

We need a few things started to process your insurance for you and get you scheduled.

- 1. Please Print this PDF booklet and fill out <u>before</u> your appointment.
- 2. You can log on through the Portal and fill out a Questionnaire with medical history, or fill out a "bubble sheet" at the office.
- 3. Please bring your Insurance Card and a Photo ID to the visit.
- 4. Please <u>arrive 30 minutes early</u> for your appointment so we can process everything and take care of your insurance for you. We ask that you arrive early so you are ready for your appointment time and the providers can spend as much time with you as possible.
- 5. If you are coming for a Complete Physical, Wellness Exam, or if you need your glucose or cholesterol tested, please be fasting. This means no food or calories after midnight, but <u>DO drink plenty of water</u> and be well hydrated.



# **Patient Registration**

First Name	Last Name	MI Date of Birth
Address	City	State Zip
Home phone	Cell phone	Work phone
May we leave a message on you	r Home phone Cell phone	Work phone None
May we text you with appointme	ent reminders Yes No	
Best # to reach you	Confidential Email	
*Race American Indian As	ian Native Hawaiian African Ar	merican White Hispanic Other
* Ethnicity Hispanic Not H	ispanic Refuse to Answer *Pref	ferred Language
*Government requires this information to pr	otect patients against discrimination.	
Pharmacy of Choice	Location of Pharmacy	Phone
Gender M F	Marital Status S M W D	SSN
Employer Name	Full-time	Part-time Not Employed Student
Emergency Contact	Relationship	Phone
How did you hear about us?		
Person responsible for bill		Relationship
SSN	DOB Home #	Cell #
Address	City	State Zip
Primary Insurance	ID#	Group #
Policyholder	Relationship to patient	DOB
Address	City	State Zip
Home phone	Cell phone	Employer
Secondary Insurance	ID#	Group #
Policyholder	Relationship to patient	DOB
Address	City	State Zip
Home phone	Cell phone	Employer
mation including protected health in see Family Medicine, PLLC to obtain	nformation to insurance companies as nee records from other sources as may be neo	ennessee Family Medicine, PLLC (b) release of inforeded to file payment for services incurred, (c) Tennescessary in the diagnosis or treatment, and (d) undercranges related to services provided or incurred by
Signature (Responsible Party )		Date



## Release of Information

Patient Name	DOB _	
YES, I give my permission to Tennessee Family N information regarding my appointments, and m		
Name	Relationship	
Name	Relationship	
Name	Relationship	
NO, I do not give permission for Tennessee Familtreatment with anyone other than me.	ily Medicine to discuss	information regarding my medical care or
F	Privacy Practices	
I acknowledge receipt of TFM's Notice of Privacy Pra	actices.	
		D.1.
Patient Signature or Responsible Party		Date
Ten	nCare or Medicaid	
I understand that Tennessee Family Medicine, PLLC of attest I do not have <u>TennCare</u> or <u>Medicaid</u> . I also un close this information to Tennessee Family Medicine under either plan and do not disclose this information charged from the practice.	nderstand if at any time e, PLLC before my next	e I acquire one of these policies, I must dis- office visit. I understand if I have coverage
	No Show Policy	
We require 24 hour notice of cancellation for appoing given to other patients that need our services. You will billed for subsequent no shows. If you have multiple low you are stating you understand this policy and continue to the continue of the continu	will receive a courtesy e no shows, you can be	letter for your 1st no show. You will be dismissed from the practice. By signing be-
C	Consent to Treat	
I hereby authorize Tennessee Family Medicine, PLLC tion(s). The risks, benefits and alternatives will be exrefuse treatment. I hereby release Tennessee Family	xplained at the time of	service. I have the right to question and/or
Patient Signature or Responsible Party		



# **Financial Policy**

Patient Name	DOB
Thank you for choosing Tennessee Family Me	dicine, PLLC.
It is our policy that all fees including co-pays, service unless other payment arrangements h	deductibles and non-covered services are due and payable on the date of ave been made.
the patient from responsibility for charges for copy of your insurance card. If we do not have	n with your insurance company. The filing of insurance does NOT release services which have been provided. Please make sure we have a current to the correct insurance information on the date of service and your ment. It is your responsibility to verify if our office is in network with your
Accounts not paid within a reasonable period subject to placement with collection agencies	of time, and for which no special arrangements have been made, will be following due notice.
Having read and understood the above stater acknowledge you have read and understand	ments, I agree to the terms set forth: (Please initial next to each item to each statement.)
I understand my co-pay, deductible or need to reschedule my appointment.	non-covered service fee is due and payable at my appointment or I will
If my insurance does not pay, I underst	and I am responsible for those charges.
In the event that I do not pay in accord I agree to pay all costs of collection, including	ance with the above policy and my account is sent to a collection agency, attorney fees.
If my account is sent to collection, I und	derstand I will be dismissed from this practice.
	heduled appointment or give 24 hour cancellation notice, I will receive pointment, I understand I will receive a bill for the missed appointment. Int is grounds for dismissal from the practice.
performance of utilization review and quality tion activities. I accept responsibility for the runless other arrangements are made. I authoinformation to process insurance claims and t	y medical record in order to comply with applicable law, to facilitate the assurance activities and to facilitate third party accreditation / certificamedical charges incurred and agree to pay all bills at the time of service, orize physician and/or clinic to render medical treatment and to release to determine Medicare benefits. I also authorize my insurance claim and / rectly to Tennessee Family Medicine, PLLC. I further agree that a photowalid as an original.
Patient Signature or Responsible Party	Date
Printed Name	Relationship to Patient



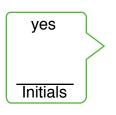
## Consent for Release of Prescription History

I authorize Tennessee Family Medicine to access my prescription history from outside sources to help keep my medical record as complete as possible. This includes many but not necessarily all medication used in the past.

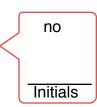
yes				no
	Name	Signature	Date	_
Initials				Initials

## **Notice of Advanced Directives**

I have formal advanced directives that dictate my preferences for medical management should I be incapacitated or unable to make decisions with good judgement.



I have durable power of attorney for my health care and will provide copies to the clinic. A **durable power of attorney (DPA)** for health care is another kind of advance directive. A DPA states whom you have chosen to make health care decisions for you. It becomes active any time you are unconscious or unable to make medical decisions. A DPA is generally more useful than a living will. But a DPA may not be a good choice if you don't have another person you trust to make these decisions for you.



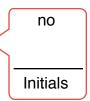
yes

I have a **living will** and will provide copies to the clinic. A living will is one type of advance directive. It is a written, legal document that describes the kind of medical treatments or life-sustaining treatments you would want if you were seriously or terminally ill. A living will doesn't let you select someone to make decisions for you.



yes

I have a **Do Not Resuscitate** order. A do not resuscitate (DNR) order is another kind of advance directive. A DNR is a request not to have cardiopulmonary resuscitation (CPR) if your heart stops or if you stop breathing. (Unless given other instructions, hospital staff will try to help all patients whose heart has stopped or who have stopped breathing.) You can use an advance directive form or tell your doctor that you don't want to be resuscitated. Forms available on our website.



Patient Name	DOB
Almost doneWe need this information to provide	e the best care:
Please list your <i>current medications</i> . We need the the medication:	e Name, Dose, How often taken and who started
To avoid dangerous interactions, please list any <i>supplements</i> , <i>vitamins</i> or <i>over the counter</i> products you use regularly:	List any <i>allergies</i> to medications or other:
Last Colonoscopy Doctor (Colon Cancer Screening)	that performed
Last Pap and Breast Exam	
Last Tetanus booster	
Last Pneumonia Vaccine	
Please list any Operations or Hospitalizations	
Anything else we need to know	



1047 Glenbrook Way Suite 120 Hendersonville, TN 37075 (615)590-2020 ph (615)590-2027 fx

Authorization to Relea	ase Patient Information		
Patient Name	Date of Birth		
Address Phone			
City	State Zip		
I authorize the use or disclosure of the above named individual	dual's health information as described belo	ow.	
Previous MD/Organization to <u>SEND</u> Medical Information:	MD/Organization to <u>RECEIVE</u> Medical Inform	nation:	
Name	Tennessee Family Medicine 1047 Glenbrook Way Ste 120		
Address			
City State Zip	Hendersonville, TN 37075 (615)590-2020 ph (615)590-2027 fx		
Phone Fax			
Information to be Released	Purpose for Disclosure		
Entire Record Lab/Pathology Reports	Changing MD/Continued Care		
Imaging Reports History & Physical	Disability Legal	l/Attorney	
Consultation Reports Other	Othe	r	
	Other		
Dates of Treatment (dates of treatment you need records for)			
From	То		
The information to be released should be detailed to specific dates, trea	tment, etc.		
I acknowledge, and hereby consent to such, that the released infand mental health issues (not including Psychotherapy notes).	ormation may contain substance abuse, HIV / /	AIDS information	
Revocation I understand that I may revoke this authorization at cine. However, the revocation will not have any effect on any use	,	essee Family Medi-	
Medicine may have made before the revocation was received.			
<u>Expiration</u> I understand that unless I revoke this authorization exmonths after the date this authorization is signed.	arlier, this authorization will automatically exp	re twelve (12)	
Redisclosure I understand that information used or disclosed in federal law, and could by redisclosed by the receiving party.	accordance with this authorization may no lon	ger be protected by	
Refusal to Sign   I understand authorizing the use or disclosure of ment.	information is voluntary. I do not have to sign	to ensure treat-	
I understand I get a copy after I sign it.			
Signature of Patient /Authorized Person	Relationship to Patient	 Date	
, , , , , , , , , , , , , , , , , , , ,	(if applicable)		
	Corp	11/21	

## **Notice of Privacy Practices**

Tennessee Family Medicine, PLLC 1047 Glenbrook Way Ste 120 Hendersonville, TN 37075 www.TennesseeFamilyMedicine.com Privacy Officer: Jill Millspaugh tnfamilymed@comcast.net (615)590-2020

## Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

## **Your Rights**

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

## Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 10 days of your request, as required by Tennessee state law. We may charge a reasonable, cost-based fee.

### Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

## **Request confidential communications**

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

#### Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

#### Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care
  operations, and certain other disclosures (such as any you asked us to make). We'll provide one
  accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one
  within 12 months.

#### Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

## Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

## File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting the Privacy Officer listed on the last page of this Notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

## **Your Choices**

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

• We may contact you for fundraising efforts, but you can tell us not to contact you again.

## **Our Uses and Disclosures**

## How do we typically use or share your health information?

We typically use or share your health information in the following ways.

#### Treat you

We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.

## Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

#### Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services

## How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

#### Do research

We can use or share your information for health research.

## Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

#### Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

#### Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

## Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

## Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

## **Our Responsibilities**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: <a href="https://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html">www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html</a>.

## **Changes to the Terms of this Notice**

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date: 11/1/2018 Privacy Officer: Jill Millspaugh 1047 Glenbrook Way Ste 120 Hendersonville ,TN 37075 (615)590-2020

tnfamilymed@comcast.net