

**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	Marital Status: Married, Single, Divorced, Widowed	
Employer Name		Employer Phone		
Employer Address				

**SURGICAL PROCEDURES:** Please list all previous surgical procedures (approximate dates).

<u>Year</u>	<u>Surgical Procedure &amp; physician providing care</u>	<u>Location of Hospital</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**ALLERGIES:** Are you allergic to:  Pain pills    Penicillin    Sulfa    Aspirin  
 Other \_\_\_\_\_

**MEDICATIONS:** Please list medications taken within the last six months:

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**PAST MEDICAL HISTORY:** Have you had any of the following conditions or illnesses?

- Asthma
- Diabetes
- Stroke
- Heart Disease
- Lung Disease
- Liver Disease
- High Blood Pressure
- Cancer
- Hepatitis/Jaundice
- Bleeding Disorder
- Other



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:

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

\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Date



# FAMILY PHYSICIANS of Johnson City

## Acknowledgment of Notice of Privacy Practices

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

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):

1. \_\_\_\_\_ Phone: \_\_\_\_\_
2. \_\_\_\_\_ Phone: \_\_\_\_\_
3. \_\_\_\_\_ Phone: \_\_\_\_\_
4. \_\_\_\_\_ Phone: \_\_\_\_\_

By signing below, I agree to the aforementioned statements.

\_\_\_\_\_  
Patient or Guardian Signature Date

\_\_\_\_\_  
Patient Name (please print) Birthday

\_\_\_\_\_  
(If Guardian, relationship to patient)

\_\_\_\_\_  
Practice Representative Date



# 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: \_\_\_\_\_

DOB: \_\_\_\_\_

Physician to provide records: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

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

Release these records:

Medical records maintained at your facility (i.e., office notes, diagnostic tests, labs, etc.)

If you do not want certain portions of your medical records released, please read this section carefully and initial the boxes for information you do not want released. Otherwise, your records will be released as specified above.

I authorize the health care provider to release the information specified to the organization, agency or individual named on this request with the exception of:

\_\_\_\_\_ Substance abuse (if any) \_\_\_\_\_ AIDS/HIV (if any)

\_\_\_\_\_ Psychological/psychiatric conditions (if any)

\_\_\_\_\_ Other (please specify) \_\_\_\_\_

I understand this authorization may be revoked in writing at any time, except to the extent action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will automatically expire 12 months after the date affixed below. A copy of this authorization may be utilized with the same effectiveness as an original. This facility, its employees and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Person Authorized to sign for patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to patient

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