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).

Year	Surgical Procedure & physician providing care	Location of Hospital
________	____	____________________
________	____	____________________
________	____	____________________
________	____	____________________

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

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

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

Office Guidelines

Appointments that are not canceled with a 24-hour notice are considered "no shows". Patients that have three (3) "no show" appointments within an 18-month period will be considered for dismissal from the practice.

If you are requesting a medication refill, please allow 72 hours for all refills and then call your pharmacy before calling the office. If you are completely out of medication, please call 282-5611 and leave a message for your doctor. Also, <u>no pain medications will be called in to the pharmacy; you must make an appointment to be seen by your physician prior to any refill on these type medications.</u>

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.

______________________________________ ___________________________________

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:

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

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

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):

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

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: ____

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

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