State of Franklin HEALTHCARE ASSOCIATES

Interventional
Pain Management

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)

State of Franklin HEALTHCARE ASSOCIATES™

Acknowledgement of Notice of Privacy Practices

May we call the telephone number you have provided and leave a message on an answering machine or with a family member/friend regarding your appointment or test results? ☐ Yes ☐ No

*If no, what other number *(i.e. cell phone, private work number)* may we try to reach you to leave a message?

_____ ☐ Cell phone ☐ Work ☐ Other: _____

May we mail your appointment or test results to your home address? ☐ Yes ☐ No

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Emergency Contact Number other than YOUR home phone number: *(Please note, you are giving permission for this emergency contact to receive your personal health information if necessary.)*

Name: _____ Phone Number: _____

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 disclosed 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 health information, i.e. lab results or billing issues, you can either leave or discuss the information with the following individual(s):

	Name	Relationship	Contact Number
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

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

_____ _____ _____
Print Patient Name Cell Date of Birth

_____ _____
Patient or Guardian Signature Date

_____ _____
Practice Representative Signature Date

ACCESS YOUR MEDICAL INFORMATION ONLINE, 24/7 ANYWHERE, ANYTIME!

☐ **YES! I would like to enjoy the benefit of accessing my personal health information, or that of my child, online through FollowMyHealth® Email Address:** _____

☐ **Teaching Physicians:** This practice may participate in training new physicians. If so, you may be seen by a physician who is a member of a James H. Quillen College of Medicine Facility. The teaching physicians who work in this office are responsible for teaching residents (postgraduate trainees). Not only will you be seen by your own physician, you may also be seen by one or more residents. We believe this adds to the depth and level of care the patient receives since patients are seen by one or more physicians and then discussed in detail. We are pleased with your willingness to participate in our teaching program. Your care will encompass a team approach to healthcare with involvement of your physician and residents. Please Initial: _____

State of Franklin HEALTHCARE ASSOCIATES™

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, 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 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, American Express and Care Credit. In an effort to simplify the payment process, we provide a convenient, highly secure Credit/Debit/HSA card and Bank ACH payment program. You will be asked to provide a card-on-file (card/ACH-based) assurance at the time of service. After the insurance claim has been filed (if applicable), we will send you an electronic bill of your final financial responsibility. Your card-on-file will be charged for your out-of-pocket responsibility after the notice period and an electronic receipt will be emailed to you.

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/guarantor.

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/guarantor.

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 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

Please list current Medications below:

Medication Name	Dosage

Please list **Medication** Allergies below.

Medication Name	Type of Reaction

Non-Medication Allergies

Are you allergic to any food? Specify_____ Type of reaction_____

Are you allergic to any non-medical things such as latex, tape, metal? ☐ No ☐ Yes

If yes, specify_____ Type of reaction_____

Are you allergic to contrast dye? ☐ No ☐ Yes Iodine/Betadine? ☐ No ☐ Yes

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_____)