Demographic Information

Name: ____ **DOB**: _____________ **Age**: _________

SSN: __________________ **Gender**: □ Male □ Female **Ethnicity**: □ Hispanic or Latino □ Non-Hispanic or Latino

Race: □ Black / African American □ Asian □White □ American Indian □ Native Hawaiian/ other Pacific Islander

□ Unknown □ Decline

Marital Status: □ Married □ Single □ Divorced □ Widowed

Home Address: ____

Home Phone: (______) _______________ **Cell**: (______) _______________ **Work**: (______) ________________

Email Address: ______________________

Emergency Contact (Name) ______________________(Relationship)______________ (Phone)________________

Primary Insurance: ___________________________ **Secondary Insurance** ____________________________

Relationship to Insured: □ Self □ Spouse □ Child □ Other ______________________________________

Insured's Name ______________________________ **Insured's SSN:** ________________**DOB** ____________

Care Team Information

Primary Physician: ________________________________ **Phone**: (______) ___________________________

Referring Physician: _______________________________ **Phone**: (______) ___________________________

Usual Pharmacy:_________________________________ **Phone**: (______) ___________________________

DME Supplier: __________________________________ **Phone**: (______) ___________________________

Authorization

I authorize Medical Specialists of Johnson City to release any medical information, including information related to Psychiatric care, drug and alcohol abuse and HIV/ AIDS confidential information necessary to process insurance claims or any medical information that is needed for utilization review or quality assurance activities. I authorize and request the above names insurance companies to pay directly to Medical Specialists of Johnson City and benefits due for their medical or surgical services rendered to me. I understand that I am responsible for payment of any and all charges incurred by me. This assignment will remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original.

____ ____________________________

(Signature of patient or responsible party) (Date)

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, disclosed, and how I may get access to this information. I have also been given the opportunity to take the 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 and billing issues, you can either leave a message or discuss my information with the following individual(s):

NAME	RELATIONSHIP

By signing below, I agree to the fore mentioned statement.

Patient/ Guardian: ____Date: _______________________

Practice Representative: ____ Date:_______________________

Automated Confirmation Notice

In order to better serve you, we have an automated appointment reminder system to provide you with the courtesy of a timely, efficient reminder of your next scheduled appointment.

You will receive a call two (2) days prior to your appointment to inform you of vital information, such as the name of your provider, the date, location, and time of your appointment. You will also be able to confirm or cancel by using your telephone keypad and pressing the following keys anytime during the message. We would greatly appreciate your response.

Press 1 to Confirm
Press 2 to repeat the message
Press 5 to cancel

If you are unavailable when the call is made and have voicemail or an answering machine, the system will leave you a brief message. If you receive this message or fail to press the correct key, please contact our office at 423-794-3040 to confirm or cancel your appointment.

Thank you.

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 MSJC'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 you will be liable for.

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 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/ Guardian Signature: ____Date: ____________

Current Medications

(Please list Name, Dose & How often you take)

*(Example: **Liptor 10mg, once a day**)*

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____
11. ____
12. ____
13. ____
14. ____
15. ____
16. ____
17. ____
18. ____
19. ____
20. ____

Past Medical Problems

(Please list problems and how long)

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____

Surgical History

(Please list Surgery and Year)

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____

Family Medical History

(Please list problem and relationship)

(Example: Diabetes- Mother)

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____

REVIEW OF SYSTEMS-Endocrinology

Name: **Date of Birth:** **Date:**

PLACE AN X IN ANY BOX NEXT TO A PROBLEM OR DISTURBANCE YOU HAVE HAD IN THE PAST YEAR

GENERAL

☐ Recent weight changes ☐ Appetite loss ☐ Persistent Fever
☐ Night sweats ☐ Weakness/Fatigue ☐ Medication Changes ☐ Chills

SKIN/HAIR/NAILS

☐ Skin Rash ☐ Dry Skin ☐ Nail changes
☐ Excessive Sweating ☐ Skin itching

HEENT

☐ Double vision ☐ Decreased Night Vision ☐ Visual Disturbances
☐ Decreased Hearing ☐ Snoring ☐ Sleep Apnea ☐ Persistent hoarseness ☐ Voice Changes

NECK

☐ Neck swelling

RESPIRATORY

☐ Frequent cough ☐ Shortness of breath

CARDIOVASCULAR

☐ Swelling of hands/feet ☐ Palpitations ☐ Chest Pain ☐ High Blood Pressure

GASTROINTESTINAL

☐ Abdominal pain ☐ Nausea ☐ Vomiting ☐ Chronic diarrhea ☐ Chronic constipation

FEMALE GENITOURINARY

☐ Painful urination ☐ Leakage of urine ☐ Blood in urine
☐ Period absent ☐ Heavy menstrual bleeding ☐ Hot Flashes ☐ Urination at night

NEUROLOGICAL

☐ Numbness ☐ Tingling ☐ Tremor ☐ Headaches
☐ Forgetful ☐ Seizures ☐ Dizziness

MUSCULOSKELETAL

☐ Joint pain ☐ Joint stiffness ☐ Muscle Pain ☐ Muscle weakness

ENDOCRINE

☐ Change in skin color ☐ Hair changes ☐ Excessive Thirst ☐ Excessive Urination
☐ Thyroid Problems ☐ Heat Intolerance ☐ Cold Sensitivity ☐ Diabetes

PSYCHIATRIC

☐ Depressed Mood ☐ Suicidal Ideation ☐ Change in Sleep pattern

MALE GENITOURINARY

☐ Painful urination ☐ Leakage of urine ☐ Blood in urine

☐ Difficulty with erection ☐ Urination at night

Name: ______________________ Chart# ______________________

Endocrinology Patient History Form

Please list any concerns you would like to discuss below

____

____

____

Social History

***Smoking**

Current ____ Former ____ No ____ (check one) How long ____ (if Current or Former) Packs/Day _______ (circle one)

Smokeless: Yes _____ No _____ Type _________ When Quit ______________________

***Alcohol**

Yes ____ No ____ (check one) How Often ____ How much ____ Type of Alcohol ______________

***Illegal Drugs**

Yes ____ No ____ (check one) How long _____ Type of Drug ______________________________

***Routine Exercise**

Yes _____ No _____ (check one) How many days a week _____ Type of Exercise ________________

***Special Diets**

Yes _____ No _____ (check one) Low Fat _____ Low Salt ______ Low Carb _____ Other _______ (please specify)

***Work Status**

Working _____ Retired _____ Disabled _____ Hours worked per week _____ Shift Worked __________

***Marital Status**

Married _____ Divorced _____ Single ______

***Biological Children:**

# of Children _____ Children's Health __________

***Living Situation**

Live Alone _____ Live with ____

Female History

Birth Control: Yes ____ No ____ **Type:** ________________ # of pregnancies ______ #Births ______

Pregnant: Yes ____ No ____ **How many weeks:** ___ **Last Mammogram:** ___ **Normal:** ___ **Abnormal:** ___ (check one)

Last Menstrual Period: ___________ **Last Pap smear:** _______ **Normal:** _______ **Abnormal:** ________ (Check one)

Any Problems: Irregular Periods ____ Painful Periods ____ Heavy Bleeding ____ Abnormal Bleeding ____ (check all that apply)

Other (please specify): ____

Allergies: ____

State of Franklin HEALTHCARE ASSOCIATES
Your Health, Our Focus

Notice of Nondiscrimination

State of Franklin Healthcare Associates complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. State of Franklin Healthcare Associates does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

State of Franklin Healthcare Associates:

- Provides free aids and services to patients with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please contact the Office Manager.

If you believe that State of Franklin Healthcare Associates has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Vicki Moody
2528 Wesley Street, Suite 2
Johnson City, TN 37601
P: 423.794.2440
F: 423-283.9730
vickimoody@sofha.net

or

Sandra Westelaken
2528 Wesley Street, Suite 1
Johnson City, TN 37601
P: 423.794.2435
F: 423.794.1842
sandrawestelaken@sofha.net

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Vicki Moody or Sandra Westelaken are available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Ave. SW
Room 509F HHH Building
Washington, DC 20201
1-800-368-1019; 1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html