FAMILY PHYSICIANS OF JOHNSON CITY

Welcome to Family Physicians of Johnson City. We appreciate the confidence you have placed in us and we intend to provide you and your family with the best in medical care. In an effort to avoid any misunderstandings and to better serve you, please read the information below. If you have any questions or problems, please feel free to ask any staff member for help. We thank you for your cooperation and understanding while we strive to provide the best in medical care and service.

APPOINTMENTS: We must work by appointments in order to be efficient. However, patients do not become ill on schedule and emergencies do occur. A sincere attempt is made to adhere to the appointment schedule. Patients who "walk-in" without an appointment time will not be seen before patients who have a scheduled appointment time. Also, it will be very helpful if you will follow these guidelines:

1) Please call well in advance to schedule physicals, immunizations and other preventive health care services. We are limited in the number of physicals we can schedule in one day.
2) Please do not ask for other family members to be seen if you did not schedule an appointment for them. If a situation arises where immediate examination or treatment is necessary, they will be worked in at the earliest possible time.
3) Appointments that are not canceled with a 24-hour notice are considered "no shows". Patients that have three "no show" appointments within a 6-month period will be considered for dismissal from the practice.
4) Your co-pay or deductible is due at the time of your visit. Please do not ask the office to bill you for this amount.
5) Always bring your insurance card, as we are required to copy this each visit.
6) Please remember to bring all your medications or a list of your medications with you at the time of your appointment with the doctor. Also, **all** medication refills need to be requested at the time of your visit. This will save time for both patient and doctor.

OFFICE HOURS: Regular office hours for patient visits are 8:00 a.m. to 4:00 p.m., Monday through Friday.

TELEPHONE CALLS:

1) If you need to make an appointment or if you have a question, please call 282-5611. When calling the office, please be certain to give the receptionist your name, your phone number, the name of your doctor and a brief description of your problem. If a message has been taken previously, let the receptionist know and this will avoid confusion.
2) If you are calling to request a referral, please call 282-5611 Ext 2006 and leave a message. Prior to calling for a referral, please check with your insurance first to make sure a referral is necessary. Then please allow 72 hours before calling the office again to check on this.
3) In the event your doctor has lab work performed, you should allow one to two weeks (depending on the type of lab performed) before calling the office for the results. However, please **do not call the lab** for these results, as they can only be given to you after the doctor has reviewed them.
4) We are experiencing heavy telephone volume during the hours of 8:00 AM to 9:00 AM and 12:00 PM to 1:00 PM. During these times, you may get a fast busy signal, which means our telephone system is on overload and, if possible, you should try your call again later.

ANSWERING SERVICE: All telephone calls after office hours will be answered by our answering service. The service always knows which doctor is on call and can reach the doctor immediately in case of an emergency. Please do not abuse after hours and weekend phone calls. After regular office hours, you may be referred to an Emergency Room. The physicians there will contact us with problems requiring our intervention or hospital admission.

ATTENTION

We are a **“scent free”** office for the comfort and protection of our employees and patients. We ask that you please not wear perfumes, colognes, scented lotions, body sprays, etc., when coming to the office. Your cooperation with this policy is appreciated.

Management
Family Physicians of Johnson City

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 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 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

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	Work/Business Phone		Marital Status: Married, Single, Divorced, Widowed
Employer Name		Employer Phone		
Employer Address				

Person Responsible for Payment

Last Name	First Name	Middle Initial	Relationship to Patient	
Address		City	State	Zip Code
Social Security Number	Home Phone	Work/Business Phone	Date of Birth	Sex M F
Employer	Employer Address		Employer Phone	

In Case of Emergency Contact

Name	Home Phone	Work/Business Phone	Cell Phone	Relationship

Insurance Information

PRIMARY INSURANCE	SECONDARY INSURANCE	Third Insurance
Insurance Name	Insurance Name	Insurance Name
Claims Address	Claims Address	Claims Address
Telephone	Telephone	Telephone
ID Number	ID Number	ID Number
Group Number Through Employer □ Yes □ No	Group Number Through Employer □ Yes □ No	Group Number Through Employer □ Yes □ No
Subscriber Sex	Subscriber Sex	Subscriber Sex
Subscriber SSN	Subscriber SSN	Subscriber SSN
Subscriber Date of Birth Effective Date	Subscriber Date of Birth Effective Date	Subscriber Date of Birth Effective Date
Patient's Relationship to Subscriber	Patient's Relationship to Subscriber	Patient's Relationship to Subscriber

Please present insurance cards so we may copy them for our files.

(Please complete both pages of this form and sign) **(1)**

Privacy Acknowledgement

1. May we call the telephone number you provided and leave a message on an answering machine or with a family member/friend regarding your appointment, test results, etc. ___yes ___ no. If no, is there another number at which we may try to reach you? _____.

2. May we mail information regarding your appointments, test results, etc., to your home address? ___ yes ___ no. If no, is there another address to which we may send information to you?

   _____

3. Do you wish for us to share health information regarding you with a family member or friend? ___ yes ___ no. If yes, please provide name of person/persons.

   _____

   _____

I have received a copy of the Physician's Practice "Notice of Privacy Practices for Protected Health Information."

_____ _____
Signature Date

Authorization

Patient and/or guarantor is responsible for charges incurred. It is a courtesy of our office to file your insurance; however, you are responsible for your co-pay and/or percentage, which the insurance company is not liable, on the day of your visit. If we are unable to obtain payment within a reasonable amount of time from the patient and/or guarantor, we will place your account with a collection agency, which will leave you liable for additional expenses incurred if applicable.

I have fully read and understand the above state of payment policy. I hereby request any benefits on my behalf be paid to the physicians. I also authorize the release of any information acquired in the course of my treatment to my insurance company as needed to issue benefits. I authorize the physicians to administer such treatment as they may deem advisable for my diagnosis and treatment. I certify that I have been made aware of the role and services offered by the physician, physician assistant and nurse practitioner, and I consent to care by such providers. I understand these services are voluntary and that I have the right to refuse these services.

_____ _____
Signature Date

_____ _____
Witness Date

I request payment of authorized Medigap (Medicare Supplement) benefits be made on my behalf to the provider for any services furnished me by that provider. I authorize any holder of medical information about me to release any information needed to determine the benefits payable for related services to Medigap insurer _____.

_____ _____
Signature Date

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

FAMILY PHYSICIANS OF JOHNSON CITY
303 MED TECH PARKWAY, SUITE 100
JOHNSON CITY, TN 37604
TELEPHONE (423) 282-5611 FAX (423) 282-5712

NAME: _____ **DATE OF BIRTH:** _____ **AGE:** _____

ADDRESS: _____ **MARITAL STATUS:** _____

_____ **OCCUPATION:** _____

TELEPHONE: _____

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

- ☐ Asthma
- ☐ Arthritis
- ☐ Diabetes
- ☐ Stroke
- ☐ Mumps
- ☐ Measles
- ☐ Malaria
- ☐ Gout
- ☐ Ulcers
- ☐ Polio
- ☐ Colitis
- ☐ Chickenpox
- ☐ Heart disease
- ☐ Head injury
- ☐ Lung disease
- ☐ Liver disease
- ☐ Eye problems
- ☐ Pneumonia
- ☐ Skin disease
- ☐ Tuberculosis
- ☐ Emphysema
- ☐ Gallstones
- ☐ Menstrual disorders
- ☐ Frequent sore throat
- ☐ High blood pressure
- ☐ Psychiatric disorder
- ☐ Thyroid disorder/goiter
- ☐ Rubella (German measles)
- ☐ Hepatitis/jaundice
- ☐ Depression/nerves
- ☐ Bleeding disorder
- ☐ Alcohol abuse
- ☐ Drug abuse
- ☐ Seizures
- ☐ Cancer
- ☐ Rheumatic fever
- ☐ Shingles
- ☐ Diverticulosis
- ☐ Spastic colon
- ☐ Mononucleosis
- ☐ Inherited diseases
- ☐ Kidney problems
- ☐ Positive TB test
- ☐ Sexually-transmitted disease

_____

_____

HOSPITAL ADMISSIONS: Please list all previous hospital admissions (approximate dates) and reason for admission.

Year	Reason for admission & physician providing care	Location of Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY HISTORY: Have your parents, brothers, sisters, children, grandparents had any of the following?

- ☐ Asthma
- ☐ Arthritis
- ☐ Diabetes
- ☐ Stroke
- ☐ Ulcers
- ☐ Gout
- ☐ Heart disease
- ☐ Lung disease
- ☐ Cancer
- ☐ Colon polyps
- ☐ Gallstones
- ☐ Seizures
- ☐ Kidney problems
- ☐ Psychiatric disorder
- ☐ High blood pressure
- ☐ Emphysema
- ☐ Depression/nerves
- ☐ High cholesterol
- ☐ Inherited diseases
- ☐ Bleeding disorder
- ☐ Alcohol abuse
- ☐ Drug abuse
- ☐ Vision/eye problems
- ☐ Thyroid disease/goiter

_____

_____

SOCIAL HISTORY: Please answer the following. Even though the questions may seem personal, the doctor will review them with you in detail.

Are you ___ married ___ single ___ divorced ___ widowed; how long _____
Do you have children ___ yes ___ no; how many _____
Do you attend church or synagogue? ___ yes ___ no; where _____
Military service? ___ yes ___ no; branch _____ years _____
How far did you go in school? _____
What is your profession/occupation?_____
How many people live in your home?_____
What is your sexual preference? _____
Does your spouse physically harm you? ___ yes ___ no
Have you had known exposure to hazardous materials? ___ yes ___ no; what _____ when _____
Do you wear seat belts? ___ yes ___ no
Do you drink more than 24 oz of caffeinated drinks daily? ___ yes ___ no
Do you use tobacco products? ___ yes ___ no; how much daily_____ how long _____
Do you use alcohol? ___ yes ___ no; what is your average intake per day/week _____
Do you use or have you ever used recreational drugs? ___ yes ___ no
Are you generally happy with your life? ___ yes ___ no
Do you have any particular problems to address during this visit? _____

_____

ALLERGIES: Are you allergic to: □ Pain pills □ Penicillin □ Sulfa □ Aspirin □ Fluid pills
□ Other _____

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

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

Do you have a Living Will? ___ yes ___ no
Do you have Durable Power of Attorney for medical purposes? ___ yes ___ no
Would you like to find out more about these? ___ yes ___ no

REVIEW OF SYSTEMS: Please indicate any regular or recurring problems with any of the following:

GENERAL
□ appetite
□ excessive thirst
□ weight loss/gain
□ too hot/too cold
□ fatigue/tired
□ sleep
□ swelling of glands
□ other

EYES
□ blurred vision
□ double vision
□ watery/itchy
□ glasses/contacts
□ loss of vision
□ seeing spots
□ pain
□ other

EARS
□ decreased hearing
□ noise/ringing
□ ear drainage
□ ear pain
□ hearing aid
□ bleeding
□ other

NOSE/THROAT
□ congestion
□ sore throat
□ nasal drainage
□ sinus pressure
□ hoarseness
□ change in voice
□ itching nose
□ other

REVIEW OF SYSTEMS (continued): Please indicate any regular or recurring problems with any of the following:

RESPIRATORY
- ☐ cough
- ☐ sputum/phlegm
- ☐ blood
- ☐ breathing with minor exertion
- ☐ breathing with lying down
- ☐ using more than one pillow
- ☐ shortness of breath certain seasons
- ☐ sensitivity to odors, perfumes, etc.
- ☐ other

CARDIAC
- ☐ chest pressure/choking
- ☐ chest pain
- ☐ pounding or irregular heart beats
- ☐ swelling in legs, feet, hands
- ☐ heart murmur
- ☐ other

GASTROINTESTINAL
- ☐ difficulty swallowing
- ☐ painful swallowing
- ☐ food lodging in chest
- ☐ indigestion/heartburn
- ☐ bloating
- ☐ feeling full too soon
- ☐ constipation
- ☐ diarrhea
- ☐ vomiting blood
- ☐ blood from rectum
- ☐ black/tarry bowel movements
- ☐ food intolerances
- ☐ hemorrhoids
- ☐ abdominal pain
- ☐ other

MUSCULOSKELETAL
- ☐ joint swelling
- ☐ stiff joints
- ☐ painful joints
- ☐ pain in bones
- ☐ pain at night
- ☐ pain in muscles
- ☐ difficulty getting up from chair
- ☐ back pain
- ☐ previous back injury
- ☐ deformity of spine or legs

NEUROLOGIC
- ☐ losing balance
- ☐ spinning room
- ☐ lightheadedness
- ☐ loss of function in body part
- ☐ change in feeling in body part
- ☐ change in speech
- ☐ change in writing
- ☐ tremor/shaking
- ☐ change in memory
- ☐ headaches

HEMATOPOIETIC
- ☐ easy bruising
- ☐ difficulty stopping minor bleeding
- ☐ bleeding from gums
- ☐ swelling in groin or armpit
- ☐ blood clots in arms or legs

PSYCHIATRIC
- ☐ crying
- ☐ nervousness
- ☐ feeling depressed
- ☐ hearing voices
- ☐ seeing visions
- ☐ considered suicide
- ☐ feeling hopeless
- ☐ feeling bad about yourself
- ☐ problems with family
- ☐ losing temper easily

GENITOURINARY
- ☐ painful urination
- ☐ unable to completely empty bladder
- ☐ unable to control bladder leaking
- ☐ blood in urine
- ☐ air in urine
- ☐ problems with sex

women only
- ☐ irregular periods
- ☐ spotting between periods
- ☐ pain, lumps, leaking in
- ☐ cramps with periods
- ☐ vaginal discharge
- ☐ rectal bleeding with period

Birth control type: _____

First day of last period:

_____

Date of last pap smear:

_____

Date of last mammogram:

_____

When your last TB skin test?_____
When was your last chest x-ray?_____
When did you have any other type x-ray? _____
When was your last EKG?_____
When was your last flu shot? _____
When was your last tetanus booster? _____
When was your last blood work? _____

AUTHORIZATION

I authorize the physicians to administer treatment as they may deem advisable for my diagnosis and treatment. I certify that I have been made aware of the role and services offered by the physician, physician assistant and nurse practitioner, and I consent to care by such providers. I understand that these services are voluntary and that I have the right to refuse these services.

_____
Please print name

_____ _____
Signature Date

Voluntary Questionnaire

Our electronic medical records system maintains certain demographic information used for a variety of purposes, including reference ranges for patient care and government reporting of statistical information. We ask all new patients to self-identify the information below and are asking our current patients to confirm it so we may verify our records. Completion of this form is voluntary and is not required. The use of information you provide will be consistent with patient care and privacy practices

Ethnicity Categories	**Select One**
Hispanic or Latino	
Non-Hispanic or Latino	
Race Categories	**Select One**
Black, African American	
Asian	
White	
American Indian, Alaska Native	
Native Hawaiian, Other Pacific Islander	
Two or More Races – please specify:	
Decline – Do Not Wish to Participate	

ETHNICITY

- **Hispanic or Latino** – A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

- **Not Hispanic or Latino** – A person not of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless or race.

RACE

- **Black or African American** – A person having origins in any of the black racial groups of Africa, including those who consider themselves to be “Haitian.”

- **Asian** – A person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian Subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.

- **White** – A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

- **American Indian or Alaska Native (not Hispanic or Latino)** – A person having origins in any of the original peoples of North and South America (including Central America) and who maintain tribal affiliation or community attachment.

- **Native Hawaiian or Other Pacific Islander (not Hispanic or Latino)** – A person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.

- **Two or More Races** – A person having origins in more than one of the above races.

_____ _____

Patient Signature or Guardian/Representative **Date**