Family Care of Middle Tennessee
713A President Place
Smyrna, Tn 37167
Phone: 615-220-0056
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Authorization to Release Healthcare Information

Patient Name: _____ Date of Birth: _____

Maiden Name (if applicable): _____ Social Security #: _____

I request and authorize Family Care of Middle Tennessee to receive healthcare information regarding the patient named above from:

Name: _____

Address: _____

City: _____ State: _____ Zipcode: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates:

_____

☐ All healthcare information

☐ Other: _____

Please Circle Yes or No

Yes No I authorize the release of my Sexually Transmitted Disease result, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes No I authorize the release of records in regards to drug, alcohol, or mental health treatment to person(s) listed above.

Patient/Guardian Signature: _____ Date: _____

Family Care of Middle Tennessee
Patient Registration Form

Date_____ Marital Status (circle status) Single Married Divorced Widowed Sep

Last Name_____ First_____ Middle_____

Address_____ Apt #_____ PO Box_____

City_____ State_____ Zip Code_____

Home #_____Cell #_____ Work #_____

Social Security #_____ Date of Birth_____ Sex_____

Email Address_____

Primary Insurance_____ ID#_____ Group#_____

Secondary Insurance_____ ID#_____ Group#_____

Employer_____ Phone#_____ Occupation_____

Race (circle which applies) White Black Asian Am Indian/Alaska Native Native Hawaiian
Pacific Islander Other

Ethnicity (circle selection) Non-Hispanic Hispanic Language Spoken_____

Emergency Contact Name_____ Phone #:_____

Relationship to Patient_____

**The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand I am financially responsible for my copays, deductibles, coninsurance and balances on day of business **

Patient Signature_____ Date_____

HIPPA Patient Authorization

Patients Name: _____

Patients Social Security Number: _____

Because of the changes made by Congress, we are required to get your explicit permission regarding how your medical information is handled. You have the right to review our privacy policy. You may request a copy of the policy from our staff, if so desired. Please read each authorization carefully and indicate your approval by signing below. Thank you for helping us fully comply with the important legislation to assure the protection of your privacy.

1. I authorize the release of all medical records maintained by Family Care of Middle TN which relates to services I have received from, or the results of tests ordered by Family Care of Middle TN. These records may be released as needed for my care, for processing insurance claims, or to satisfy the requirements of a managed care organization in which I am a member.
2. I authorize direct payment of benefits from my insurance plan to Family Care of Middle TN. I understand that I am responsible for payment of professional fees charged by Family Care of Middle Tn which may not be covered, or not properly reimbursed, under the terms of my insurance plan.
3. I will provide Family Care of Middle TN with the phone numbers I authorize for staff to contact me. I authorize the use of messaging person or system, voicemail and/or answering machine to convey information regarding my care. We may disclose to a member of your family, relative, a close friend, or any other person your protected health information directly relates to that persons involvement in your healthcare **UNLESS OTHERWISE NAMED HERE**:

   _____

   _____
4. I authorize the use of faxing or email to send my information to myself or to other parties that have the right to receive my information. I understand that every effort is made to protect my privacy, however, no absolute privacy guarantee is given when faxing or email is used.
5. I understand that is it my right to request limited access to my records and to withdraw permission for the release of my records. I understand that this request must be in writing.

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____ acknowledge that I have received, been advised and informed of Family Care of Middle TN Notice of Privacy Practices. This notice describes how Family Care of Middle Tn may disclose and use my protected health information, certain restriction on use and disclosure of my healthcare information, and rights that I have in regards to my medical information.

_____ _____

Patient or Guardian Signature Date

Family Care of Middle Tennessee

Patient Financial Policy

Thank you for choosing us as your primary care provider. Our office policy requires payment at the time of service for copayments, coinsurance, and deductibles. It is the responsibility of the patient to know their own insurance plans and know what copayment, deductible, or coinsurance is due at the time of their visit.

If you are a member of an HMO or PPO and have chosen our physicians/providers as a provider of care, it is your responsibility to:

1. Provide our office with full and accurate insurance information, including ALL insurance cards, employer information, date of birth, address, and social security number. This information is requested on the Patient Registration Form and we ask it is completed in it's entirety.
2. Pay your copayment, deductible, or coinsurance at the time of service.
3. Pay outstanding balances or set up a payment plan with our billing department. All balances, including those on a payment plan are required to be paid within a 90-day time period.
4. Pay for any services not covered by your insurance carrier, including any medical form completion such as **FMLA and DISABILITY.**
5. To fully understand your insurance benefits.

It is our responsibility to:

1. Submit your claim to the insurance provided by the patient
2. Provide your carrier with information necessary to determine the medical care you received.
3. Keep all appointments with office or cancel 24 hours in advanced. No show to appt will result in a $25 no show fee that will be your responsibility. Also, after 3 no shows in a calendar year you are subject to discharge from office.

We accept cash, most major credit cards, and personal checks. (A $35.00 fee will be added with any returned checks)

When your bill is unpaid for a period of 90 days or your payment agreement has not been followed through with, a collection agency may be chosen to handle the delinquent accounts. If your account is placed with a collection agency, you are responsible for all costs associated with the collection process. Also, be advised it is at our office discretion whether or not we continue to see you as patient if your balance is delinquent.

Thank you for allowing our providers the opportunity to provide your healthcare needs.

_____ _____

Patient Signature Date