New Patient Enrollment Form

Patient Demographics

Summit Primary Care

Chart # _____

PCP: _____ Date: _____ Staff: _____

Patient Information

Name_____ Sex: Male Female
First MI Last

Address_____ City_____State_____Zip_____

Social Security #_____ Date of Birth_____ Race _____

Email _____

Home Phone_____ Cell Phone_____

Ethnicity: Hispanic/Latino Non Hispanic/Non Latino Other/Undertermined

Language _____ Marital Status: Single Married Divorced Widowed

Place of Employment_____ Occupation_____

Responsible Party (If patient is under 18 Years of Age)

Name_____ Sex: Male Female
First MI Last

Relationship to patient_____ SS#_____ Date of Birth_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Place of Employment_____

Insurance Information (Located on your Insurance Card)

Insurance Company_____Identification#_____Group #_____

Address to file claims_____
City State Zip

Insurance Cardholder's Name_____
First MI Last

Insurance Cardholder's SS#_____ Date of Birth_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Prescription Coverage Plan (Located on your Pharmacy Benefits Card)

Rx BIN# _____ PCN Code _____

Rx IC# _____ Rx Group _____

Emergency Notification (In the event of Hospitalization)

Name_____Relationship to patient_____
First MI Last

Home Phone_____ Work Phone_____ Cell Phone_____

Patient Medical Data

Patient Name : _____ Dr : _____ **Chart #** _____

DOB : _____ Staff : _____

Medical History- Respond to each category below as needed

Today's problems _____

Chronic Medical Conditions _____

Surgery and approx. dates

1 _____ 3 _____

2 _____ 4 _____

Current Medications

1 _____ 5 _____

2 _____ 6 _____

3 _____ 7 _____

4 _____ 8 _____

Allergies to Medications _____ **Other Allergies** _____

History of Symptoms- Circle all that apply

Y / N	Shortness of Breath	Y / N	Fatigue	Y / N	Abdominal Pain	Y / N	Back Pain	Y / N	Constipation
Y / N	Chest Pain	Y / N	Fever	Y / N	Loss of Appetite	Y / N	Joint Pain/Swelling	Y / N	Diarrhea
Y / N	Palpitations	Y / N	Sore Throat	Y / N	Weight Changes	Y / N	Heat or Cold Intolerance	Y / N	Bloody Stool
Y / N	Rashes	Y / N	Change in Hearing	Y / N	Heartburn	Y / N	Headache	Y / N	Blood in Urine
Y / N	Changing Moles	Y / N	Cough	Y / N	Nausea & Vomiting	Y / N	Nervousness	Y / N	Frequent Urination
Y / N	Numbness or Weakness	Y / N	Depression	Y / N	Nasal Congestion	Y / N	Difficulty Sleeping	Y / N	Memory Loss

Family History

Please indicate which Family Member along with history _____ _____

Women Only

Date of last PAP: _____ Date of last mammogram: _____

Where was test performed? _____ Where was test performed? _____

Date of last menstrual period: _____ Date of menopause onset: _____

Pregnancy History _____ _____

Adult Vaccination Information (Children under 18 must bring immunization records)

Last Tetanus vaccine date: _____ Last Pneumonia vaccine date: _____ Last Flu vaccine date: _____

Other Medical Care data

Pharmacy Information **Pharmacy Name:** _____ **Pharmacy Location:** _____

Specialists you are currently seeing _____

Patient Certification- My signature below shows that I attest to the accuracy of the information above.

Guardian/Patient Signature: _____ **Date:** _____

Release Of Medical Information

Chart #: _____

Staff: _____

NAME *(Please print)*:_____ DOB: _____

By Signing Below, I Authorize Summit Primary Care To Release My Medical And Billing Information To:

RELATIONSHIP			NAME OF DESIGNATED PERSON AND PHONE NUMBER
SPOUSE	YES	NO	_____
CHILDREN	YES	NO	_____
IN-LAWS	YES	NO	_____
CAREGIVERS	YES	NO	_____
PARENTS	YES	NO	_____

OTHERS _____

PATIENT SIGNATURE_____ **DATE** _____

Pharmacy Acknowledgement:

In order to maintain an Accurate and Up to Date Medical Record we request Permission to query outside resources to obtain a list of your Current Medications. By giving this permission the nurses will be able to view an external Rx History to get a list of the Patient's Medications.

PATIENT SIGNATURE_____ **DATE** _____

Patient Portal Acknowledgement:

Our patient portal allows secure two-way communications between you and Summit Primary Care that meets all government security requirements for sending Protected Health Information (PHI) between patients and their providers.
ONLY ONE EMAIL ADDRESS PER PORTAL ACCOUNT IS ALLOWED.

***** PLEASE NOTE: IF YOU HAVE AN EXISTING PORTAL ACCOUNT BUT DO NOT PROVIDE YOUR EMAIL BELOW, THEN WE WILL ASSUME YOU NO LONGER WANT A PORTAL ACCOUNT AND WILL DEACTIVATE IT.**

Please provide your personal (home) email address:

Email address:_____ **@**_____

If patient is a minor, please indicate to whom the above email belongs:

Relation to patient: _____

I give permission to leave voicemail containing PHI on my cell phone. YES NO

I am aware I will receive appointment reminders via text messages. YES NO

I authorize the following to pick up prescriptions, X-rays, etc.

RELATIONSHIP			
SPOUSE	YES	NO	_____
RELATIVE	YES	NO	_____
CAREGIVER	YES	NO	_____

PATIENT SIGNATURE_____ **DATE** _____

I understand that Summit Primary Care will ask for identification of the person picking up patient medical information or products.

Patient Financial Policy

Chart #: _____

Patient: _____ **Staff:** _____

This is an agreement between Summit Primary Care dba AdvancedHEALTH, as creditor, and the Patient/Debtor named on this form and indicated by patient/debtor signature below.
In this agreement the words "you", "your" and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us" and "our" refer to Summit Primary Care dba AdvancedHEALTH. By executing this agreement, you are agreeing to pay for all services that are rendered.
Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect. A copy of your signed financial agreement will be provided to you.

HEALTH INSURANCE - It is YOUR responsibility to:

- Ensure we have been provided with the most current insurance information relative to filing your claim including insurance card, ID number, employer, birth date and patient address. This information will be located on our patient registration form.
- Ensure we are contracted with your insurance carrier to receive maximum benefits.
- Pay your co-payment or patient portion at the time of service.
- Inform us of any insurance changes made after this signed agreement/date of service. Insurance carriers have specific timely filing guidelines and pre-authorization requirements for certain services. If revised insurance information is not provided to us within your insurances' timely filing limits, you will be required to pay for services in full. If prior authorization was required for services already received and your claim is denied for lack of authorization, you will be required to pay for services in full.
- Contact your insurance company if no correspondence is received by you within 45 days of the date of service.

It is OUR responsibility to:

- Submit a claim to your health insurance carrier based on the information provided by the patient/debtor at the time of service or as updated information is provided.
- Provide your health insurance carrier with information necessary to determine benefits. This may include medical records and/or a copy of your insurance card.
- Provide MVA patients a courtesy health insurance claim form for their records upon request.

PAYMENT OPTIONS: Per our contracted agreement with your insurance carrier, we are required to collect your co-payment on the day of service. If you do not have insurance, you are required to pay for treatment at the time of service unless other arrangements have been formally made. A separate self-pay financial agreement will be provided to you. Our office collects all copays plus estimated coinsurance and deductibles at the time of service

We accept the following: Cash Check Credit Card *(Visa, MasterCard, Discover, American Express)* *A*

twenty-five dollar ($25.00) returned check fee will be assessed to the patient account per incident.

For convenience, payments may be made online at **www.ePayItOnline.com.** To utilize this service you will need your account number, access code, and Code ID. This information can be found on the patient statement you will receive reflecting your balance. ***Patients who no-show may be subject to a no-show fee.***

PENDING APPROVALS FOR SERVICES: In the event we are unable to obtain approval for services and you wish to proceed, we will not bill your insurance. Services will be reduced to the in-network insurance allowable amount and will apply to the patient's responsibility.

_____ Initials

Patient and/or Debtor Signature: Date:

WORKERS' COMPENSATION INJURIES: Written approval/authorization by your employer and/or workers' compensation carrier prior to your initial visit is needed. We will contact your case manager and/or supervisor to confirm your workers' compensation injury. If this claim is denied, for any reason by your employer or your employer's workers' compensation carrier, you will be responsible for payment in full. If denial is made by workers' compensation, health insurance can be filed for these denied services and you will be held responsible for the account.

BILLING INFORMATION

STATEMENTS:
A statement of account will be provided to you if insurance has paid leaving a patient portion, denied or no response is received. Due to the type of service we provide, you may receive billing from more than one practice, otherwise known as split billing. The balance on your statement is due and payable within 30 days of receipt unless other arrangements are made with our billing department. The statement will be sent to the address provided at the time of service. In the event your mailing address changes after your service date and your account has not been paid in full, you are required to notify our billing office of this change by calling 615-239-2018. In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child at time of service will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, court documentation is required for any guarantor address changes; otherwise, it is the authorizing/custodial parent's responsibility to collect from the other parent. Any account with a credit balance of less than <$5.00> will not be refunded without specific request from the patient/debtor.

DELINQUENT ACCOUNTS:
We review past due accounts frequently and at every statement cycle. Your communication and involvement to ensure your balance is paid timely is important to us. It is imperative that you maintain communications and fulfill your financial agreement and arrangements to keep your account active and in good standing.

If your account becomes sixty (60) days past due, further steps to collect this debt may be taken. If you fail to pay on time and we refer your account(s) to a third party for collection, a collection fee will be assessed and will be due at the time of the referral to the third party. The fee will be calculated at the maximum percentage permitted by applicable law, not to exceed 18%. In addition, we reserve the right to deny future non-emergency treatment for any and all debtor-related unpaid account balances.

CONSENT TO CONTACT:
I grant permission and consent to AdvancedHealth and its agents, assignees, and contractors (which may include third party debt collectors for past due obligations): (1) to contact me by phone at any number associated with me, if provided by me or another person on my behalf; (2) to leave messages for me and include in any such messages amounts owed to me; (3) to send me text messages or emails using any email address I provided or any phone number associated with me, if provided by me or another person on my behalf; and (4) to use prerecorded/artificial voice messages and /or an automated telephone dialing system (an auto dialer) as defined by the Telephone Consumer Protection Act in connection with any communications made to me as provided herein or any related scheduled services and my account. I understand that my refusal to provide the consumer described in this paragraph will not affect, directly or indirectly, my right to receive healthcare services.

WAIVER OF CONFIDENTIALITY:
You understand if your account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

MEDICAL RECORDS:
You will be required to request in writing or sign a medical authorization form for the release of your medical records to any organization or physician.

Patient and/or Debtor Signature: Date:

SUMMIT Primary Care
AdvancedHEALTH

3939 Central Pike
Hermitage, TN
37076
615-883-2331

ADVANCE BENEFICIARY NOTICE (ABN)

Patient Name: _____

Chart #: _____

Provider: _____

Please be advised:

Your Medical Insurance plan may determine that one or more of the medically necessary services you receive from your SPC Provider is not a Covered Service under your plan and refuse to pay us for it. Because there are so many different insurance plans, our office often does not know if a service will be denied for coverage/payment until we receive back a statement from your insurance. If your insurance denies payment on any such services we expect you to be responsible for payment of the allowable charges. At any visit you have the right to discuss with your Provider any particular service they order during your visit and refuse said service.

Signing below indicates you understand this notice and that you agree that you are responsible for payment of Services that your insurance denies as described above unless you indicated you refused the service to your Provider during your visit.
Note: you must request a copy of this form if you want a copy.

Signature:	**Date:**