bleeding Disc				
☐ Other	71401			

Medicare "B" Signature Authorization

I authorize any holder of medical or other information about me to release to Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carriers, or to the billing agent of this physician or supplier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

i understand this is a lifetime signature authorization.				
Signature	Date			
	Authorization			
however, you are responsible to your visit. If we are unable to a place your account with a colled I have fully read and u paid to the physicians. I also a company as needed to issue the for my diagnosis and treatments.	responsible for charges incurred. It is a courtesy of our office to file your insurance; our co-pay and/or percentage, which the insurance company is not liable, on the day of a payment within a reasonable amount of time from the patient and/or guarantor, we will agency, which will leave you liable for additional expenses incurred if applicable. It is above state of payment policy. I hereby request any benefits on my behalf be trize the release of any information acquired in the course of my treatment to my insurance its. I authorize the physicians to administer such treatment as they may deem advisable tertify that I have been made aware of the role and services offered by the physician, citioner, and I consent to care by such providers. I understand these services are or refuse these services.			
Signature	Date			
Witness	Date			
services furnished me by that	edigap (Medicare Supplement) benefits be made on my behalf to the provider for any der. I authorize any holder of medical information about me to release any information ayable for related services to Medigap insurer.			
Signature	 Date			

State of Franklin Healthcare Associates, PLLC Family Physicians of Johnson City

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, co-insurance or co-pay 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 high deductible health plan that have not met their annual deductible amount on the date of service will be asked to pay SoFHA's estimate of the allowed charges at the time of service. 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:

Patient or Guardian Signature

- 1. Your insurance is a contract between you and your insurance company. We are not a party to that contract. You are responsible to know your insurance benefits and the portion for which you are liable.
- 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 contracts. 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 the 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

Date



Christina R. Hutchins, MD M. Dean McLaughlin, MD Andrew L. Becker, DO Barnabas Hines, DO Kathleen Jenkins, FNP-BC Pamela Trantham, FNP-BC

FAMILY PHYSICIANS

of Johnson City

Acknowledgment 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 discussed 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):

Phone:
Phone:
Phone:
Phone:
ntioned statements.
Detail
Date
Pull-land
Birthday
Date

303 Med Tech Parkway, Suite 100 Johnson City, TN 37604 (423) 282-5611



FAMILY PHYSICIANS of Johnson City

Authorization to Release Medical Records/Information

Christina R. Hutchins, MD M. Dean McLaughlin, MD Andrew L. Becker, DO Barnabas Hines, DO Kathleen Jenkins, FNP-BC Pamela Trantham, FNP-BC

Patient Name	ə:	
DOB:		
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Physician to	provide records:_	
	Address:	
	Telephone:	Fax:
	тоюрноно	
Physician to	receive records:	
		Family Physicians of Johnson City
		303 Med Tech Parkway, Suite 100
		Johnson City, TN 37604 Telephone: 423-282-5611
		Fax: 423-282-5712
If you do not initial the box specified about I authorize the individual nare Substa	want certain portion tes for information you ove. te health care provid med on this request ance abuse (if any) pological/psychiatric o	s of your medical records released, please read this section carefully and u do not want released. Otherwise, your records will be released as er to release the information specified to the organization, agency or with the exception of: AIDS/HIV (if any)
taken in relia expire 12 mo effectiveness	nce on this authoriza inths after the date a as an original. This	by be revoked in writing at any time, except to the extent action has been tion. Unless otherwise revoked, this authorization will automatically ffixed below. A copy of this authorization may be utilized with the same facility, its employees and physicians are hereby released from any isclosure of the above information to the extent indicated and authorized
Patient Signa	ature	Date
Patient Name	e (please print)	
Person Author	orized to sign for pat	ent Date

303 Med Tech Parkway, Suite 100 Johnson City, TN 37604 (423) 282-5611

Relationship to patient