Patient Registration

Chart: _____

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

DOB: _____ Sex: ☐ Female ☐ Male Social Security Number: _____

Marital Status: _____ Email: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

PHARMACY NAME & PHONE NUMBER: _____

PRIMARY CARE PHYSICIAN: _____ **REFERRING PHYSICIAN:** _____

PARENT OR GUARDIAN INFORMATION *(Only fill out if the patient is under the age of 18)*

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address: _____

City: _____ State: _____ Zip: _____

DOB: _____ Social Security Number: _____ Relationship to Patient: _____

Home Phone: _____ Cell Phone: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to Patient: _____

Home Phone: _____ Cell Phone: _____

EMPLOYER: _____

PRIMARY INSURANCE INFORMATION

Insurance Plan Name: _____ Subscriber ID: _____

POLICY HOLDER NAME *(if other than patient)*: _____

DOB: _____ Sex: ☐ Female ☐ Male Relationship to Patient: _____

SECONDARY INSURANCE INFORMATION

Insurance Plan Name: _____ Subscriber ID: _____

POLICY HOLDER NAME *(if other than patient)*: _____

DOB: _____ Sex: ☐ Female ☐ Male Relationship to Patient: _____

The information below is being collected pursuant to the requirements of the TN Department of Health in compliance with Tennessee state law.

RACE: ☐ White ☐ Black ☐ American Indian ☐ Eskimo or Aleut ☐ Asian or Pacific Islander ☐ Other Race ☐ Unknown Race

ETHNICITY: ☐ Hispanic Origin ☐ Not Hispanic Origin

Please check the appropriate box in answer to the following question. Have you executed an Advanced Health Care Directive, A Living Will or a Power of Attorney? ☐ Yes ☐ No

Do you want anyone to have access to your Protected Health Information (PHI)? ☐ Yes ☐ No

If yes, who: _____

Signature: _____ **Date:** _____

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.

Notice of Privacy Practices

Chart: _____

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.

The Health Insurance Portability and Accountability Act (HIPAA; "Act") of 1996, revised in 2013, requires us as your health care provider to maintain the privacy of your protected health information, to provide you with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We are required to maintain these records of your health care and to maintain confidentiality of these records.

The Act also allows us to use your information for treatment, payment, and certain health operations unless otherwise prohibited by law and without your authorization.

- **Treatment:** We may disclose your protected health information to you and to our staff or to other health care providers in order to get you the care you need. This includes information that may go to the pharmacy to get your prescription filled, to a diagnostic center to assist with your diagnosis, or to the hospital should you need to be admitted. If necessary to ensure that you get this care, we may also discuss the minimum necessary with friends or family members involved in your care unless you request otherwise.
- **Payment:** We may send information to you or to your health plan in order to receive payment for the service or item we delivered. We may discuss the minimum necessary with friends or family members involved in your payment unless you request otherwise.
- **Health operations:** We are allowed to use or disclose your protected health information to train new healthcare workers, to evaluate the healthcare delivered, to improve our business development, or for other internal needs.
- We are required to disclose information as required by law, such as public health regulations, health care oversight activities, certain lawsuits, and law enforcement.

Certain ways that your protected health information could be used disclosed require an authorization from you: disclosure of psychotherapy notes, use or disclosure of your information for marketing, disclosures or uses that constitute a sale of protected health information, and any uses or disclosures not described in this NPP. We cannot disclose your protected health information to your employer or to your school without your authorization unless required by law. You will receive a copy of your authorization and may revoke the authorization in writing. We will honor that revocation beginning the date we receive the written signed revocation.

You have several rights concerning your protected health information. When you wish to use one of these rights, please inform our office so that we may give you the correct form for documenting your request.

- You have the right to access your records and/or to receive a copy of your records, with the exception of psychotherapy notes. Your request must be in writing, and we must verify your identity before allowing the requested access. We are required to allow the access or provide the copy within 30 days of your request. We may provide the copy to you or to your designee in an electronic format acceptable to you or as a hard copy. We may charge you our cost for making and providing the copy. If your request is denied, you may request a review of this denial by a licensed healthcare provider.
- You have the right to request restrictions on how your protected health information is used for treatment, payment, and health operations. For example, you may request that a certain friend or family member not have access to this information. We are not required to agree to this request, but if we agree to your request, we are obligated to fulfill the request, except in an emergency where this restriction might interfere with your care. We may terminate these restrictions if necessary to fulfill treatment and payment.
- We are required to grant your request for restriction if the requested restriction applies only to information that would be submitted to a health plan for payment for a health care service or item for which you have paid in full out-of-pocket, and if the restriction is not otherwise forbidden by law. For example, we are required to submit information to federal health plans and managed care organizations even if you request a restriction. We must have your restriction documented prior to initiating the service. Some exceptions may apply, so ask for a form to request the restriction and to get additional information. We are not required to inform other covered entities of this request, but we are not allowed to use or disclose information that has been restricted to business associates that may disclose the information to the health plan.
- You have the right to request confidential communications. For example, you may prefer that we call your cell phone number rather than your home phone. These requests must be in writing, may be revoked in writing, and must give us an effective means of communication for us to comply. If the alternate means of communication incurs additional cost, that cost will be passed on to you.
- Your medical records are legal documents that provide crucial information regarding your care. You have the right to request an amendment to your medical records, but you must make this request in writing and understand that we are not required to grant this request.
- You have the right to an accounting of disclosures. This will tell you how we have used or disclosed your protected health information. We are required to inform you of a breach that may have affected your protected health information.
- You have the right to receive a copy of this notice, either electronic or paper or both.
- You have the right to opt out of fundraising communications.

If you have any questions about our privacy practices, please contact our Privacy Officer at the number below.

You have the right to file a complaint with us or with the Office for Civil Rights. We will not discriminate or retaliate in any way for this action. To file a complaint, please contact the applicable party:

Privacy Officer: Ryan D. Brown

Mailing Address: 3024 Business Park Circle, Goodlettsville, TN 37072

Email: Ryan.Brown@OurAdvancedHEALTH.com

Office for Civil Rights:
http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

We are required to abide by the policies stated in this Notice of Privacy Practices, which became effective on 10/01/09.

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my Protected Health Information (PHI). I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

Patient Name or Legal Guardian: _____

Signature: _____ Date: _____

PRACTICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date: _____ Initials: _____

Reason: _____

Patient Financial Policy

Chart: _____

This is an agreement between 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 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. 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. To utilize this service you will need your unique statement code. 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.

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.

MOTOR VEHICLE ACCIDENTS (MVA's) – Yes, I was involved in a MVA on _____. Unless prior agreement has been reached or I am a Medicare recipient, my **health insurance** will be filed for services related to this accident. In the event I do not provide insurance information upon initial visit, I understand insurance denials may occur depending on type of service(s) received or carrier specific filing requirements. I agree, as the patient or patient's guardian, I am ultimately responsible for all balance(s) due to this facility and/or its physician(s) for services rendered regardless of insurance denial(s) or unfavorable case outcomes. If I have chosen an attorney to oversee my case, this financial agreement will serve as a Letter of Protection to my attorney. I further understand my account may be handled by an outside entity that specializes in attorney lien accounts at the facilities discretion.

☐ Yes, I have chosen to retain an attorney. Signed: _____ Date: _____

Attorney Name: _____ Phone: _____

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 email at Billing@OurAdvancedHEALTH.com or call 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 a 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. 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 by me; (3) to send me text message 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 consent 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. Please note that you will be charged a $20 flat rate for 1-5 pages plus .50 per additional page and postage to cover the cost of the production of your medical records.

- If age 18 years and over, you should contain documentation of whether a medical advance directive has been executed for Medicaid/Medicare members. A copy should be on file within the office

- Please notify the office if you have a Living Will or Power of Attorney

Patient and/or Debtor Signature: _____ Date: _____