North Clarksville Medical Center
351 Dover Road
Clarksville, Tennessee 37042
(Office): 931-552-4495
(Fax): 931-552-1944

FINANCIAL AND OFFICE POLICY / BASIC INSURANCE INFORMATION

There is no time limit on balance statements. Please pay when you receive your explanation of benefits. We have up to six years to collect on your balance from your last transaction. We feel that everyone benefits when there is a definite and clear understanding of our financial policy.

1. An Estimate of your total fee for treatment will be outlined in detail with you at the time of your visit.
2. Patients without insurance/balances after insurance has paid: for any visit under $200.00 all patients are expected to pay in full. For visits over $200.00 payment plans may be set up. There is a 10% interest for payment plans/balances not paid in full within 90 days upon receiving billing statement and/or signing payment plan. No interest is charged for bills paid within 90 days or less.
3. Patients with insurance: Our office will file your insurance if you provide us with the proper information. If you provide our office with incorrect insurance information, you will be expected to pay your bill in full as soon as you are notified your insurance was incorrect. We can re-file to a different insurance company. There is a $35.00 re-file fee for each claim that is returned to our office due to incorrect insurance information provided by you. Patients with insurance will not be seen without current insurance cards on file. We will not retro back. We provide informatoion for you to do so.
4. Secondary insurance: If you have Medicare primary, our office will file. As Medicare will automatically send your claim to any secondary insurance. We will file secondary insurance only if you provide our office the information at your first visit otherwise it will be your responsibility.
5. Broken appointments: There will be a broken appointment charge for any patients who cancel with less than 24 hours notice or who are not present at the appointment time. This charge is as follows:
    a. First missed appointment - We will give you one non-charge warning, thereafter all missed appointments will be $105.00
    b. Surgical procedures 20% of the total fee of the surgical procedure.
6. It is your responsibility to monitor your benefits and annual maximum: This includes being knowledgeable regarding if our office is in network or out of network with your insurance company. We will be happy to assist you with any resubmissions, but we cannot make telephone calls to your insurance company on your behalf.
7. Co-pays: All co-pays are due prior to services being rendered. Please pay the front desk staff at the time of signing in.
8. Deductibles: You are expected to pay 50% towards your deductible at time of your appointment. In the event of your insurance making an overpayment, we will refund you as soon as our office receives and post the payment information. You will receive refunds within 90 - 120 days of our office posting the payment from the explanation of benefit. Posting may take up to 6 months after receiving the explanation of benefits. Any overpayment $10.00 or less will be held in your account towards future claims. If you have outstanding claims any credit will be held in your account until payment and explanation of benefits has been received. If you are then due a refund you'll receive it within 90 days after our office has posted payment from the explanation of benefits.
9. If you're insurance does not respond within 90 days of our office filing your claim, you are responsible for the remaining balance. You will continue to receive statements until all insurances have paid and have been posted. If you know you do not owe or have made a payment that is not yet posted then just hold the statement until you receive one that has everything posted. It may take up to 90 - 120 days, but may take up to two years for all payments to be posted and statements to be sent. This is due to our small billing dept. We will gladly check on individual payments if this is put into writing. Please allow up to 30 days for this follow-up. Payment is due when you receive your explanation of benefit. State and federal law allow up to six (6) years for collecting the balance after your insurance has paid. If we bill you and you do not respond, the 6 year time period begins with the last billing date not necessarily the date of service. You are responsible for the balance within that 6 year time period regardless if you did or did not receive a billing statement. It is your responsibility to keep up with your balance.
10. Collections: Should it be necessary to send your bill to a collection agency you will be responsible for the entire collection fee and any legal fees related to the process of collection. This will be added to your total charges. We do not routinely send individuals to collections unless there is no other choice. Generally, it will take about 6 months after everything has posted. We will make every effort to work with you to avoid this process as it does not benefit either our clinic or you as the patient. Interest rate of 10% monthly will begin accruing after one unpaid billing cycle. You will be responsible for all collection and legal fees should it be necessary to send for collection and/or for legal action. We have a right to withhold nonurgent care and/or discharge for nonpayment on your account.
11. Bankruptcy: It is our policy that if you file bankruptcy, we will make you a self pay and you will need to pay up front. You will need to file your own insurance regardless of what insurance you may have. We will provide you all the necessary insurance information so that you may file. Per federal and state of Tennessee law we must stop any billing until the bankruptcy is finalized for only the balance prior to your filing bankruptcy. You are responsible for any balance after the date of filing. If your bankruptcy is denied then you will be billed for the previous pre-bankruptcy balance as per federal and state of Tennessee laws. It is your responsibility to make sure that we receive paperwork regarding any bankruptcy filing. Do not assume that the state has sent the necessary paperwork to our office. If once you file your insurance and they have reimbursed you and they state that you have made an overpayment to our office, we will refund what your insurance requires or apply it to your next office visit.

12. Check cashing/returned checks policy: We use a check service that will charge you a fee if your check has been returned. In addition to this fee we will charge you a $35.00 fee for our office to process this check to the check service. We use Tele Check Service. They require that we obtain the following information:
    a. Driver's License number
    b. Work and Home phone numbers
    c. Date of Birth

    Tele check will not allow our office to accept post dated checks. Your check will be electronically presented.
13. Copying medical records: We will provide medical records to any specialist our office refers you to. Due to the high cost of supplies and equipment that is used for copying medical records we find in necessary to charge for medical records for any other purpose. The rate is based on number of pages and current postal rates. Medical records request will take up to 10 business days to process. You will be notified of any difficulty locating your records. Federal and state law allow a modest fee for copying medical records $20.00 for first 40 pages and $0.25 cents for each page thereafter.
14. Waived charges: These are charges that most insurance will not cover or pay so little on that we cannot even cover our cost for the item. These are mostly supplies and medication charges but may include others such as routine visits. These are charges that you will be responsible for as we will not bill the insurance because we know up front that they will not pay or they will pay so little that we will not take the write off. You will be asked to sign a waiver at the time the services are provided.
15. Privacy policy: Please see our privacy form for more details. Complaints regarding privacy violations may be filed with the office administrator and/or office manager. Filing should be done in writing. Complaint forms are available at the front desk. If you feel that you have not received satisfaction from the administrator then you may file a complaint with the state office of Health and Human Services.
16. Security of information: Our office is secured with an alarm system. Medical files are in secured areas of the office. Computer information is guarded by a firewall. Limited web sites are allowed to be accessed by staff. Non-secure sites are not allowed to be accessed. Staff must sign a confidentiality statement and comply with HIPAA regulations.
17. Discharge: We reserve the right to discharge any individual for disruptive, vulgar behavior, misuse of controlled substances, and for nonpayment or violation of pain management contract without prior notice.
18. Video and audio equipment may be in use at front desk area, waiting areas, hallways, entry and exit areas. Video and audio surveillance will not be used in exam areas.
19. We cannot accept cash or money orders from patients receiving pain management. Per Tennessee State Regulations we can accept credit cards or checks for those services.
    For your convenience we accept cash, personal checks, money orders, Visa, MasterCard, American Express and Discover for all other services.

Please note by signing the authorization of treatment and assignment of benefits on the authorization form you are also agreeing to abide by the above financial agreement. A copy of this agreement is found on back of all billing statements and authorization forms.

Signature: _____ Date: _____

Witness Signature: _____ Date: _____

North Clarksville Medical Center

351 Dover Road
Clarksville, Tennessee 37042
(Office): 931-552-4495
(Fax): 931-552-1944

Dr. Ramon J. Aquino *Deborah L. Aquino, R.N. Administrator*

PATIENTS BILL OF RIGHTS

Your rights as a health care consumer

1. The patient has the right to considerate and respectful care, regardless of gender, race, sexual orientation, age, culture, disabilities, or religious beliefs.

2. The patient has the right to make informed choices about health products, health services and health care practitioners.

3. The patient has the right to receive complete and current information concerning his/her diagnosis and treatment from his/her provider in terms the patient can reasonably be expected to understand when the patient is unable to comprehend medical information or it is not medically advisable to give this information to the patient. The information will be made available to a person designated or authorized by the patient, on behalf of the patient.

4. The patient has the right to receive all of the necessary and pertinent information to make informed decisions/consent about health care treatment. The information should come from the patient's provider and should be provided in every case except in an emergency where delay could harm the patient. The patient should be told about alternatives to the proposed treatment and/or procedure and has the right to know who will be responsible for the treatment and/or procedure.

5. The patient has the right to a complete and thorough examination by the health care professional including appropriate assessment and effective pain management of pain and disease process.

6. The patient has the right to refuse treatment, as permitted by law, and to be informed of the medical consequences of that action.

7. The patient has the right to every consideration of privacy regarding the medical care provided.

8. The patient has the right to expect that all communications and records pertaining to health care will be treated as confidential. Patients will be afforded the opportunity to approve or refuse the release of records, except when required by law.

9. The patient has the right to expect that, within its capacity, North Clarksville Medical Center will make all reasonable efforts to provide requested services.

10. The patient has the right to know if North Clarksville Medical Center is engaging in research about health care and the right to refuse participation in such research.

11. The patient has the right to expect reasonable continuity of health care.

12. The patient has the right to examine and receive an explanation of costs of treatment.

13. The patient has the right to register complaints regarding health care or privacy violations with the provider and/or administrator. The patient also has the right to file a complaint with the office of Health and Human Services regarding any violations of privacy or confidential information violations. The patient has the right to complete the in office complaint form or if the patient feels that they have not received adequate satisfaction from the office administrative staff then they may call the Health and Human Services department to file a complaint. They may be required to file this complaint in writing. Complaints may be filed in the office of North Clarksville Medical Center and/or with the Health and Human Services department without fear of retaliation and/or reprisal.

14. The patient has the right to have an advanced directive such as a living will, health care proxy, or durable power of attorney for health care concerning treatment or designating a surrogate decision maker with the expectation that the provider will honor the intent of that directive to the extent permitted by the law. The patient should be asked if he/she has an advance directive and include that information in the patient's records. The patient has the right to revoke an advance directive at anytime.

15. The patient has the right to review the medical records pertaining to his/her medical care and have the information explained or interpreted as necessary, except when restricted by law. The chart review must be done within the office and written request is required in order to review the records. The original chart cannot be removed from the office of North Clarksville Medical Center.

Your responsibilities as a health care consumer

1. The patient has the responsibility to ask questions if he/she does not understand the explanation of the diagnosis, treatment, prognosis or any instructions.

2. The patient has the responsibility to follow instructions concerning medications, follow-up visits, education recommendations, and other essential steps in the treatment plan and to notify the health care provider if this plan cannot be followed or if problems develop.

3. The patient has the responsibility for treating the other patients, staff and the providers at North Clarksville Medical Center in a respectful manner. The patient has the responsibility to behave in a responsible manner. The patient has the responsibility to conduct themselves in a courteous and civil way with respect to others.

4. The patient has the responsibility to be aware of their balance and pay it in a reasonable and timely fashion.

5. The patient has the responsibility to notify the billing staff of North Clarksville Medical Center if there is a question regarding the billing statement or cost of treatment. It is appreciated that we are notified prior to calling your insurance company as we should be able to resolve any problems and answer any questions.

6. The patient has the responsibility to arrive as scheduled for appointments and to notify North Clarksville Medical Center at least 24 hours prior to their scheduled appointment if they will not be able to keep their scheduled appointment. The patient has the responsibility to pay any fees assessed for missed appointments in accordance with North Clarksville Medical Center's office policy and in accordance with what is allowable by the law.

7. The patient has the responsibility to carry health insurance information and provide this information to the office personnel of North Clarksville Medical Center. The patient has the responsibility to be familiar with their policy coverage.

8. The patient has the responsibility to give his/her health care provider as much information as possible to assist in the assessment of your medical needs. This includes complete history, medications, allergies, and any other pertinent information that the health care provider will need in order to provide sound medical care and decisions regarding treatment.

9. The patient has the responsibility to complete all forms that are necessary for the providers of North Clarksville Medical Center to file the insurance billing, comply with state and federal regulations such as authorization forms, history forms, advance directive, bill of rights forms, pain management forms, or any other informational or contractual form that the clinic and/or providers may need to meet state, federal and insurance laws and regulations.

I acknowledge I have received this information and that this will be kept as a permanent record in my medical record.

Patient's Signature: _____ Date: _____

Witness's Signature: _____ Date: _____

NORTH CLARKSVILL MEDICAL CENTER PAYMENT POLICY

PATIENT'S COVERAGE BY HEALTH INSURANCE

This office will file your health insurance as a courtesy to you. You are responsible for your bill regardless of insurance coverage. It is customary to pay for services when rendered. Persons covered by HMO policies are required to make co-payments at the time of service. Failure to make the co-payment can result in denial of your claim. If you are covered by a fee-for-service policy and have not met your deductible, you should pay for services rendered on the date they occur and we will file a claim to have the charges counted towards your deductible. It is our suggestion that you learn the coverage options that your insurance policy gives you. The staff in our office try hard to keep knowledgeable on the insurances we accept but there are many types of insurance available and policies can differ from person to person even within the same insurance company. Ultimately, you are the person that pays for the policy and should know what it covers and how it works.

Generally, an insurance company has up to 60 days in which to make payment on a claim. If we do not receive payment within 60 days, we reserve the right to bill you or the person responsible for the outstanding balance. Any balance that has reached 120 days is subject to interest and may be turned over to a collection agency. (Please see our financial agreement). You are responsible for knowing when you have a balance even if for some reason you have not received a statement from our office. You will receive and explanation of benefits from your insurance that will tell you what you owe. You need to pay when that is received as it may be 4-6 weeks after you receive your explanation of benefits before we are ever paid by your insurance company. If for some reason you do not receive any explanation of benefit from your insurance or statement from our office that does not absolve you from your responsibility. Please call our office to make sure we have the correct insurance information, your correct address and any other information we may need.

It is very important that should your insurance company send you a request for previous medical information or a request that states they believe you have other primary insurance that you return the answer to them in a timely manner. It is also important that you notify our office if any problem has occurred that will hold up payment of your claim by the insurance company. We may be able to help if we know what is going on. Please feel free to ask our staff any questions you may have regarding your claims.

TO ALL PATIENTS

Our billing is done in-house (North Clarksville Medical Center). Your statements will arrive in envelopes from us, with the following address: North Clarksville Medical Center, 351 Dover Road, Clarksville, Tennessee 37042. Pleas call 931-552-4495 should you have any questions regarding statements.

I HAVE READ, UNDERSTAND, AND AGREE TO COMPLY WITH THE ABOVE PAYMENT POLICY.

SIGNATURE: _____ DATE: _____

WITNESS: _____ DATE: _____

NOTICE OF PRIVACY PRACTICES

THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPPA) OF 1996. PUBLIC LAW 104-191 EFFECTIVE DATE APRIL 14, 2003.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

THE DEPARTMENT OF HEALTH AND HUMAN SERVICES HAS ESTABLISHED A "PRIVACY RULE" TO HELP INSURE THAT PERSONAL HEALTH CARE INFORMATION IS PROTECTED FOR PRIVACY. THE PRIVACY RULE WAS ALSO CREATED IN ORDER TO PROVIDE A STANDARD FOR CERTAIN HEALTH CARE PROVIDERS TO OBTAIN THEIR PATIENTS' CONSENT FOR USES AND DISCLOSURES OF HEALTH INFORMATION ABOUT THE PATIENT TO CARRY OUT TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS.

AS OUR PATIENT WE WANT YOU TO KNOW THAT WE RESPECT THE PRIVACY OF YOUR PERSONAL MEDICAL RECORDS AND WILL DO ALL WE CAN TO SECURE AND PROTECT THAT PRIVACY. WE STRIVE TO ALWAYS TAKE REASONABLE PRECAUTIONS TO PROTECT YOUR PRIVACY. WHEN IT IS APPROPRIATE AND NECESSARY, WE PROVIDE THE MINIMUM NECESSARY INFORMATION TO ONLY THOSE WE FEEL ARE IN NEED OF YOUR HEALTH CARE INFORMATION AND INFORMATION ABOUT TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS, IN ORDER TO PROVIDE HEALTH CARE THAT IS IN YOUR BEST INTEREST.

WE ALSO WANT YOU TO KNOW THAT WE SUPPORT YOUR FULL ACCESS TO YOUR PERSONAL MEDICAL RECORDS. WE MAY HAVE INDIRECT TREATMENT RELATIONSHIPS WITH YOU (SUCH AS LABORATORIES THAT ONLY INTERACT WITH PHYSICIANS AND NOT PATIENTS), AND MAY HAVE TO DISCLOSE PERSONAL HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS. THESE ENTITIES ARE MOST OFTEN NOT REQUIRED TO OBTAIN PATIENT CONSENT.

YOU MAY REFUSE TO CONSENT TO THE USE OR DISCLOSURE OF YOUR PERSONAL HEALTH INFORMATION, BUT THIS MUST BE IN WRITING. UNDER THIS LAW, WE HAVE THE RIGHT TO REFUSE TO TREAT YOU SHOULD YOU CHOOSE TO REFUSE TO DISCLOSE YOUR PERSONAL HEALTH INFORMATION **(PHI)**. IF YOU CHOOSE TO GIVE CONSENT IN THIS DOCUMENT, AT SOME FUTURE TIME YOU MAY REQUEST TO REFUSE ALL OR PART OF YOUR **PHI**. YOU MAY NOT REVOKE ACTIONS THAT HAVE ALREADY BEEN TAKEN WHICH RELIED ON THIS OR PREVIOUSLY SIGNED CONSENT.

IF YOU HAVE ANY OBJECTIONS TO THIS FORM, PLEASE ASK TO SPEAK WITH OUR **HIPPA** COMPLIANCE OFFICER.

YOU HAVE THE RIGHT TO REVIEW OUR PRIVACY NOTICE, TO REQUEST RESTRICTIONS, AND REVOKE CONSENT IN WRITING AFTER YOU HAVE REVIEWED OUR PRIVACY NOTICE.

YOU HAVE THE RIGHT TO FILE A COMPLAINT WITH REGARDS TO ANY VIOLATION OF YOUR PRIVACY TO THE PROVIDER AND/OR OFFICE ADMINISTRATOR. YOU ALSO HAV E THE RIGHT TO FILE A COMPLAINT WITH THE OFFICE OF HEALTH AND HUMAN SERVICES IF YOU FEEL YOU HAVE NOT RECEIVED SATISFATION FROM THE PROVIDER AND/OR ADMINISTRATOR OF NORTH CLARKSVILLE MEDICAL CENTER.

IN ADDITION TO THE AUTHORIZATION FORM THAT YOU SIGN GIVING OUR OFFICE CONSENT TO TREAT AND RELEASE INFORMATION TO THE INSURANCE COMPANY YOU HAVE DOCUMENTED ON THE AUTHORIZATION AND OTHER RELATED AREAS SUCH AS LABS, SPECIALISTS, AND REFERRAL SOURCES YOU MAY WANT TO GIVE PERMISSION FOR OUR OFFICE TO RELEASE INFORMATION TO ALL OR ANY OF THE FOLLOWING. WITHOUT THIS CONSENT WE WILL NOT BE ABLE TO RELEASE INFORMATION TO ANYONE OTHER THAN YOURSELF AND ONLY IN PERSON. PLEASE ALSO UNDERSTAND THERE MAY ALSO BE ADDITIONAL CONSENTS TO BE SIGNED FOR MORE SPECIFIC INFORMATION SUCH AS RELEASE OF YOUR ENTIRE MEDICAL RECORD AND UPON FORM CHANGES.

I WISH TO BE CONTACTED AND/OR INFORMATION RELEASED IN THE FOLLOWING MANNER (INITIAL ALL THAT APPLIES; PLEASE NOTE ANY AREA NOT INITIAL WILL BE REGARDED AS NO.)

___ **HOME TELEPHONE** _____

___ **OKAY TO LEAVE MESSAGE WITH DETAILED INFORMATION RE;** ____ **TEST RESULTS** ____ **CONDITION** ____ **APPOINTMENTS INFORMATION MAY BE LEFT WITH** _____

_____

___ **LEAVE MESSAGE WITH CALL-BACK NUMBER ONLY**

____ **WORK TELEPHONE** _____

___ **OKAY TO LEAVE MESSAGE WITH DETAILED INFORMATION RE:** ____ **TEST RESULTS** ____ **CONDITION** ____ **APPOINTMENTS INFORMATION MAY BE LEFT WITH** _____

_____

___ **LEAVE MESSAGE WITH CALL BACK NUMBER ONLY**

___ **WRITTEN COMMUNICATION**

___ **OKAY TO MAIL TO MY HOME ADDRESS**

___ **OKAY TO MAIL TO MY WORK/OFFICE ADDRESS**

___ **OKAY TO FAX TO THIS NUMBER** _____

___ **PHARMACY NAME** _____

___ **ALTERNATE PHARMACY** _____

___ **REFERRAL SOURCES**

___ **SPOUSE NAME** _____

___ **OTHER** _____

_____

PRINT NAME: _____ SIGNATURE: _____ DATE: _____

NOTE: USES AND DISCLOSURES FOR INFORMATION MAY BE PERMITTED WITHOUT PRIOR CONSENT IN AN EMERGENCY. PLEASE READ THE BACK OF THIS FORM FOR FURTHER INFORMATION ON OUR COMPLIANCE ASSURANCE TO OUR PATIENTS

PLEASE UNDERSTAND YOU DO NOT HAVE TO SIGN THIS FORM BUT IF YOU DO NOT, WE WILL NOT BE ABLE TO PROVIDE INFORMATION EXCEPT TO YOU IN PERSON.

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

TO OUR VALUED PATIENT:

THE MISUSE OF PERSONAL HEALTH INFORMATION (**PHI**) HAS BEEN IDENTIFIED AS A NATIONAL PROBLEM CAUSING PATIENTS INCONVENIENCE, AGGRAVATION, AND MONEY. WE WANT YOU TO KNOW THAT ALL OF OUR EMPLOYEES, MANAGERS, AND PROVIDERS CONTINUALLY UNDERGO TRAINING SO THAT THEY MAY UNDERSTAND AND COMPLY WITH GOVERNMENT RULES AND REGULATIONS REGARDING THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (**HIPPA**) WITH PARTICULAR EMPHASIS ON THE "PRIVACY RULE." WE STRIVE TO ACHIEVE THE VERY HIGHEST STANDARDS OF ETHICS AND INTEGRITY IN PERFORMING SERVICES FOR OUR PATIENTS.

IT IS OUR POLICY TO PROPERLY DETERMINE APPROPRIATE USES OF PHI IN ACCORDANCE WITH THE GOVERNMENTAL RULES, LAWS AND REGULATIONS. WE WANT TO ENSURE THAT OUR PRACTICE NEVER CONTRIBUTES IN ANY TO THE GROWING PROBLEM OF IMPROPER DISCLOSURE OF PHI. AS PART OF THIS PLAN, WE HAVE IMPLEMENTED A COMPLIANCE PROGRAM THAT WE BELIEVE WILL HELP US PREVENT ANY INAPPROPRIATE USES OF PHI. WE CANNOT PROVIDE MEDICAL RECORDS THAT HAVE BEEN PROVIDED TO OUR OFFICE FROM OTHER SPECIALISTS OR CLINICS WITHOUT THEIR WRITTEN PERMISSION AS WELL AS YOUR WRITTEN PERMISSION. YOU HAVE THE RIGHT TO LOOK AT OR GET COPIES OF YOUR MEDICAL INFORMATION GENERATED BY THIS OFFICE. YOU MUST MAKE YOUR REQUEST IN WRITING. IF YOU REQUEST COPIES, WE WILL CHARGE YOU $20.00 FOR THE **FIRST 40 PAGES AND $ 0.25 CENTS** FOR EACH PAGE THEREAFTER, AND POSTAGE IF YOU WANT THE COPIES MAILED TO YOU.

WE ALSO KNOW THAT WE ARE NOT PERFECT! BECAUSE OF THIS FACT, OUR POLICY IS TO LISTEN TO OUR EMPLOYEES AND OUR PATIENTS WITHOUT ANY THOUGHT OF PENALIZATION IF THEY FEEL THAT AN EVENT IN ANY WAY COMPROMISES OUR POLICY OF INTEGRITY. MORE SO, WE WELCOME YOUR INPUT REGARDING ANY SERVICE PROBLEM SO THAT WE MAY REMEDY THE SITUATION PROMPTLY.

THANK YOU FOR BEING ONE OF OUR HIGHLY VALUED PATIENTS.

NORTH CLARKSVILLE MEDICAL CENTER
351 DOVER ROAD
CLARKSVILLE, TENNESSEE 37042

ADVANCE DIRECTIVE ACKNOWLEDGMENT
(SELF-DETERMINATION ACT)

Federal and State Law requires that N0RTH CLARKSVILLE MEDICAL CENTER inquire if you have executed a living will and/or durable power of attorney for healthcare, at this facility, or any other healthcare facility.

Please indicate if you have the following documents by placing your initials on the appropriate line. Please do not use check marks.

Yes	No	
___	___	Living Will
___	___	copy provided
___	___	Durable power of Attorney for Healthcare
___	___	copy provided

If yes, is it still in effect? Living Will Yes ____ No ____ Durable power of Attorney Yes ____ No ____

I achnowledge having received, from NORTH CLARKSVILLE MEDICALCENTER, written materials regarding my right to make advance healthcare decisions.

I understand that I am not required to have an Advance Directive and NORTH CLARKSVILLE MEDICAL CENTER will not condition the provision of care or otherwise discriminate against me based on whether I have made an Advance Directive.

_____ **I DO NOT want counseling concerning Advance Directive, however, I have been provided information by NORTH CLARKVILLE MEDICAL CENTER REGARDING Advance Directives. (To be initialed only If patient does not desire counseling.)**

_____ **I DO have an Advance Directive that specifically prohits a facility or persons in a medical setting from Performing any life-sustaining treatment, including resuscitative services in emergency situations.**

_____ **I DO NOT have an Advance Directive that specifically prohibits a facility or persons in a medical Setting from performing any life- sustaining treatment, including resuscitative services in emergency Situations.**

I do understand that I may revoke all or part of the Advance Directive at any time. I also understand that if I do not provide NORTH CLARKSVILLE MEDICAL CENTER with a copy of my Advance Directive that I nor any of my family members can hold NORTH CLARKSVILLE MEDICAL CENTER or any of the facility's staff or providers responsible should resuscitative services care be provided in an emergency situation. I also understand that should my any of my family be present during an emergency situation that they may act as my agent and revoke my Advance Directive on my behalf.

SIGNATURE _____ **DATE** _____
Patient

_____ **DATE** _____
Patient's agent or representative

_____
Relationship to Patient

This form will become part of your permanent medical record

UPDATED 051403

Initial History (Adult)

Name of Patient _____ Sex: ❒ Male ❒ Female DOB ___ /___ /___ Chart #

Form completed by _____ Relation (if other than patient) _____ Date__ /__ /__

Family

Are you: ❒ single ❒ married ❒ partner ❒ separated/divorced ❒ widowed _____

List members of the immediate family

Name	Age	Relation	Health Problem

Work History

Are you currently employed outside the home? ❒ Yes ❒ No If not, are you: ❒retired ❒ disabled ❒ other _____

Present type of work _____

In your work, are you exposed to: ❒ harmful toxins ❒ heavy lifting ❒ extremes in temperature ❒ undue stress ❒ other potential hazards

Current Medical History

Are immunizations up-to-date? ❒ Yes ❒ No

Are you having any medical problems? ❒ Yes ❒ No

Current Medications:

Drug Allergies? ❒ Yes ❒ No

Past Medical History

Have you ever had a serious medical problem? ❒ Yes ❒ No _____

Have you ever been hospitalized or had surgery? ❒ Yes ❒ No _____

Have you ever had a serious injury? ❒ Yes ❒ No _____

History Update *(date / initial) Changes in history noted in chart on day of visit*

_____ ___ _____ ___ _____ ___ _____ ___ _____ ___ _____ ___

_____ ___ _____ ___ _____ ___ _____ ___ _____ ___ _____ ___

Name of Patient _____ Date ___ / ___ / ___ Chart # _____

Review of Systems *Are you concerned about (circle concerns):*

	Yes	No	
1. eating habits, weight loss, ↓ energy, sleep problems	❒	❒	_____
2. eye pain, redness, ↑ tearing, drainage, blurred or ↓ vision	❒	❒	_____
3. ear, nose, mouth, throat, sinus problems; ↓ hearing;	❒	❒	_____
4. heart problems, chest pain, ↑ blood pressure, leg swelling	❒	❒	_____
5. lung problems: difficult breathing, wheezing, infections	❒	❒	_____
6. abdominal pain, vomiting, indigestion, excessive gas	❒	❒	_____
7. diarrhea, constipation, blood in stools, hemorrhoids	❒	❒	_____
8. kidney or bladder problems, infections, blood in urine	❒	❒	_____
9. joint pain, stiffness, swelling; muscle pain, weakness	❒	❒	_____
10. skin: rashes, itching, dryness; hair or nail problems	❒	❒	_____
11. headaches, dizziness, numbness, weakness, seizures	❒	❒	_____
12. stress, anxiety, sadness, depression, suicidal thoughts	❒	❒	_____
13. excessive thirst or hunger, ↑ urination, weight loss	❒	❒	_____
14. anemia, bruising, bleeding problem, had blood transfusions	❒	❒	_____
15. allergies: food, hay fever, asthma, ↑ infections	❒	❒	_____
16. (women) breast, menstruation, irregular, bleeding patterns,hot flashes, pain or bleeding with intercourse, other sexual concerns	❒	❒	_____
Do you now take or have you taken hormone therapy?	❒	❒	_____
List approximate date of last: menstrual period _____			_____
Pap Test _____ Mammogram_____			_____
17. (men) lesions or swelling on penis, scrotum or testicles; difficulty urinating, enlarge prostate, difficulty getting or sustaining an erection, other sexual concerns	❒	❒	_____
Have you had a PSA (prostate) test? When _____	❒	❒	_____
18. Do you exercise for 30 minutes? ❒ Daily ❒ Weekly ❒ Seldomly	❒	❒	_____
19. Do you take calcium, multivitamins, or folic acid?	❒	❒	_____
20. Do you smoke, drink alcohol or use recreational drugs?	❒	❒	_____

Family History

1. ❒ _____ Allergies	11. ❒ _____ High cholesterol	21. ❒ _____ Cancer
2. ❒ _____ Drug Allergies	12. ❒ _____ High blood pressure before 50 yrs	22. ❒ _____ Neurological / Seizures
3. ❒ _____ Eczema / Skin problems	13. ❒ _____ Heart attack / stroke before 50 yrs	23. ❒ _____ Arthritis
4. ❒ _____ Asthma / Lung problems	14. ❒ _____ Other heart problems	24. ❒ _____ Phlebitis
5. ❒ _____ Respiratory infections	15. ❒ _____ Anemia / Blood disorders	25. ❒ _____ Hereditary problems
6. ❒ _____ Eye or visual problems	16. ❒ _____ Diabetes before 50 yrs	26. ❒ _____ Emotional / Behavioral
7. ❒ _____ Ear problems / Deafness	17. ❒ _____ Thyroid or other endocrine prob.	27. ❒ _____ Mental Illness
8. ❒ _____ Tuberculosis	18. ❒ _____ Obesity	28. ❒ _____ Mental retardation
9. ❒ _____ Liver Disease	19. ❒ _____ Bladder / Kidney problems	29. ❒ _____ Drug / Alcohol abuse
10. ❒ _____ Immunity problems / HIV	20. ❒ _____ Stomach / GI problems	30. ❒ _____ Other

Provider Comments

History Reviewed by _____

Patient Registration *(Adult)*

Patient Information

Date _____ Chart No. [ ]

Patient _____ Spouse _____

Sex: ❒ M ❒ F Marital Status _____ Sex: ❒ M ❒ F Marital Status _____

DoB ___ /___ /___ SS# _____ DoB ___ /___ /___ SS# _____

Address _____ Address (if not yours) _____

City _____ St. _____ Zip _____ City _____ St. _____ Zip _____

Home Phone (_____) _____ Home Phone (_____) _____

Employer _____ Employer _____

Work Phone (_____) _____ Work Phone (_____) _____

Cell Phone (_____) _____ Cell Phone (_____) _____

Email Address _____ Email Address _____

Ethnicity _____ Language _____ Race _____

Responsible for Payment/Guarantor ❒ Self ❒ Spouse ❒ Other _____

Address (if not yours) _____ Home Phone (_____) _____

City _____ St. _____ Zip _____ Work Phone (_____) _____

Emergency Contact Person _____ Relation _____ Phone _____

Referred by _____

Insurance Information

Primary _____ Claims Address _____

Policy # _____ Group # _____ Co-payment $ _____

Secondary _____ Claims Address _____

Policy # _____ Group # _____ Co-payment $ _____

Name of Insured _____ DoB ___/___ /___ Relation _____

Medicaid / Champus / Other _____ Current Card # _____

Physician Listed on Card _____ Phone _____

Authorization of Treatment and Assignment of Benefit

I authorize _____ to treat me. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to _____ for all medical or surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original.

I understand that if my physician, or any person employed by or under the direction and control of my physician(s), is directly exposed to my body fluids in any manner which may, according to the then current guidelines for the Center for Disease Control, transmit the human immunodeficiency virus (HIV) or hepatitis B or C viruses, that I am deemed by law to have consented to testing for infection with HIV or hepatitis B or C viruses. I further understand that by law I will have deemed to have consented to the release of these test results to the person who is exposed to my body fluids.

May we contact you by email for results, schedule changes or other information? _____ YES _____ NO (PATIENT INITIAL)

Please read and sign attached financial agreement form.

Patient Signature _____ Date _____

Witness signature _____ Date _____

❒ I prefer to do my own insurance filing. Signed _____ Date _____

HIPPA Authorization Statement

Please complete and sign the attached privacy agreement.