Campbell Station Primary Care Associates

Comprehensive Health Care / Exceptional Service

Robert M. Martin, MS, CFNP
J.K. Buchanan, MD – Consultant
E. Ann Park, MS, CFNP

(865) 675-7522 PH
(865) 671-3196 FAX

Campbell Station Primary Care
11541 Kingston Pike, # 101
Knoxville, TN 37922

Family Practice ♦ Primary Care
Board Certified Family Nurse Practitioner
FED ID# 62-1864574

INFORMACION DEL PACIENTE

PLEASE PRINT

APELLIDO	PRIMER.NOMB	SEG.NOMB	FECHA

Direccion	TELEFONO FIJO	MARITAL STATUS
CIUDAD / ESTADO, CODIGO POSTAL	FECH.D.NACI	#SEG,SOCIAL

PERSONA RESPONSABLE DE PAGOS **Insurance Carrier:**
Subscriberno: SubscriberGroupNo

Pharmacy:

APELLIDO	PRI,NOMB	SEG NOMB	RELACION,CON EL PACIET

DIRECCION	CIUDAD	STADO	CDGO,POST
		TN	

#DE SEG SOCIAL .	TELENO,FIJO	BUS. PHONE	FECH.D NACIM	SEX

NOMBRE,DEL EMPLEADOR	DIRECCION ,	TELEFONO

EMERGENCIA DE CONTACTO

NOMBRE	TELEFONO	BUSINESS PHONE	RELACION

VIVE USTED CON ESTA PERSONA? .Esta. al dia con sus vacunas ?

PRESCRIPTION, REFERRAL, LABORATORY, AND DIAGNOSTIC POLICY

Con el fin de proporcionar a los pacientes un mejor servicio con la misma, Atencion deberan cumplir las siguientes Reglas

1. se regresan llamadas telefonica durante 24 horas si es una emergencia presentese a la sala de emer o llamar al l 911.
2. para una prescripcion el plazo es dentro de 48 houras – debido a la responsabilidad y el orden de su llamada
3. los resultados de laboratorios y diagnostico la mayoria de los casos estan listos en 5 dia abiles ,

TM

Please Sign indicating that you have read this policy _____________

Advantage Family Healthcare
Precall Information

Date:

Name:

We will bill your insurance if your coverage can be verified, if it cannot, payment for the visit is due at the time of service.

El valor de la consulta .son $75.00. si es necesario hacerle examenes de lab los cargos seran el minimo los examenes de laboratorio tendran el mismo valor de la visita incluyendo descuento I

Si la aseguransa . no cubre el costo de la visita y usted. no tiene el valor de la visita , estaremos en la. obligacion de cambiarle su cita *Do you have any Questions?*

Office use: Insurance Verified?

Nombre de su ultimo doctor :

Farmacia y numero de telefono:

Do you have a living Will or Durable Power of Attorney? Yes, No, or Unsure

Esta usted al dia con sus vacunas ? si o , No, Unsure

- **Print** *

Name: SS # Fe,nac: Age: Direccs: Marital Status: Telef # Email: **Insurance:** **Member #**	**medical / Specialists** medico de fami: **Martin, CFNP** Other MD'S: ____ **Other PCP**	**HISTORIAN** Who is filling out this form? Patient ☐ Spouse ☐ Child ☐ Parent ☐ Other: **Pharmacy:**

Personal Health History

☐ prob renales ☐ Hypertension ☐ hipertencion Cardiovascular e ☐ pulmonares ☐COPD, ☐Asma, ☐Emphysema ☐ ifarto ☐ Diabetes ☐ Tiroide disease ☐ Hepatitis ☐ higado or Pancreatic enfer Enferme del estom ☐ Frecuen Urinacion, Urgencia, or Accidents ☐ Cancer -> TiPo:	☐ Depression ☐ Aciedad ☐ Emocional or Psychiatrico s ☐ Victima abuso Sexual ☐ Sconstante abuso ☐ Alcohol, ☐Tobacco, or ☐ Drugs ☐ Fracturas ☐ Arthritis ☐ Frecuen dol de cabeza ☐ enf con, ojos, oidos,gargat ☐ha testado hospital por insolacion ☐ dolor en la espalda ☐ hepilectico	Any Other Problems We Have Not Mentioned: Notes:

Historia medica en el pas

Acute Health Problems:

Problemas de salud cronicos s

1.

2.

3.

4.

5.

Sirugia / Hospitalizaciones / Em cn fecha (s)

1.

2.

3.

4.

5.

6.

Familia con hist salud prob

medicos ?

madre: lviven☐ deceased ☐

padrer: viven ☐ deceased ☐

hermanos: ___

Ninos : _______

G__P__A

Social History

1. Living Arrangements:
2. Alcohol ☐ CUANTOS POR SEMANAk?
3. Tobaco ☐ CUANTOS POR DIAy?
4. RESTICIONES DE DRUG ☐

Health Maintenance:

ULT PAP/PelvicO

ULTMA MAMOG:

VACUNAS: __________Tetanus:
Other

ES ALERGICO A DROG: NKDA ☐ _______ ; _______ ;
SIYes ☐ No ☐ Provider Signature: __________________
____

ALERGICO A COMIDA s: SI ☐ No ☐ ___ ⇐FIRMA DEL PACT: __________________

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Family Practice ♦ Primary Care

Board Certified Family Nurse Practitioner

FED ID# 62-1864574

Robert M. Martin, MS, CFNP
J.K. Buchanan, MD - Consult
E. Ann Park, MS, CFNP
Knoxville Evening Clinic
11541 Kingston Pike, Ste 101
Knoxville, TN 37934
(865) 675-7522
(865) 671-3196 FAX

Autorizacion de historia medica

INFORMACION DEL PACIENTE			
APELLIDO	PRIM NOMB T	SEG NOMB	FECHA
DIRECC		HOME PHONE	
CIUDAD / STATADO	CODG POST	FECH,NECI	

ADDRESSED TO HEALTH CARE PROVIDER:			
DR.			
DIRECC	CIUDAD	STA	CODG POST
NUM TELEF	NUMER FAX		

AUTORIZACION

YO autorizo de realizar mi historia medicas (iincluyendo labs, progress notes, x-ray reports, and all correspondence) to :

Campbell Station Primary Care Associates
Advantage Family Healthcare, PLLC
Robert M. Martin, MS, CFNP

Campbell Station Primary Care ☐
11541 Kingston Pike, Ste 101
Knoxville, TN 37934
(865) 675-7522
(865) 671-3196 FAX

Advantage Family Healthcare, PLLC ☐
8406 Foxworth
Powell, TN 37849
(865) 675-7522
(865) 671-3196 FAX

firmaE: ______________________________ **fecha:**

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FINANCIAL RESPONSIBILITY

PLEASE PRINT

LAST NAME	FIRST NAME	DOB

INSURANCE INFORMATION
(Please allow us to make a copy of your insurance card)

PRIMARY INSURANCE		SECONDARY INSURANCE	
INSURANCE NAME		INSURANCE NAME	
CLAIMS ADDRESS		CLAIMS ADDRESS	
INSURANCE PHONE NO.		INSURANCE PHONE NUMBER	
ID NUMBER:		ID NUMBER	
GROUP NUMBER:		GROUP NUMBER	
SUBSCRIBER'S NAME:		SUBSCRIBER'S NAME	
SUBSCRIBER'S SS #		SUBSCRIBER'S SS #	
SUBSCRIBER DATE OF BIRTH	SEX	SUBSCRIBER DATE OF BIRTH	SEX
PATIENT'S RELATIONSHIP TO SUBSCRIBER:		PATIENT'S RELATIONSHIP TO SUBSCRIBER	
EFFECTIVE DATE		EFFECTIVE DATE	

IMPORTANT! **PLEASE READ**

The patient (or guardian) is ultimately responsible for all fees, regardless of insurance coverage or pending litigation. If you have insurance coverage, a claim will be filed, however, the patient (or guardian) is responsible for all fees. It is the patient's (or guardian's responsibility to assure that the provide is a member of your insurance plan and inform our office, prior to being seen, or if you have been scheduled with a non-provider. It is also your primary responsibility to inform our office of any needed prior authorizations.

AUTHORIZATION and ASSIGNMENT of BENEFITS

I hereby authorize Advantage Family Healthcare, PLLC, to furnish information to my insurance carrier concerning my illness and treatment and to request additional medical information from any hospital or provider who has cared for me.

I hereby assign Advantage Family Healthcare, PLLC, all payments for medical services rendered to my dependents or myself. I understand that in the event that the signee defaults or becomes delinquent on the terms of this agreement, a finance charge of 1.5% per month will be added to the balance from the date of service. Should the provider of service be required to employ an Attorney or a collection service to collect the balance, a fee of 50% shall be added to the amount due, plus any court costs and attorney fees if necessary to enforce this agreement.

Patient Signature (or guardian): ___________________________________ Date:

PATIENT CONSENT FORM

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 our health dare 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 of 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 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 taken been taken which relied on this or a 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.

Print Name: ____________________________ Signature: _____________________ Date: _______

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENT

To our Valued Patients:
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 n any way to the growing problem of improper disclosure of PHI. As par of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

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. Moreover, 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.

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

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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.

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PATIENT TESTING AFTER HEALTHCARE WORKER EXPOSURE

PLEASE PRINT

LAST NAME	FIRST	MIDDLE	DATE

POLICY

Advantage Family Healthcare and other health care workers handle blood and other body fluids for many reasons, such as when performing lab tests, inserting tubing, and cleaning equipment. It is the policy of Advantage Family Healthcare, PLLC to test a patient for Hepatitis B, Hepatitis C, and HIV (the virus that causes AIDS) if any employee or other health care worker is exposed to a patient's blood or other body fluids in such a way that transmission of these infections could occur. An example of an accidental exposure is a needle stick with a needle that has been used on you. Should an accidental exposure occur, the tests would be at no cost to you. We are requesting that you sign this consent form prior to treatment, but you are not required to do so.

AUTHORIZATION FOR TESTING

If any employee or other health care worker is exposed to my blood or body fluids, I hereby authorize Advantage Family Healthcare, PLLC to test my blood for Hepatitis B, Hepatitis C, and HIV.

______________________________ ______________________
Patient's Signature Date

______________________________ ______________________
Witness Date

I decline to authorize the above testing.

______________________________ ______________________
Patient's Signature Date

______________________________ ______________________
Witness Date

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CAMPBELL STATION PRIMARY CARE ASSOC

BILLING POLICY AND CREDIT CARD AUTHORIZATION

To decrease billing expenses for the cost of collections and to facilitate payments for our patients, your balance after insurance payment will be automatically charged to a credit or debit card. You will see a debit on your card statement from Advantage Family Healthcare, PLLC. If your insurance does make additional payments on your account creating a credit in your favor, your card will be refunded immediately.

Please be assured that we protect all of your personal information.

Patient Name: ________________________

Name as Printed on Credit Card:
____

Home Phone: _________________________ Work or Cell Phone: ____________________

Credit Card Information:
Visa _______ Mastercard ______ Discover _______ American Express _____

Billing Address for the Card

Card Number __________________________ Expiration Date: ________________
CVC Number ________

I authorize Advantage Family Healthcare to automatically bill the card listed above for any personal balance I incur after insurance payment has been made.

Signature ____________________________ Date _encdate_______

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Payment Plan Agreement

I, ____________________________ agree to pay Advantage Family Healthcare, PLLC the balance of incurred charges for my account according to the payment schedule set out below. I understand that I am responsible for all fees and agree to stated payment policies, including collection fees and/or legal fees should I default on repayment.

Name:
Advantage Family Healthcare Payment Plan:

Balance	Repayment Period to be Paid In Full by:
$ 1 - $99	3 months from date of Service
$100 - $499	6 months from date of Service
$500 and Greater	9 months from date of Service

I understand that at the time of service, I will be responsible for my co-pay, if applicable, plus 1/2 the outstanding balance or $50 whichever is less.

Name:

Patient Signature (or Guardian) ______________________________________ Date: encdate

Payment may be in the form of Cash, Check, Visa, or Mastercard paid in person or by US Mail payable to:

AFHC
Campbell Station Primary Care Associates
11541 Kingston Pike, #101
Knoxville, TN 37922

Reminders will be sent out on the 1st of each month whenever the account maintains an indebted balance. This payment plan has been made available to help you the patient continue to receive quality health care when full payment at the time of service is not financially possible. AFHC reserves the right to request payment in full should the account remain delinquent beyond the stated time periods.
Thank you for your cooperation.

Advantage

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MEDICATION HISTORY

PATIENT NAME:
PHARMACY:

Medication	Dose	Start Date	Stop Date