IM&P Internal Medicine & Pediatrics Clinic, PLLC
COOL SPRINGS • NORTH FRANKLIN

Patient Name: _____

Date of Birth: _____

Today's Date: _____

Patient Health Questionnaire (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Please circle the most fitting number)

	Not at all	Several Days	More than half the days	Nearly every day
1. Little Interest of pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

add columns _____ + _____ + _____

TOTAL: _____

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

_____ Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult

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Completed By: _____ Relationship to Patient: _____

Questions for Parents of Children 13-16 Years of Age

Instructions: Please fill out this questionnaire regarding your child. This is not intended to replace the interview, but will allow your doctor to focus on those areas which are of concern to you. Your responses will be discussed with you and/or you teenage child.

Do you have concerns regarding your teenager's usual mood and attitude?

Do you have concerns regarding how your teenager expresses him/herself?

Do you have concerns regarding your teenager's choice of friends?

Do you have concerns regarding drug or alcohol use?

Do you have concerns regarding grades, truancy, or homework?

Do you have concerns regarding self-image or the possibility of an eating disorder?

Do you have concerns regarding depression, withdrawal, or suicide?

Do you have concerns regarding the sexual activity of your teenager?

Do you have concerns regarding homosexuality and/or ability to cope with sexual orientation?

Please list any additional concerns you would like to address with your provider today. Please be aware that if problems unrelated to health maintenance are covered during this visit there may be an additional problem focused charge.

_____

_____

_____

_____

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Today's Date: _____

Consent to Treat Minor

Any patient under 18 years of age must be accompanied by a parent or legal guardian unless consent is given. Please complete the following information ONLY if you want to allow your minor child to be seen without a parent or legal guardian present.

I, _____, (Parent/Legal Guardian) give North Franklin Internal Medicine & Pediatrics permission to treat (including any and all services) the minor child named above in my absence.

_____ _____

Signature of Parent/Legal Guardian | Date Signed

Consent for Minor Accompaniment

If there are other adult(s) over the age 18 that may accompany your minor child to any physician visit, please complete the information below.

I, _____, (Parent/Legal Guardian) give the following adult(s) permission to accompany the minor child named above to North Franklin Internal Medicine & Pediatrics in my absence. These individuals may give consent for treatment, including any and all services, in my absence.

_____ _____

Name of Adult | Relationship

_____ _____

Name of Adult | Relationship

_____ _____

Name of Adult | Relationship

_____ _____

Name of Adult | Relationship

_____ _____

Signature of Parent/Guardian | Date Signed

Reviewed and updated 06/22/2020

IMP Internal Medicine & Pediatrics Clinic, PLLC
COOL SPRINGS • NORTH FRANKLIN

Patient Name: _____

Date of Birth: _____

Today's Date: _____

North Franklin Internal Medicine & Pediatrics
HIPAA Compliance Form

In accordance with federal government privacy rules implemented through the Health Insurance Portability and Accountability Act (HIPAA), in order for your physician or the staff of **North Franklin Internal Medicine & Pediatrics (NFIMP)** to give copies of and/or discuss your condition, exams, procedures, or x-rays with members of your family or other individuals that you designate other than your primary care doctor or specialist, we must obtain your authorization prior to doing so. We must also obtain your authorization to discuss financial information with members of your family or other individuals that you designate other than insurance companies or third party payers and their agents. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

☐ I authorize NFIMP to communicate with me by any means I provide. I also authorize NFIMP to share my information with the following individuals:
Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

☐ I authorize NFIMP to communicate with only me by any means I provide.

☐ I DO NOT authorize NFIMP to communicate with me by any means other than in person, by phone, or via the portal. I acknowledge by choosing this option it may delay care and thereby adversely affect the quality of my care.

Medication Access Authorization

☐ I authorize NFIMP to obtain/download medication information from my pharmacy via Surescripts.

☐ I DO NOT authorize NFIMP to obtain/download medication information from my pharmacy via Surescripts. I acknowledge by choosing this option it may delay care and thereby adversely affect the quality of my care.

Immunization Access Authorization

☐ I authorize NFIMP to download or update my immunization information to the Tennessee Department of Health Immunization Registry.

☐ I DO NOT authorize NFIMP to download or update my immunization information to the Tennessee Department of Health Immunization Registry.

I acknowledge receipt of the Notice of Privacy Practices in accordance with the Health Insurance Portability and Accountability Act about how NFIMP may use and disclose my protected health information. I understand that NFIMP reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me.

_____ _____

Signature of Patient/Guardian Date Signed

Reviewed and updated 06/22/2020

IMP Internal Medicine & Pediatrics Clinic, PLLC
COOL SPRINGS • NORTH FRANKLIN

Patient Name: _____

Date of Birth: _____

Today's Date: _____

North Franklin Internal Medicine & Pediatrics, PLLC
Patient Down Payment Policy

Based on the insurance information you provide Cool Springs Internal Medicine & Pediatrics/North Franklin Internal Medicine & Pediatrics (CSIMP/NFIMP), either a down payment or a co-payment may apply for your visit. Below are details regarding these payment types:

- **Down Payment** -Where a deductible remains, CSIMP/NFIMP collects a $50 down payment per visit towards what will eventually be due once your insurance receives and processes our claims. You will be billed the difference between what you have already paid and what your insurance applies to your responsibility. Down payments are not payments in full for services rendered. **Example**: Mr. Smith has $1500 remaining on his deductible. He paid a $50 down payment for his visit. The claim for the visit is processed and his insurance assigns $150 to the patient's (Mr. Smith) responsibility. CSIMP/NFIMP will bill Mr. Smith for the remaining $100.
- **Self-Pay** – Patients who do not have insurance will be required to make a down payment of $100 per visit towards what will be eventually due once charges have processed through our billing department. New patients who are self-pay will be required to pay $140 at their first visit. Self-Pay down payments are not payments in full for services rendered. **Example**: Mrs. Johnson does not have insurance. She paid a $100 down payment for her self-pay visit. After the provider has completed the visit note and submitted charges, the total charge for the visit is $200. CSIMP/NFIMP will bill Mrs. Johnson for the remaining $100.
- **Co-Payment** – Where a co-pay applies, CSIMP/NFIMP collects a fixed amount per visit. This amount is not always shown on insurance cards and it is the patient's responsibility to let CSIMP/NFIMP know if they have a co-payment. The patient is required by their insurance to pay this fixed amount at each visit. Patients who refuse to pay their co-payment amount will not be seen.
- **None** – Based on verification made, CSIMP/NFIMP will not be collecting on a per visit basis. Patient will not be required to make payment before visit if the patient has met their out of pocket maximum. This can also be the case if the patient has a primary & secondary insurance where no deducible needs to be met. A balance still may be due and will be billed to the patient once the claim has been processed.
- **Wellness Visits** – Most health plans will pay for one wellness or preventative exam per year. Your insurance provider may consider this to be once per calendar year or one year and one day since the date of your last wellness exam. Patients will not be required to pay down payments for wellness visits.
- **CSIMP/NFIMP unable to guarantee benefits details** – Insurance does not mandate that healthcare providers verify and communicate benefits to patients. CSIMP/NFIMP does this as a courtesy. CSIMP/NFIMP is unable to obtain guarantees regarding benefits we verify and therefore cannot pass any guarantees along to our patients. Benefits differ from insurance plan to insurance plan.
- **Independent verification** – We ask that patients contact their insurance company and obtain benefits for services independent of CSIMP/NFIMP.

_____ _____

Signature of Patient or Legal Guardian Date Signed

Reviewed and updated 06/22/2020

IMP Internal Medicine & Pediatrics Clinic, PLLC
COOL SPRINGS • NORTH FRANKLIN

Patient Name: _____

Date of Birth: _____

Today's Date: _____

North Franklin Internal Medicine & Pediatrics, PLLC
Telemedicine Patient Consent Form

1. The purpose of this form is to obtain your consent to participate in a telemedicine or electronic consult.
2. During the telemedicine consultation:
    a. Details of your medical history, examination, imaging, and test results will be used.
    b. You will be speaking with a licensed provider through the use of patient portal, telecommunication, and or interactive video.
3. Medical information and records: All existing laws regarding access to your medical information and copies of your medical records apply to this telemedicine consultation. Please note, telecommunications are not recorded or stored.
4. Confidentiality: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation, and all existing confidentiality protection under federal and Tennessee state law apply to information disclosed during the telemedicine consultation.
5. Rights: You may withhold or withdraw consent to the telemedicine consultation at any time.
6. No Shows: A "missed" telemedicine appointment is considered the same as a missed in office visit. We respectfully request our patients cancel or reschedule their appointment a minimum of 24 hours in advance of the appointment time. If a 24-hour notice is not reasonable for the circumstances, any notice prior to the appointment will be accepted.

By signing below, I acknowledge I have been advised of all the potential risks, consequences, and benefits of telemedicine. I had the opportunity to ask questions about the information presented on this form and the telemedicine consultation. All questions have been answered and I understand the written information provided above.

_____ _____

Signature of Patient or Guardian Date Signed

Reviewed and updated 06/22/2020