CLINTON FAMILY PHYSICIANS

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Patient name: _____ DOB: _____

From time to time it may be necessary for items to be left at the front desk for you to pick up (prescriptions, letters, insurance forms, etc.). Due to HIPAA privacy regulations, we may release these only to the patient themselves or someone the patient has designated to pick up items on their behalf.

Please check one of the following options:

☐ **Practice may NOT release items to anyone other than me.**

☐ **Practice may release items left for me to: _____.**

Please be aware that a Photo ID will be required from anyone picking up items at the front desk.

Patient Signature: _____

Date: _____

This authorization will remain in force until it is revoked in writing or a new authorization is completed in its place.

102 S. CHARLES SEIVERS BLVD. • CLINTON, TN 37716
TELEPHONE: (865) 457-4702 • FAX: (865) 457-7178

CLINTON FAMILY PHYSICIANS

Date: _____

PATIENT INFORMATION

Name (Last, First, Middle):	SSN#	Birthdate	Age	Sex

Mailing Address	City, State, Zip

Home Phone	Cell Phone	Email Address

Marital Status	Student Status	Smoker?	Veteran (Y/N)?	Ethnicity: Hispanic or	Primary Care Physician
	☐Full-Time ☐Part-Time	Yes or No		Non-Hispanic	

Referring Physician	Referring Physician Contact #	Other Medical Providers

Race (**Circle Answer**): African American, Alaskan Native, Asian, French, German, Greek, Hawaiian, Hispanic, Indian, Multi-Racial, Native American Indian, Pacific Islander, White	Language

Emergency Contact Name	Emergency Contact Phone #s
	Hm: Cell:

Employer Name and Address	Work Phone #

If patient is a minor, please fill out this portion

Parent or Guardian's Name:	Parent or Guardian's Phone #s
	Hm: Wk: Cell:

RESPONSIBLE PARTY INFORMATION

Name (Last, First Middle	SSN#	Birthdate	Sex

Address	City, State, Zip

Home Phone	Cell Phone	Work Phone	Relationship to patient

PRIMARY INSURANCE

Name of Insurance Company	Name of Insured	Address of Insured (if different than address above)	
Insured's Birthdate	Insured's SSN #	Insured's Insurance ID #	Relationship to patient

SECONDARY INSURANCE (if applicable)

Name of Insurance Company	Name of Insured	Address of Insured (if different than address above)	
Insured's Birthdate	Insured's SSN#	Insured's Insurance ID #	Relationship to patient

Workers Compensation

Are you here for workers compensation YES____NO____ Date:

Accident

Auto ☐ Work ☐ Other ☐ Date of Accident:

Do you have any Advanced Directives? (e.g., Living will or Advanced Care Plan) Yes_____ No_____

Do you have a Power of Attorney? Yes_____ No_____

If yes to the above questions please make sure we have a copy for your medical record.

Patient Name: _____

Date of Birth: _____

IN CONSIDERATION OF THIS PHYSICIAN PRACTICE (THE "PRACTICE") FURNISHING SERVICES TO THE PATIENT, PATIENT (OR PATIENT'S LEGALLY AUTHORIZED REPRESENTATIVE, ON PATIENT'S BEHALF) AGREES AS FOLLOWS:

I. CONSENT TO MEDICAL TREATMENT AND SERVICES: The below-signed individual hereby authorizes the Practice and its associated professionals to furnish medical treatment and services to the patient and consents to diagnostic and therapeutic medical care, items, services, and procedures furnished by the Practice, its professionals, and their assistants and designees. Such consent includes consent to photographic/video documentation of the patient's medical treatment as the patient's treating professional finds medically necessary. There are potential risks and hazards to any medical treatment or service, and there is no guarantee any particular treatment or service furnished by the Practice or its professionals will be successful. It is the Practice physician's responsibility to provide adequate information concerning a proposed treatment or service and to obtain any additional necessary consent before proceeding except as limited by emergency or other time-sensitive circumstances. The Practice's staff may obtain signature for such consent. The patient has the right to question and refuse treatment; however, if a proposed treatment is refused, the undersigned agrees CMG, the Practice, and their associated professionals and staff shall be released from any and all liability for failure to provide treatment to the patient.

II. CONSENT TO COMMUNICABLE DISEASE TESTING: The below-signed individual consents for the patient to be tested for hepatitis, human immunodeficiency virus infection, or any other blood-borne infectious disease, as well as for any other communicable disease or condition, if and when another patient, a health care practitioner, or other individual furnishing services to patient at the Practice, a Practice employee, or an emergency aid worker has a potential exposure from the patient. If such testing becomes necessary, it will be performed at no charge to the patient.

III. CALCULATION AND PAYMENT OF CHARGES: The patient is liable and individually obligated for payment of the Practice's charges on the patient's account and the undersigned individual understands and agrees to the following: (1) The Practice's charges are set out in a chargemaster, the relevant portions of which may be examined for purposes of verifying the patient's account during regular business hours in our billing office. The Practice reserves the right to change the rates in the chargemaster. Charges on the patient's account are calculated based on chargemaster rates in effect as of the date charges for items or services are accrued. (2) The patient is liable for the uninsured portion of the Practice bill, which is due in full when services are rendered. Any amount not paid in full by insurance, for any reason, is the responsibility of the patient. (3) The Practice has both an uninsured patient discount policy and an indigent care policy. If the patient is uninsured, the patient is automatically entitled to a discount on chargemaster rates in accordance with the Practice's uninsured patient discount policy. In addition, if the patient is uninsured and meets certain criteria set forth in the Practice's indigent care policy (including, without limitation, income criteria), the patient may be entitled to further discounts to chargemaster rates. Please contact the Practice's financial counselors in our office or the CMG billing office at 865-374-5200 for more information. (4) The amount of the patient's Practice charges may differ from amounts other patients are obligated to pay based upon each patient's insurance coverage, Medicare/Medicaid coverage, or lack of insurance coverage. The amount of any discount from charges varies based on the circumstances applicable to each individual under the Practice's policies. (5) After reasonable notice, delinquent accounts may be turned over to a collection agency and/or attorney for collection. The patient agrees to pay the costs of collection, including court costs, reasonable attorney fees, collections charges, and reasonable interest charges, associated with Practice's efforts to collect amounts due.

IV. MEDICARE/MEDICAID PATIENT CERTIFICATION AND ASSIGNMENT OF BENEFITS: The undersigned individual certifies that the information provided in applying for payment or reimbursement under Titles XVIII and XIX of the Social Security Act is true and correct. Further, the undersigned certifies that correct and complete information has been provided regarding the patient's insurance, HMO, health plan, workers' compensation, or other coverage for services and items furnished to the patient by the Practice, and the undersigned consents to the Practice's billing such payers for items and services furnished by the Practice to patient. The undersigned hereby irrevocably assigns to CMG (or, if Practice professionals are not CMG employees, to Practice) all rights, title, and interest in compensation or payments otherwise payable to the patient, or received by or on behalf of the patient, for Practice items or services from any source or payer on file for the patient's account, including Medicare/Medicaid/TennCare, insurance companies, HMOs, and any other third-party payer or financially responsible person, not to exceed charges for services or items rendered. Any person, corporation, or government entity having notice of this assignment is authorized and directed to pay directly to CMG (or, if Practice professionals are not CMG employees, to Practice) all amounts due for health care items and services provided to the patient by the Practice. Except as provided in Section III or by law, the patient is financially responsible to the Practice for the charges not covered by these authorizations. The undersigned understands there are certain items and services for which payers, including Medicare and TRICARE/CHAMPUS/CHAMPVA, do not pay. Any sums not paid by a third-party payer are the patient's obligation. **The patient is responsible for all health insurance or health plan deductibles and co-insurance, as well as noncovered or excluded items or services.** If it is later determined the patient has an HMO or other health plan primary to Medicare and failed to inform the Practice prior to service of such election, the patient shall be

Patient Name: _____

Date of Birth: _____

responsible for paying the account. In the case of series services furnished to the patient by Practice, this Agreement shall remain in full force and effect for all such series services until specifically revoked in writing. The undersigned agrees to sign such further documents as may be reasonably requested to confirm and substantiate the Practice's or CMG's rights hereunder. The undersigned further agrees that a copy of this assignment may be used in place of the original copy.

V. RECEIPT OF NOTICE OF PRIVACY PRACTICES; CONSENT TO USE AND DISCLOSE HEALTH INFORMATION: The undersigned acknowledges receipt of the Practice's Notice of Privacy Practices, which is incorporated into this Agreement by reference, and consents to use and disclosure of the patient's protected health information and other patient records (a) consistent with such Notice, including without limitation, for purposes of the treatment, payment, and health care operations functions described in such Notice, whether through electronic health information exchange or otherwise; and (b) as authorized or permitted by federal or state law. Consistent with the above, the undersigned agrees to the Practice's disclosure of all or part of the patient's medical record for treatment purposes and to any person, corporation, or agency that is or may be liable for charges incurred at the Practice or for determining the necessity, appropriateness, amount, or other matter related to such services or charges, including, without limitation, insurance companies, HMOs, PPOs, workers compensation carriers, welfare funds, governmental health plans, the Social Security Administration, the Centers for Medicare & Medicaid Services, or any contractors of the same. The undersigned also consents to release by the patient's health plan or other insurance carrier to the Practice and CMG of any eligibility, utilization, or plan data concerning the patient's coverage that may be required.

VI. PATIENT IDENTIFICATION; PERSONAL VALUABLES: The undersigned consents to photographic documentation of the patient for purposes of identification and registration. Further, the undersigned agrees that Practice is not responsible for loss of or damage to any money, jewelry, eyeglasses, clothing, hearing aids, or other personal property.

VII. HEALTH PLAN NOTIFICATION/AUTHORIZATION; APPOINTMENT: If the patient's health plan, insurer, or other coverage requires notification/authorization as a condition of payment for services, the patient must provide such notification and obtain such authorization. The patient hereby assumes full financial responsibility for charges incurred as a result of failure to comply with prior notification/authorization requirements. Notwithstanding the foregoing, the undersigned hereby appoints Practice as patient's agent for purposes of requesting prior authorization for services Practice professionals order at a Covenant Health hospital (e.g., lab services) and agrees Practice may delegate such appointment to such hospital. The undersigned acknowledges there is no guarantee or assurance authorization will be obtained.

VIII. AMENDMENTS: Revisions to this Agreement are not effective or enforceable unless accepted in writing by a CMG corporate officer.

IX. CONTACTING PATIENT. Patient may be contacted at the following number: _____. In addition, ***please check one of the following***:

☐ Practice may contact or leave messages regarding appointments and lab/test results with the following:

Name:_____Relation to patient:_____Phone:_____
Name:_____Relation to patient:_____Phone:_____

☐ Practice may not leave messages regarding appointments and lab/test results with anyone other than patient.

I HAVE READ AND UNDERSTAND THIS REGISTRATION AGREEMENT AND BY SIGNING BELOW, AGREE TO ITS TERMS. IF THE UNDERSIGNED IS NOT THE PATIENT, SUCH INDIVIDUAL HEREBY CERTIFIES THAT HE/SHE IS THE PATIENT'S AUTHORIZED REPRESENTATIVE AND HAS ALL NECESSARY LEGAL AUTHORITY TO ENTER INTO THIS AGREEMENT ON THE PATIENT'S BEHALF.

SIGNATURE: PATIENT (OR PATIENT'S LEGALLY AUTHORIZED REPRESENTATIVE)

SIGNED _____ PRINTED NAME _____

PATIENT NAME _____ RELATIONSHIP TO PATIENT _____

DATE _____ TIME _____ AM/PM

A copy of this agreement will be provided on request.

CLINTON FAMILY PHYSICIANS

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

Marital Status: ___Married ___Single ___Divorced ___Widowed ___Separated

Occupation: ___Unemployed ___Homemaker ___Office worker ___Factory worker ___Student

___Retired ___Disabled ___Teacher ___Other:_____

Living Will: ___ Has a living will ___Does not have a living will

Medications: Please list all medications

Medication:	Dosage:

Allergies: Please list any allergies

Allergen:	Reaction:

Immunizations: Date of Last

Tetanus/Lockjaw	
TB Skin Test	
Flu	
PneumoVax	
Other:_____	

CLINTON FAMILY PHYSICIANS

Past Medical /Surgical History

Past Medical History: Please circle conditions you have currently or have had in the past.

Allergies	COPD	Hepatitis / Liver Disease
Anemia	Coronary artery disease	Hypertension
Angina	Depression	Irritable bowel disease
Anxiety	Diabetes	Myocardial infarction
Arthritis	Elevated lipids	Osteoporosis
Asthma	Gallbladder disease	Renal disease
Atrial fibrilation	GERD	Seizure disorder
Blood clots	Headache, migraine	Stroke
Cancer (Type _____)	Heart disease	Thyroid disease
Cardiac arrhythmia	Heart valve disorder	Other (List below)

_____

_____

Past Surgical History: Please circle any surgeries you have had.

Angioplasty	Carpal tunnel release	Hysterectomy
Appendectomy	Cataract extraction	Knee replacement
Arthroscopy	Cholecystectomy	LASIK
Back surgery	Colectomy	Mastectomy
Bilateral tubal ligation	Colostomy	Myomectomy
Blood transfusion	D&C	ORIF
Breast augmentation	Gastric bypass	Thyroidectomy
CABG	Hernia repair	Tonsillectomy
Cardiac pacemaker	Hip replacement	Other (List below)

_____

_____

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Family History

Please indicate Mother (M), Father (F), Sister (S), Brother (B)

Family Member		Family Member		Family Member	
	ADD/ADHD		CVA (stroke)		Mental illness
	Alcoholism		Depression		Migraines
	Allergies		Developmental delay		Obesity
	Alzheimer's disease		Diabetes		Osteoarthritis
	Asthma		Eczema		Osteoporosis
	Blood disease		Hearing deficiency		PVD
	CAD		Hyperlipidemia		Renal Disease
	CAD-premature		Hypertension		Seizure disorder
	Cancer: Type_____		Irritable bowel Syndrome		Other:_____

Social History

Uses Tobacco: ___Current ___Former ___Never. If currently smoking, how many packs per day? _____ How many years?_____

Former smoker: What age did you start? _____ What age did you quit? _____ What year did you quit? _____

Alcohol: ___Yes ___No If yes, Type:_____ Amount:_____ Frequency:_____

Caffeine: ___Yes ___No If yes, Type:_____ Amount:_____ Frequency:_____

Exercise: ___Yes ___No If yes, Type:_____ Hours per week:_____

Hand dominance: ____ Right ____ Left ____ Ambidextrous