RIVERCITY FAMILY MEDICINE, PLLC

Patient Registration

Name:_____

Patient Information

First Name	Last Name	MI	Date of Birth
Address	City	State	Zip

Please check Primary phone	Home Phone ☐	Work Phone ☐	Cell Phone ☐
Other Name(s) Used	E-mail Address		
Gender ☐ M ☐ F	SSN	Preferred Language	Driver's License

Marital Status
- ☐ Married
- ☐ Single
- ☐ Divorced
- ☐ Separated
- ☐ Widowed
- ☐ Life Partner

Preferred Contact
- ☐ Mail
- ☐ Home Phone
- ☐ Day Phone
- ☐ Cell Phone
- ☐ Patient Portal (MyChart)

Ethnicity
- ☐ Hispanic/Latino
- ☐ Non-Hispanic
- ☐ Decline
- ☐

Race
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ White
- ☐ Other

Primary Care Provider	Referring Provider

Responsible Party (Guarantor) ☐ Same as patient

First Name	Last Name	MI	Date of Birth
Address	City	State	Zip

Please check Primary Phone	Home Phone ☐	Work Phone ☐	Cell Phone ☐
SSN	Relationship to Patient	Preferred Language	Driver's License

Emergency Contact (for minor child, this section may be used for other parent)

First Name	Last Name	MI	Date of Birth
Address	City	State	Zip

Please check Primary Phone	Home Phone ☐	Work Phone ☐	Cell Phone ☐

I/We do hereby consent to and authorize the performance of all treatments, surgeries and medical services deemed advisable by the physicians and staff of the RiverCity Family Medicine, PLLC to me or to the above-named minor of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained hereon are true. I understand that I am directly responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage, excluding only authorized services provided under a valid prepaid HMO contract. I furthermore agree to pay legal interest, collection expenses, and attorneys' fees incurred to collect any amount I may owe. I also hereby authorize RiverCity Family Medicine, PLLC to release information requested by insurance company and/or its representatives. I fully understand this agreement and consent will continue until cancelled by me in writing.

_____ _____

Signature of Patient/Responsible Party Date

_____ _____

Name of Patient/Responsible Party (Please Print) Relationship to Patient

Pharmacy Information	
Preferred Pharmacy	Secondary Pharmacy
Name	Name
Address	Address
Phone	Phone
Fax	Fax

Advanced Directives

☐ None ☐ Do Not Resuscitate ☐ Durable Power of Attorney ☐ Living Will ☐ HC Proxy

Date Reviewed:

Medications – List all medications you take, prescription and non-prescription, and the dosage

☐ I do not take any medications

Medication Name	Dosage

Medication and Food Allergies – List all known allergies (drugs, food, animals, etc.)

☐ No Known Allergies

Health Maintenance – Check if you have received the following, and date of most recent exam.

Exam	Date	Exam	Date
☐ None		☐ GYN Exam	
☐ Breast Exam		☐ Influenza Vaccine	
☐ Cardiac Stress Test		☐ Lipid Panel	
☐ Colonoscopy		☐ Mammogram	
☐ DEXA Scan		☐ Pap Test	
☐ Echocardiogram		☐ Physical Exam	
☐ EKG		☐ Pneumococcal Vaccine	
☐ Eye Exam		☐ Pulmonary Function Test	
☐ FOBT (stool card for hidden blood)		☐ Sismoidoscopy	
☐ Foot Exam		☐ Tetanus	
☐		☐	

MedicalCare Team (Other Doctors)

Doctor Name	Specialty	Doctor Name	Specialty

RiverCity Family Medicine, PLLC

Name:_____

Past Medical History

Please CIRCLE if you <u>have</u> or <u>have had</u> any of the following:

CARDIOVASCULAR
Anemia
Arrhythmia
Atrial Fibrillation Bleeding Disorder
Blood Disease
Cerebrovascular Disease
Chest Pain/Angina
Congestive Heart Failure
Deep Vein Thrombosis
Enlarged Heart
Heart Attack
Heart Disease
Heart Murmur
Hypertension
Hyperlipidemia
Leukemia
Mitral Valve Prolapse
PVD
Renal Disease
Rheumatic Fever
Sickle Cell Anemia
Varicose Veins

ENDOCRINE/METABOLIC
Diabetes Type 1 or 2
Goiter
Gout
Hyperthyroidism
Hypothyroidism
Obesity

GENERAL
Alcoholism
(HIV) AIDS
Eczema
Exposure to Chemicals
Hepatitis A B or C
High Cholesterol
Infectious Disease
Lipid Disorder
Malaise
Obesity

GI
Gallstones
Constipation
Colon Cancer
Colon Condition
Crohn's Disease
Diarrhea
Diverticulitis/ Diverticulosis
GERD
Hemorrhoids
Hernia
Irritable Bowel Syndrome
Liver Disease
Pancreatitis
Pancreatic Cancer
Rectal Cancer
Rectal Fissure
Stomach Cancer
Stomach Ulcer

GU
Bladder Cancer
Bladder Outlet
Obstruction Bladder Stone
Blood in Urine
Elevated PSA
Erectile Dysfunction
Interstitial Cystitis
Kidney Cancer
Kidney Disease
Kidney Stones
Libido Decreased
Orchitis
Penile Discharge
Prostate Cancer
Renal Failure
Testicular Cancer
Transplant Recipient
Ureteral Cancer
Undescended Testicle
Urinary Tract Infection
Venereal Disease

GYN/OB
Breast Cancer
Breast Disease
Cervical Cancer
Endometriosis
Fibrocystic Breast Disease
Menopause
Menstrual Problems
Osteoporosis
Ovarian Cancer
Uterine Cancer
Uterine Fibroids

HEENT
Brain Cancer
Brain Tumor
Blindness
Cataracts
Deviated Septum
Deafness
Ear Infections
Glaucoma
Hay Fever
Hearing Deficiency
Laryngeal Cancer
Meniere's
Mumps
Sinusitis
Tinnitis
Vertigo

MUSCULOSKELETAL
Arthritis
Back Pain
Carpal Tunnel Syndrome
Fibromyalgia
Mortons Neuroma
Osteoarthritis
Osteoporosis

NEUROLOGICAL/ PSYCHOLOGICAL
ADD
ADHD
Alcoholism
Alzheimer's Disease
Anxiety
Bi-polar Disorder
Chronic Fatigue Syndrome
Dementia
Depression Developmental
Delay Eating Disorder
Epilepsy
Herniated Disc
Mental Illness
Migraine
Multiple Sclerosis
Nervous Breakdown
Neuropathy
Parkinson's
Polio
Schizophrenia
Seizures
Spinal Cord Injury
Stroke
Suicide Attempt

RESPIRATORY
Allergies
Asthma
Bronchitis
COPD
Emphysema
Lung Cancer
Lung Disease
Pneumonia
Pulmonary Embolism
Sleep Apnea
Tuberculosis

TUMORS
Lymphoma
Melanoma
Sarcoidosis

OTHER_____

Name:_____

Surgical History

Please CIRCLE if you <u>have had</u> any of the following surgeries and date of surgery:

CARDIOVASCULAR
Angioplasty
Angioplasty w/Stent
CABG (heart bypass) Carotid
Artery Surgery Heart Surgery
Heart Transplant Pacemaker
Insertion Vein Stripping
Pacemaker

GENERAL
Appendectomy
Brain Surgery
Cholecystectomy Colectomy
Colostomy
Gastric Bypass
Hernia Repair Laminectomy
Lymphatic Node Dissection
Parathyroidectomy Pilondial
Cyst Incision
Skin Grafting
Small Bowel Resection

GI
Appendectomy
Bowel Resection
Colonoscopy
Colon Resection
EGD / Dilation
Esophagus Fissurectomy
Gallbladder removed
Hemorrhoidectomy
Ileostomy Laparoscopy
Liver Biopsy
Liver Surgery
Splenectomy
Stomach Surgery

GU
Bladder Surgery
Brachytherapy
Circumcision Cystoscopy
Ileal Conduit Lithotripsy
(ESWL) Needle Biopsy
Prostate Nephrectomy
Prostate Biopsy Radical
Prostatectomy Renal
Transplant TURP(Trans-
urethal resection of
prostate) Vasectomy

GYN/OB
Augmentation Mammoplasty
Bilateral Tubal Ligation
Breast Biopsy
Bladder Tack
Cesarean Section
D and C
Hysterectomy Lumpectomy
of Breast Mastectomy
Myomectomy Oophorectomy
Reduction Mammoplasty
Vaginal Sling
Vaginal Hysterectomy

HEENT
Cataract Extraction
Ear Surgery
Eye Surgery
Facial Surgery
LASIK
Mastoid Surgery
Nasal Surgery
Thyroid Surgery
TMJ Surgery
Tonsillectomy

MUSCULOSKELETAL
Amputation Arthroscopy
Knee
Back Surgery
Carpal Tunnel Surgery
Cervical Spine Surgery
Disc Surgery
Foot Surgery
Hand Surgery
Hip Replacement
Hip Surgery
Knee Replacement Knee
Surgery
Leg Surgery
Rotator Cuff Surgery
Shoulder Replacement
Shoulder Surgery

RESPIRATORY
Lung Surgery
Trachea Surgery

SKIN
Basal Cell Carcinoma
Melanoma
Squamous Cell Carcinoma

OTHER:

_____

_____

_____

Name:_____

Social History

Current Marital Status: Please indicate number of years.

Single___ Married___ Separated___ Life Partner___ Common Law Spouse___

Divorced___ Widowed___

Occupation_____ **Employer** _____

Do you have children? Yes or No **How many?** Female(s)____ Male(s)_____

Alcohol Use: Yes or No

Daily Weekly Occasional/Social Former / Quit Date:____ HX of Alcoholism: Yes or No

Beer Wine Liquor Other_____ Number of drinks ___ day month week year

Tobacco Use:

___No _____Yes #___packs/day _____Cigarettes/day _____Smokeless Tobacco

If you previously stopped/ Quit - Date:_____

Do you /or have you used illicit street / Recreational drugs: Yes or No If yes, please list:_____ Type of Drug _____

Caffeine Use:

Yes or No Daily, # drinks a day ___ Weekly ___ Occasional ___ Former / Year quit _____

Chocolate Coffee Energy Drinks Soda Tea Tablets Other

Exercise Activity:

Yes or No Daily Weekly Occasional Does Not exercise

Do you wear your seatbelt? Yes or No

Do you feel safe in your home? Yes or No

Do you practice safe sex? Yes or No

Do you keep a firearms on your home? Yes or No

Do you have smoke detectors in your home? Yes or No

Do you eat healthy? Yes or No

Do you take a daily aspirin? Yes or No **What milligram?** _____

Name:_____

FAMILY HISTORY

Please indicate which family member has/had any of the following: (Mother, Father, Brother, Sister, Grandmother, Grandfather, Uncle, Aunt) Alive or Deceased, age at time of death.

Alcholism	_____	A or D	Leukemia	_____	A or D
Allergies	_____	A or D	Malignant Melanoma	_____	A or D
Alzheimer's Disease	_____	A or D	Mental Illness	_____	A or D
Asthma	_____	A or D	Multiple Sclerosis	_____	A or D
Arthritis	_____	A or D	Laryngeal Cancer	_____	A or D
Bedwetting	_____	A or D	Pancreatic Cancer	_____	A or D
Blood Disease	_____	A or D	Parkinson's	_____	A or D
Bladder Cancer	_____	A or D	Prostate Cancer	_____	A or D
Blood Disease	_____	A or D	Thyroid Disease	_____	A or D
CAD (Heart Attack)	_____	A or D	Tuberculosis Obesity	_____	A or D
Cancer- Site Unknown):	_____	A or D	Osteoarthritis	_____	A or D
Crohn's Disease	_____	A or D	Osteoporosis	_____	A or D
CVA (Stroke)	_____	A or D	PVD	_____	A or D
Depression	_____	A or D	Renal Disease	_____	A or D
Developmental Delay	_____	A or D	Other	_____	A or D
Diabetes	_____	A or D	Other	_____	A or D
Eczema	_____	A or D			
Gout	_____	A or D			
Hearing Deficiency	_____	A or D			
Hyperlipidemia (High Cholesterol)	_____	A or D			
Hypertension (High Blood Pressure)	_____	A or D			
Irritable Bowel Disease	_____	A or D			
Kidney Cancer	_____	A or D			
Kidney Disease	_____	A or D			
Learning Disability	_____	A or D			

RiverCity Family Medicine, PLLC

Name:_____

Patient Privacy Policy

Acknowledgment Form

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to Protected Health Information (PHI). In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their PHI. The individual is also provided the right to request confidential communications or that a communication of PHI to be made by alternative means, such as sending correspondence to the individual's home. If you have any objections to this form, please ask to speak with our HIPPA compliance officer in person or by phone at (423) 802-1919.

Patient Name: _____

___ Home Telephone

___ OK to leave message with detailed information

___ Leave message with call back number only

___ Work Telephone

___ OK to leave message with detailed information ___

Leave message with call back number only

___ Written Communication

___ OK to mail to my home

___ OK to Email

___ OK to fax to this number

___ Other: _____

_____

Authorization to release Protected Health Information to individuals/family members

___ I authorize RiverCity Family Medicine to verbally, or with written consent, release any or all of my PHI to the following individuals:

Name:_____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

___ I do not authorize RiverCity Family Medicineto release any of my PHI to any individuals/family members except as set forth above.

Patient Signature: _____ Date: _____

Witness: _____

RIVERCITY FAMILY MEDICINE, PLLC

Name:_____

New Patient Package
Notification and Releases

We want to welcome you to our practice. We want to make your experience with every aspect of our service meet or exceed your expectations. If you have any questions, concerns, comments or suggestions for improvement in our services, please do not hesitate to speak with any of our staff or physicians. Listed below are several notices that outline certain responsibilities of ours and yours. Please read them carefully and sign where indicated that you have read each statement.

General Consent for Treatment

We look forward to treating you as a patient. However, we need your permission for our physicians to examine you, provide treatments and perform diagnostic studies as necessary. If more invasive procedures are deemed necessary, the risks and benefits of those invasive treatments will be explained to you. When you agree to proceed with an invasive treatment, you will be asked to sign a more detailed consent.

I give general consent to be treated by _____ D.O.

Patient: _____ Date: _____

Financial Policy/Assignment of Benefits

As a courtesy to our patients, the practice will accept assignment for most commercial insurance programs and Medicare. We will file your primary insurance claim for you. Once the primary insurance has paid, we will also file your secondary insurance, if you have provided us with that information. However, insurance is a contract between you and your insurance company. Therefore, we ask that you acknowledge your responsibility for the payment of our services. If the insurance denies coverage, disallows a service, or otherwise does not pay the claim, you are still responsible for the fees. In addition, if the fees for our services are not paid, we may turn the account over to a collection agency. If an account is turned over for collection, their fees, attorney's fees and court cost will be added to the account balance. Also, your insurance company may ask us to provide information concerning your treatment before they will pay for the services.

I acknowledge responsibility for payment of fees for services provided by the practice and authorize the practice to release any medical information, if necessary, to my insurance company.

Patient/Guarantor: _____ Privacy Policy Date: _____

New federal regulations require physician practices to keep your medical information private. Our practice has always guarded the privacy of our patients. If you would like a copy of our privacy policies, please ask any of our staff and we will be happy to give it to you. We only share your medical information with other healthcare providers that are participating in your care, your insurance company to provide your benefits or for medical management issues. If anyone else helps us with our internal operations, we will require them to keep any patient information they may see confidential. All other releases of information have to be specifically authorized by you. If you ask us to account for these releases of information, we will provide that to you. You may also request and receive a copy of your medical record and ask questions about its content. We will keep your record as long as you are a patient of the practice and seven years after your last visit. Unless you tell us otherwise, when we contact you by phone and you are not available, we will leave a message with the person who answered or we will leave a voicemail message, if available.

Patient: _____ Date: _____

Name:_____

FORMS POLICY

There will be a $20 fee to fill out FMLA forms, and $25 for disability forms to be completed by our office.

This fee is per form and must be paid in full before the forms will be completed.

Please allow 7-10 business days for the forms to be finished.

By signing this form, I understand the above policy and agree to pay the fee if I have forms to be filled out.

Print Name: _____

Sign Name: _____

Date: _____

RIVERCITY FAMILY MEDICINE, PLLC

Financial Policy

Insurance Verification

At each visit, the patient must provide an active insurance card with current, correct information. Without proof of insurance, the patient may be re-scheduled. RiverCity Family Medicine, PLLC makes it a priority to verify proof of a patient's insurance; however, it is the patient's responsibility to know his/her benefits **including wellness benefits** prior to time of service.

Patient Cost Co-Pays & Co-Insurance

Insurance companies require RiverCity Family Medicine, PLLC to collect co-pays, deductibles or co-insurance amounts at the time of service. A deposit equal to 1/3 of costly procedures or visits is required in advance for services not covered by the patient's insurance.

A $12.00 processing fee will be added for co-pays that are not paid at the time of service.

Outstanding Balances

Patients will be asked to settle any outstanding balances with RiverCity Family Medicine, PLLC before their appointment.

Patients with outstanding balances may be declined treatment or triaged for non-emergency care until the balance is resolved.

Patient balances which are not resolved in a timely manner will be sent to an outside collection agency. If the patient's balance is transferred to an outside agency, the patient will be responsible for paying any additional collection fees associated with the collection of the patient balance.

Self-Pay

RiverCity Family Medicine, PLLC recognizes that not everyone has insurance coverage. It is difficult to accurately predict what services a patient may ultimately need, but RiverCity Family Medicine, PLLC will try to work with the patients to help them anticipate charges and manage their healthcare expenses.

Patients without insurance who pay in full at the time of service may be eligible for a discount.

Billing Insurance

RiverCity Family Medicne, PLLC contracts with most insurance companies for patient services. The patient remains financially responsible for all his or her care, but the remaining balance for services rendered to the patient will not be billed to the patient until payment is received from the insurance company(s), the insurance company denies the claim, or the insurance company unreasonably fails to pay in a timely manner. A statement will be sent to the patient or responsible party. The billed amount on the statement is due when the first statement is received. If payment is not received within 30 days, 10% interest will be applied to the outstanding balance until the account is paid in full.

No-show and Late cancellation Fee

Patients who cancel appointments with less than 24 hours notice or do not come to scheduled appointments may be subject to a $25.00 fee, not for any service, but for the lost opportunity to see another patient.

Payments

RiverCity Family Medicine, PLLC accepts cash, check, Visa, MasterCard or Discover. There is a $30.00 fee for all returned checks.

Payment can be sent to:

RiverCity Family Medicine, PLLC
P.O. Box 307
Hixson, TN 37343

To bring payment in person:

RiverCity Family Medicine, PLLC
P.O. Box 307
Hixson, TN 37343

To Pay Online:

http://poral.kareo.com

If you have any questions regarding our financial policies, please contact our Patient Business Services Representative at **(423) 802-1919**.

NOTE:

Patient Accounts with outstanding balances and no payment activity may be forwarded to a collection agency at the patient's expense. In addition to any outstanding balances, the Patient or the Patient's representative who signs below agrees to pay interest on the balance at 10%, plus all costs associated with such collection activity, including reasonable collection agency fees, attorney fees, and court costs.

_____
Patient Signature

_____
Date

_____
Printed Patient Name

RIVERCITY FAMILY MEDICINE, PLLC

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____Date of Birth: _____
Patient Name: _____Date of Birth: _____
Patient Name: _____Date of Birth: _____

Release records to (name and address):
RiverCity Family Medicine, PLLC
6106 Shallowford Rd Suite 104
Chattanooga, TN 37421
Phone_423-802-1919___Fax_423-269-8747___

Release records from (name and address):
_____
_____
_____
Phone_____Fax_____

☐ **Medical Record from (insert date) _____ to (insert date) _____**

☐ **Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other health care providers.**

☐ **Other:** Last 3 Years - patient histories, office notes, test results & studies, referrals, consults and records received from other health care providers.

Include: (Indicate by Initialing)

_____ Drug, Alcohol or Substance Abuse Records **_____ Mental Health Records (Except Psychotherapy Notes)**

_____ HIV/HIDS - Related Information (Including HIV/AIDS Test Results)

_____ Genetic Information (Including Genetic Test Results)

Reason For Records Release:_____

I understand that I may revoke this authorization at any time and that unless an earlier date is specified it will automatically expire 12 months after the date affixed below. **Treatment, payment, enrollment or eligibility of benefits** are not conditioned on signing the authorization or a description of the consequences to the patient if he or she refuses to sign the authorization. Once the information is used or disclosed, it may no longer be protected. A copy of this authorization may be utilized with the same effectiveness as an original. My signature below indicates that I am authorized to obtain/release records on the patient(s) indicated and there is no court order denying guardianship, parental rights, or authorization to obtain/release these records.

Signature **Date** **Relationship to Patient**

_____

RiverCity Family Medicine, PLLC

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

Please add Minors Below:

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Release records to (name and address):

RiverCity Family Medicine, PLLC
6106 Shallowford RD Suite 104
Chattanooga, TN 37421

Phone 423-802-1919 Fax 423-269-8747

Release records from (name and address):

_____
_____
_____

Phone_____Fax_____

☐ **Medical Record from (insert date) _____ to (insert date) _____**

☐ **Entire Medical Record, including patient histories, office notes, test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other health care providers.**

☐ **Other:** Medication List, Procedures, Labs, Vaccine records, Notes, for the last 3 years.

Include: (Indicate by Initialing)

_____ Drug, Alcohol or Substance Abuse Records **_____ Mental Health Records (Except Psychotherapy Notes)**

_____ HIV/HIDS - Related Information (Including HIV/AIDS Test Results)

_____ Genetic Information (Including Genetic Test Results)

Reason For Records Release:_____

I understand that I may revoke this authorization at any time and that unless an earlier date is specified it will automatically expire 12 months after the date affixed below. **Treatment, payment, enrollment or eligibility of benefits** are not conditioned on signing the authorization or a description of the consequences to the patient if he or she refuses to sign the authorization. Once the information is used or disclosed, it may no longer be protected. A copy of this authorization may be utilized with the same effectiveness as an original. My signature below indicates that I am authorized to obtain/release records on the patient(s) indicated and there is no court order denying guardianship, parental rights, or authorization to obtain/release these records.

Signature_____ Date_____