TENNESSEE FAMILY MEDICINE

John Millspaugh, MD
Tim O'Leary, PA-C
Mark Compton, PA-C

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 before 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 arrive 30 minutes early 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 DO drink plenty of water and be well hydrated.

TENNESSEE FAMILY MEDICINE

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 your Home phone Cell phone Work phone None

May we text you with appointment reminders Yes No

Best # to reach you _____ Confidential Email _____

*Race American Indian Asian Native Hawaiian African American White Hispanic Other

* Ethnicity Hispanic Not Hispanic Refuse to Answer *Preferred Language _____

*Government requires this information to protect 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 _____

I hereby authorize (a) payment of insurance benefits to be made directly to Tennessee Family Medicine, PLLC (b) release of information including protected health information to insurance companies as needed to file payment for services incurred, (c) Tennessee Family Medicine, PLLC to obtain records from other sources as may be necessary in the diagnosis or treatment, and (d) understand that I am financially responsible to Tennessee Family Medicine, PLLC for charges related to services provided or incurred by me or my dependents.

Signature (Responsible Party) _____ Date _____

TENNESSEE FAMILY MEDICINE

Release of Information

Patient Name _____ DOB _____

☐ YES, I give my permission to Tennessee Family Medicine to discuss my medical condition(s), my treatment, and information regarding my appointments, and my financial account with the following individuals:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

☐ NO, I do not give permission for Tennessee Family Medicine to discuss information regarding my medical care or treatment with anyone other than me.

Privacy Practices

I acknowledge receipt of TFM's Notice of Privacy Practices.

_____ _____

Patient Signature or Responsible Party Date

TennCare or Medicaid

I understand that Tennessee Family Medicine, PLLC does not accept **TennCare** or any **Medicaid** plans. In signing this, I attest I do not have **TennCare** or **Medicaid**. I also understand if at any time I acquire one of these policies, I must disclose this information to Tennessee Family Medicine, PLLC before my next office visit. I understand if I have coverage under either plan and do not disclose this information, my actions will be considered fraudulent and I will be discharged from the practice.

No Show Policy

We require 24 hour notice of cancellation for appointments. No show appointments are visits that could have been given to other patients that need our services. You will receive a courtesy letter for your 1st no show. You will be billed for subsequent no shows. If you have multiple no shows, you can be dismissed from the practice. By signing below you are stating you understand this policy and consent to financial liability for missed appointments.

Consent to Treat

I hereby authorize Tennessee Family Medicine, PLLC and any of its physicians and/or staff to treat my medical condition(s). The risks, benefits and alternatives will be explained at the time of service. I have the right to question and/or refuse treatment. I hereby release Tennessee Family Medicine, PLLC and its physicians and/or staff from any liability.

_____ _____

Patient Signature or Responsible Party Date

TENNESSEE
FAMILY MEDICINE

Financial Policy

Patient Name _____ DOB _____

Thank you for choosing Tennessee Family Medicine, PLLC.

It is our policy that all fees including co-pays, deductibles and non-covered services are due and payable on the date of service unless other payment arrangements have been made.

As a service to our patients, we will file a claim with your insurance company. The filing of insurance does NOT release the patient from responsibility for charges for services which have been provided. Please make sure we have a current copy of your insurance card. **If we do not have the correct insurance information on the date of service and your claim is denied, you are responsible for payment.** It is your responsibility to verify if our office is in network with your plan.

Accounts not paid within a reasonable period of time, and for which no special arrangements have been made, will be subject to placement with collection agencies following due notice.

Having read and understood the above statements, I agree to the terms set forth: ***(Please initial next to each item to acknowledge you have read and understand each statement.)***

_____ I understand my co-pay, deductible or non-covered service fee is due and payable at my appointment or I will need to reschedule my appointment.

_____ If my insurance does not pay, I understand I am responsible for those charges.

_____ In the event that I do not pay in accordance with the above policy and my account is sent to a collection agency, I agree to pay all costs of collection, including attorney fees.

_____ If my account is sent to collection, I understand I will be dismissed from this practice.

_____ I understand if I fail to show up for a scheduled appointment or give 24 hour cancellation notice, I will receive one courtesy notice. For a second no show appointment, I understand I will receive a bill for the missed appointment.
_____ I understand a third missed appointment is grounds for dismissal from the practice.

I authorize the release of information from my medical record in order to comply with applicable law, to facilitate the performance of utilization review and quality assurance activities and to facilitate third party accreditation / certification activities. I accept responsibility for the medical charges incurred and agree to pay all bills at the time of service, unless other arrangements are made. I authorize physician and/or clinic to render medical treatment and to release information to process insurance claims and to determine Medicare benefits. I also authorize my insurance claim and / or authorized Medicare benefits to be paid directly to Tennessee Family Medicine, PLLC. I further agree that a photocopy of this document is to be considered as valid as an original.

_____ _____

Patient Signature or Responsible Party Date

_____ _____

Printed Name Relationship to Patient

TENNESSEE FAMILY MEDICINE

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 _____ Initials

_____
Name Signature Date

no _____ 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.

yes _____ Initials

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.

no _____ Initials

yes _____ Initials

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.

no _____ Initials

yes _____ Initials

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.

no _____ Initials

Patient Name _____ DOB _____

Almost done...We need this information to provide the best care:

Please list your ***current medications***. We need the Name, Dose, How often taken and who started the medication:

_____

_____

_____

_____

_____

_____

To avoid dangerous interactions, please list any ***supplements***, ***vitamins*** or ***over the counter*** products you use regularly:

_____

_____

_____

_____

_____

_____

_____

_____

List any ***allergies*** to medications or other:

_____

_____

_____

_____

_____

_____

_____

_____

Last Colonoscopy _____ Doctor that performed _____
(Colon Cancer Screening)

Last Pap and Breast Exam _____

Last Tetanus booster _____

Last Pneumonia Vaccine _____

Please list any Operations or Hospitalizations _____

_____

_____

Anything else we need to know _____

_____

_____

_____

TENNESSEE FAMILY MEDICINE

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

Authorization to Release Patient Information

Patient Name _____ Date of Birth _____

Address _____ Phone _____

City _____ State _____ Zip _____

I authorize the use or disclosure of the above named individual's health information as described below.

Previous MD/Organization to SEND Medical Information:

Name _____

Address _____

City _____ State _____ Zip _____

Phone_____ Fax _____

MD/Organization to RECEIVE Medical Information:

Tennessee Family Medicine
1047 Glenbrook Way Ste 120
Hendersonville, TN 37075
(615)590-2020 ph (615)590-2027 fx

Information to be Released

___ Entire Record
___ Lab/Pathology Reports
___ Imaging Reports
___ History & Physical
___ Consultation Reports
___ Other _____

Purpose for Disclosure

___ Changing MD/Continued Care
___ Disability
___ Legal/Attorney
___ Insurance
___ Other
___ Other _____

Dates of Treatment (dates of treatment you need records for)

From _____ To _____

The information to be released should be detailed to specific dates, treatment, etc.

I acknowledge, and hereby consent to such, that the released information may contain substance abuse, HIV / AIDS information and mental health issues (not including Psychotherapy notes).

Revocation I understand that I may revoke this authorization at any time by sending a written notice to Tennessee Family Medicine. However, the revocation will not have any effect on any uses or disclosures Tennessee Family

Medicine may have made before the revocation was received.

Expiration I understand that unless I revoke this authorization earlier, this authorization will automatically expire twelve (12) months after the date this authorization is signed.

Redisclosure I understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could by redisclosed by the receiving party.

Refusal to Sign I understand authorizing the use or disclosure of information is voluntary. I do not have to sign to ensure treatment.

I understand I get a copy after I sign it.

_____ _____ _____

Signature of Patient /Authorized Person | Relationship to Patient (if applicable) | Date

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: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

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