

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 State of Franklin Healthcare Associates 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 State of Franklin Healthcare Associates 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 423-794-5580 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: _____

Past Medical History- Problems you have been *diagnosed with*:

Check all that apply

- Cancer Type_____
- Migraine Headache
- Glaucoma
- Angina
- Atrial Fibrillation
- Cong. Heart Failure
- Heart Attack
- Heart Disease
- Hypertension
- Asthma
- COPD
- Gastrointestinal Reflux
- Hepatitis Type_____
- Kidney Disease
- Arthritis Type_____
- Disk Disorder neck
- Disk Disorder back
- Osteoporosis
- Scoliosis
- Spinal Stenosis
- Shingles
- Neuritis
- Epilepsy
- Stroke
- Anxiety
- Depression
- Diabetes Type_____
- Thyroid Deficiency
- Thyroid Excess
- Anemia
- Hemophilia
- HIV/AIDS
- Other_____

Surgeries and Hospitalizations

Have had problems with anesthesia (being numbed or put to sleep)? No Yes

If yes please list what type of problems _____

Have you ever had surgery before? No Yes

If yes please list all surgeries and dates they occurred:

Family History

Heart Disease Father Mother Brother Sister

Hypertension Father Mother Brother Sister

Arthritis Father Mother Brother Sister

Osteoporosis Father Mother Brother Sister

Dementia Father Mother Brother Sister

Epilepsy Father Mother Brother Sister

Stroke Father Mother Brother Sister

Alcoholism Father Mother Brother Sister

Depression Father Mother Brother Sister

Diabetes Father Mother Brother Sister

Bleeding problems Father Mother Brother Sister

Anemia Father Mother Brother Sister

HIV/AIDS Father Mother Brother Sister

Social History

What is your occupation? _____ Check here if you are retired

Marital Status: Single Married Divorced Separated Widowed

Tobacco Use: None Current packs per day _____ other type of tobacco

Have you smoked in the past? no yes _____ packs per day How long did you smoke? _____

Alcohol Use: None Socially Rarely Moderately Heavily

Drug Use: None Type/Frequency _____

Describe your home setting (living alone, with children, with parents, nursing home, other _____)