Morristown Family Medicine
300 Boyd School Rd
Morristown, TN 37813

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

How did you learn about our office? Please circle one. Billboard Ad Direct Mail Hospital Referral
Insurance Newspaper Ad Patient Referral Physician Referral Previous Patient
Internet Self-Referral Yellow Pages Other:

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 (if different from above)

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.

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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

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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.

Morristown Family Medicine

Danielle Darter, M.D.

Mary Serbin, NP

Medications

Name:_____ DOB:_____

Pharmacy:_____

Allergies:_____

Medicine	Directions	Notes

APPOINTMENT CANCELLATION AND NO-SHOW POLICY

Last minute cancellation and same day no-shows make it difficult to serve other patients who are waiting to be scheduled. We ask that you give a twenty four (24) hour notice of cancellation or reschedule prior to your appointment if you will be unable to keep that appointment. We will be happy to reschedule your appointment. Scheduled appointments that you do not show up for, will result in a $25.00 fee. No show fees are the sole responsibility of the patient and will be billed to the patient.

Patient Printed Name: _____

Patient Signature: _____ Date: _____

Covenant HEALTH

ACCOUNT NUMBER:_____

PROVIDER AUTHORIZED TO RELEASE HEALTH INFORMATION (check all that apply):

❑Claiborne Medical Center ❑Cumberland Medical Center ❑Ft. Loudoun Medical Center ❑Ft Sanders Regional Medical Center
❑LeConte Medical Center ❑Methodist Medical Center ❑Morristown Hamblen Health System ❑Parkwest Medical Center
❑Peninsula Behavioral Health ❑Roane Medical Center ❑Thompson Cancer Survival Center ❑Covenant Home Care
❑ Other: _____
□ PENINSULA OUTPATIENT CLINICS: □ Blount □ Knoxville □ Loudoun □ Sevier □ IOP □ WIT

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name: _____

Date of Birth: ___/___/_____ **Date of Death,** if applicable: ___/___/_____ **Social Security Number:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

The information is to be disclosed to the following persons or organizations (Self or Authorized Receiving Party):

Name/Title: _____ Phone: _____ Fax: _____
Address: _____ City: _____ State: _____ Zip: _____

Purpose: ❑At the request of patient ❑ Legal Purposes ❑Other: _____

INFORMATION TO BE DISCLOSED includes dates of service from _____ to _____

❑ **Entire medical record**

OR

❑ Discharge Summary	❑ Progress Notes	**PENINSULA SPECIFIC:**
❑ History and Physical Exam	❑ EKG/s	❑ Assessment(s)
❑ Consultation Report/s	❑ Photographs, videotapes, or other image	❑ Treatment(s)/Therapies
❑ Operative Report	❑ HIV Test Results and Treatment	❑ Substance Use Disorder
❑ Pathology Report	❑ Mental or Behavioral Health	**OTHER:**
❑ Emergency Room Record	❑ Physical/Occupational/Speech Therapy	
❑ Lab Results	❑ Cardiac Rehabilitation	
❑ Radiology Report/s	❑ Implant Records	

I understand that this information may include, but is not limited to, information related to Acquired Immune Deficiency/HIV, psychiatric or psychological treatment, and treatment for drug and/or alcohol use.

EXPIRATION: I understand that unless I revoke the authorization earlier, this authorization will automatically expire on the later of the following: 1) One year after the date this authorization is signed **or** 2) On the occurrence of the following event: _____.

I understand I may revoke this authorization at any time by sending a written notice to each provider marked above. Revocation will not affect any uses or disclosures provider(s) may have made before receiving revocation. I understand information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be re-disclosed by the receiving party. I understand I may refuse to sign this authorization and that provider(s) will not condition treatment, enrollment, or eligibility for benefits on whether I sign this Authorization. I understand that there may be a reasonable copying fee, as permitted by applicable law.

SIGNATURE_____ **DATE**____/____/_____**TIME**_____

If signed by patient's legal representative please complete the following and attach appropriate documentation

Printed Name: _____ **Relationship:** _____

FOR PROVIDER USE ONLY

How was identity verified? _____ Copy made? ❑ Yes ❑ No
How was authority verified? _____ Copy made? ❑ Yes ❑ No
By: _____ Title: _____ Date: _____
❑ Picked up ❑ Mailed ❑ Faxed Date: ___/___/_____ Released by: _____

Patient Health Assessment Questionnaire

Date:_____

Name:_____ DOB:_____ Age:_____

Male:_____Female:_____ Status: Married: _____Single:____Divorced:_____Widowed:_____

Emergency Contact:_____Phone:_____

Current Occupation:_____

Specific Problems or concerns that you wish to discuss at this visit?_____

_____

YES	NO		
		Do you smoke?	_____# Packs/day _____Years
		Chew Tobacco/Snuff?	
		Use illicit drugs?	Treated for substance abuse? _____Yes_____No
		Drink alcohol?	_____# day _____# week
		Drink Caffeine?	# Cups per day_____
		Wear glasses?	Date of last Exam:
		Wear dentures?	Date of Last Exam:
		Do you wear seatbelts?	
		Do you regularly exercise?	Type of exercise: Days per week:

List Date you had:

Flu Vaccine_____

Pneumonia Vaccine_____

Tetanus_____

Name:_____

MEDICAL HISTORY: List any conditions you are currently or have been receiving treatment:

_____

_____

_____

SURGERIES: List all operations/date you have had:

_____ _____

_____ _____

_____ _____

FAMILY HISTORY

	Living?	Y	N	Age	Medical Problems
Mother					
Father					
Siblings					

FAMILY HISTORY OF:

YES	NO		YES	NO	
		Heart Attack			Lung Disease
		Heart Disease			Kidney Disease
		High Blood Pressure			Thyroid Disease
		Stroke			Seizures
		Cholesterol Problems			Bleeding Disorder
		Diabetes			Cancer

Name:_____

Please check if you have problems with the systems listed:

GENERAL:

Frequent Headaches_____ Weight Changes_____

Dizziness_____ Fainting Spells_____

HEAD/NECK:

Cataracts_____ Glaucoma_____ Visual Problems_____ Sinus Problems_____

Hearing Difficulties _____ Earaches_____ Mouth Problems _____ Swollen Glands _____

LUNGS:

Frequent Cough _____ Frequent Colds _____ Cough Up Blood _____

Asthma _____ Lung Disease _____ Tuberculosis (TB) _____

Shortness of Breath _____ Breathing Problems while Sleeping _____

HEART:

Chest Pain _____ Chest Pain with Exertion _____ Palpitations _____ Heart Murmur _____

Heart Attack _____ Heart Failure _____ Scarlet Fever _____ Rheumatic Fever _____

GASTROINTESTINAL:

Trouble Swallowing _____ Vomit Blood _____ Abdominal Pains _____

Diarrhea _____ Constipation _____ Blood in Stools _____ Black Tarry Stools _____

Change in Bowel Habit _____ Hemorrhoids _____ Ulcers _____ Jaundice _____

Hepatitis _____ Gallbladder Problems _____

URINARY

Frequent Urination _____ Loss of control of urine _____ Urinary urgency _____

Blood in urine _____ Kidney Stones _____ Chronic Infections _____ STD's _____

SKELETAL

Back Pain _____ Arthritis _____ Numbness/Tingling _____ Difficulty Walking _____

NEUROLOGICAL

Strokes _____ Seizures _____ Speech Problems _____ Depression/Anxiety _____

Psychiatric Treatment _____ Suicide Attempts _____

Reviewed By: _____ Date: _____

CONSENT TO EMAIL AND/OR TEXT MESSAGE COMMUNICATIONS

This physician practice (the "Practice") has the ability to send email and/or text messages to patients reminding them of upcoming appointments. The Practice also may send an email or text message after appointments with a link to a brief survey in order to allow the Practice to improve quality and service.

Consent to Email and/or Text Communications. By signing below, I authorize the Practice to contact me by email and/or text message for appointment reminders, survey requests, and other health-related communications using the cellular telephone number and/or email address I have provided on my patient intake forms.

Security Advisement. I understand that text messaging and email are not secure forms of communication and information contained in texts and emails sent to the telephone number or email address I have provided could be accessed or used by unauthorized third parties. I further understand that my wireless carrier may charge for text messages and that these messages may come from an automated dialing system. By signing below, I understand and agree not to include any sensitive or private information in any responses to surveys I receive, because such survey responses are not transmitted by secure means and could be intercepted by unauthorized third parties.

Opt Out. I understand that I may opt out of receiving text message and/or email communications at any time by contacting the Practice.

Signature: _____

Name: _____

Date: _____