Patient Acct #_____ Date: _____

Blue Ridge Family Medicine

Patient Registration Form

Name:_____
Last First Middle

Mailing Address:_____

City:_____ **State:**_____ **Zip Code:**_____ **Home Phone:**_____

Cell Phone:_____ **Sex: Male/Female** **E-Mail Address:**_____

Date of Birth:_____ **Marital Status:**_____ **Race:**_____ **Hispanic/Non-Hispanic**

Language:_____ **Social Security #:**_____ **Employer:**_____

Person Responsible for Payment (if different from person listed above)

Name:_____
Last First Middle

Relationship to patient:_____ **Home Phone:** _____ **Cell Phone:**_____

Mailing Address:_____

City:_____ **State:**_____ **Zip Code:**_____ **Employer:**_____

Social Security #:_____ **Date of Birth:**_____

Insurance Information

Name of Primary Insurance:_____ **Subscriber ID#:**_____

Policy Holder:_____ **Date of Birth:**_____ **Group #:**_____

Name of Secondary Insurance:_____ **Subscriber ID#:**_____

Policy Holder:_____ **Date of Birth:**_____ **Group #:**_____

Emergency Contact Information

Name:_____

Relationship to patient:_____ **Home Phone:**_____ **Cell Phone:**_____

_____ _____
Patient (or guardian) Signature Date

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

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

---

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: _____

Patient Acct #_____ Date: _____

State of Franklin HEALTHCARE ASSOCIATES

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 voluntary 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 of 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.**

_____ **Date:**_____

Patient Signature or Guardian/Representative

Patient Acct #_____ Date: _____

State of Franklin HEALTHCARE ASSOCIATES

Personal Health History

Name: _____ Sex: M/F Age: _____ D.O.B. _____

Advance Directives

Do you have a Living Will? Yes / No If not, please notify us and we will provide this to you.

Do you have a Durable Power of Attorney for Healthcare? Yes / No

*If so, please bring a copy with you.

Allergies

Please list any medication or contactant allergies (latex, adhesive tape, etc.) _____

_____

Hospitalizations and Surgeries

	Procedure	Date	Facility
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Immunizations

Pneumonia Date: _____ Flu Date: _____ Tetanus Date: _____

Women's Health

Number of Pregnancies: _____ Children Born: _____ Last Menstrual Period: _____

Age of Menopause: _____ Date of last PAP, Pelvic Exam: _____

Date of last Mammogram: _____ Do you perform regular self-breast exams? Yes/No

Social History

Occupation: _____

Marital Status: Married / Divorced / Widowed Spouse's Name: _____

Church/Religious Affiliation: _____

Tobacco Use: Smoker/Non-smoker Packs per day: _____ Smoked for how many years? _____

Smokeless Tobacco (snuff, chewing tobacco): Yes / No How many years? _____

Alcohol Use: How many drinks per day: _____ week: _____ Drinking for how many years? _____

Do you wear seat belts? Yes / No

Patient Acct #_____ Date: _____

State of Franklin
HEALTHCARE ASSOCIATES

How many days per week do you exercise? None ___ 3-4 times ___ Daily ___ Every other day ___

Family History

List all major illnesses, or cause of death experienced by your family members (blood relatives)

	DOB	Living	Deceased at age	Major illnesses or cause of death
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Sister (s)	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Brother (s)	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Daughter (s)	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Son (s)	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

Medical History

Please check if you have had any of the following:

__Diabetes	__Asthma	__Ear Disease	__Bladder Infections
__Thyroid Disease	__Bronchitis	__Sinus Problems	__Prostate Problems
__High Blood Pressure	__Seasonal Allergies	__Ulcers	__Urinary Problems
__Heart Attack	__Colitis, Bowel Disease	__Skin Problems	__Venereal Disease
__Angina (chest pain)	__Liver Disease, Hepatitis	__Chronic Headaches	__Alcoholism
__Heart Rhythm Problem	__Gallbladder Disease	__Seizures	__Depression
__Heart Murmur	__Anemia	__Stroke	__Drug Abuse
__Rheumatic Fever	__Easy Bleeding	__Paralysis	__Nervous Breakdown
__High Cholesterol	__Blood Clots	__Arthritis	__Suicide Attempt
__Lung Disease	__Cancer or Tumor	__Lupus	__Psychiatric Disorder
__Emphysema	__Eye Disease	__Bone Fractures	__Other
__Pneumonia	__Glaucoma	__Muscular Problems	_____
__Tuberculosis (TB)	__Cataracts	__Kidney Stones	_____

Patient Acct #_____ Date: _____

State of Franklin
HEALTHCARE ASSOCIATES

List of Other Providers Who Treat You

	Name	Specialty	Phone/Fax Numbers
1.			
2.			
3			
4.			
5.			

Medications

	Name	Dosage (mg)	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

Pharmacy Preference

_____

_____

Patient Acct #_____ Date: _____

State of Franklin HEALTHCARE ASSOCIATES

Physical Exam Questionnaire

Name:_____ Date:_____

Please check all that apply:

General:
__Feeling Well
__Weight Gain
__Weight Loss
__Fatigue
__Fever

Skin:
__Bruising
__Change in Wart/Mole
__Excessive Sweating
__Hair Loss
__New Lesions
__Rash

Hearing: Eyes, Ears, Nose & Throat:
__Double Vision
__Visual Loss
__Hearing Loss
__Ear Pain
__Ringing in the Ears
__Nose Bleed
__Seasonal Allergies
__Runny Nose
__Sinus Pain

Neck:
__Neck Pain
__Swollen Glands

Respiratory:
__Cough
__Chronic Cough
__Difficulty Breathing
__Wheezing
__Shortness of Breath

Breast (Females Only):
__Breast Mass
__Breast Pain
__Breast Tenderness
__Nipple Discharge

Cardiovascular:
__Chest Pain
__Fainting
__Blacking Out
__Palpitations
__Irregular Heart Beat
__Abnormal Blood Pressure
__Difficulty Breathing Laying Down
__Swelling of Extremities/Edema

Gastrointestinal:
__Abdominal Mass
__Abdominal Pain
__Black, Tarry Stool
__Bloody Stool
__Change in Bowel Habits
__Constipation
__Diarrhea
__Heartburn
__Nausea
__Vomiting

Female Genitourinary:
__Blood in Urine
__Change in Bladder Habits
__Incontinence
__Menstrual Irregularities
__Painful Intercourse
__Painful Urination
__Pelvic Pain
__Urgency
__Urinating at Night
__Vaginal Discharge

Male Genitourinary:
__Blood in Urine
__Change in Bladder Habits
__Impotence
__Testicular Mass
__Urinating at Night
__Need for Erection Meds.

Musculoskeletal:
__Leg Cramps
__Back Pain
__Joint Pain
__Joint Stiffness
__Muscle Pain
__Muscle Weakness

Neurological:
__Decreased Memory
__Difficulty Swallowing
__Headaches
__Numbness
__Tingling
__Seizures
__Tremor
__Dizziness

Psychiatric:
__Anxiety
__Depression
__Insomnia
__Panic Attacks
__Suicidal Thoughts

Endocrine:
__Appetite Changes
__Cold Intolerance
__Excessive Thirst
__Excessive Urination
__Thyroid Problems
__Heat Intolerance

Hematology:
__Abnormal Bleeding
__Anemia
__Blood Clots
__Easy Bruising
__Enlarged Lymph Nodes

Authorization for Use or Disclosure of Protected Health Information (Medical Records Release)

(Release/Request)

1. I hereby authorize **State of Franklin Healthcare Associates, PLLC** to [ ] the following information:

Patient Name: _____ **Date of Birth:** _____

Telephone: _____ **Last 4 of SSN: xxx-xx-**_____

2. **Person(s) or Entity Authorized to Receive the Disclosure. Name or specifically describe the persons/organizations (or the classes of persons and/or organizations), including us, (1) who you are authorizing to make use of the protected health information described below and who you are authorizing to disclose the protected health information described below, and (2) to whom you are authorizing the disclosure and subsequent use of the protected health information described below.**

TO:	FROM:
_____ Name of Healthcare Provider/ Other	_____ Name of Healthcare Provider/ Other
_____ Street Address	_____ Street Address
_____ City, State, Zip Code	_____ City, State, Zip Code
_____ _____ Phone Fax	_____ _____ Phone Fax

3. **Protected Health Information to be used or disclosed. Specifically and meaningfully describe the protected health information you are authorizing to be used and/or disclosed:**
   - ☐ My health information relating to the following treatment or condition: _____
   - ☐ My health records for the following date(s):_____
   - ☐ Most recent _____ years of record
   - ☐ Complete health record:
     - ☐ Include: ☐ Exclude: My health information related to psychiatric or psychological conditions or treatment, except psychotherapy notes; alcohol and drug abuse; sickle cell anemia; and acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV).
   - ☐ Immunization Record
   - ☐ Last Physical
   - ☐ Other information to be used or disclosed (describe information in detail):

4. **Purpose of use or disclosure:**
   - ☐ Treatment, Payment, or Healthcare Operations
   - ☐ Transfer of Care
   - ☐ Personal Use
   - ☐ Disclosure to Life Insurer for Coverage Purposes
   - ☐ Disclosure to Employer of results for pre-employment physical or lab tests
   - ☐ Other (describe each purpose of the requested use/disclosure in detail):

5. **If not previously revoked, this Authorization will expire within 1 year from the date listed or ☐ upon the happening of the following event:** _____.

Authorization for Use or Disclosure of Protected Health Information (Medical Records Release)

(Page 2 of 2)

Authorization and Signature: I authorize the release of my confidential protected health information, as described in my directions above. I have had the opportunity to read and consider the contents of this authorization. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. I further understand that refusing to sign this authorization will not affect my treatment, payment, enrollment, or eligibility for benefits. I understand that I may revoke this authorization in writing, except for any actions already taken based upon it. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is covered by federal or state laws that limit the use and/or disclosure of my confidential protected health information.

Signature of Patient or Personal Representative: _____ Date: _____

Relationship if Personal Representative: _____

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("***HIPAA***").

1. Tell your provider if you do not understand this authorization, and the provider will explain it to you.
2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to State of Franklin Healthcare Associates at the following address: Attn: Privacy Officer, 2528 Wesley Street, Suite 2, Johnson City, TN 37601. Unless otherwise revoked, this authorization will expire as indicated on page 1 or within one year from the time the form was signed.
3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, enrollment or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized your provider to disclose information about you to a third party. If you refuse to sign this authorization, and you have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice.
4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA. If the person or entity receiving this information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.
5. You may inspect or copy the protected health information to be used or disclosed under this authorization. You do not have the right of access to the following protected health information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act ("CLIA") prohibits access, or information held by certain research laboratories. In addition, our provider may deny access if the provider reasonably believes access could cause harm to you or another individual in some of these circumstances, an individual has a right to have the denial reviewed by a licensed health care professional designated by the covered entity who did not participate in the original decision to deny.
6. If this office initiated this authorization, you must receive a copy of the signed authorization.
7. ***Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes.*** HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. Except for limited circumstances set forth in HIPAA, in order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes.
8. You have a right to an accounting of the disclosures of your protected health information by the provider or its business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request. The provider is not required to provide an accounting for disclosures: (a) for treatment, payment, or health care operations; (b) to you or your personal representative; (c) for notification of or to persons involved in an individual's health care or payment for health care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to health oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.

Patient or Personal Representative MUST receive a copy of this form once completed.

State of Franklin HEALTHCARE ASSOCIATES