Faculty Internal Medicine
Patient Registration

Patient information:

NAME (last, first, middle):____ TITLE:___________

HOME ADDRESS:____

PREFERRED NAME:_________________________ SS#______-______-______ DOB:_____/_____/_____

HOME PHONE:___________________ CELL PHONE:_________________________ SEX: M____F_____

EMPLOYER/ADDRESS: ______________________________ WORK PHONE:___________________

WHOM MAY WE THANK FOR THIS REFERRAL? ____
****

PRIMARY Insurance: ____
(Please provide your insurance card to our front office staff to be copied.)

Policyholder Name:____________________________________ Relationship to Patient: ______________

Policyholder Address: ____

Employer:____ DOB:________/________/__________
****

SECONDARY Insurance: ____
(Please provide your insurance card to our front office staff to be copied.)

Policyholder Name :_________________________________ Relationship to Patient: ________________

Policyholder Address:____

Employer: ____ DOB:________/________/__________
****

Emergency Contact Information:

Name: _________________________ Relationship to Patient: ____________ Phone #: ______________
****

Tennessee Law requires that we ask, **"Do you have a Living Will"?** ___ Yes ___ No
If yes, please provide our office a copy of your Living Will for our records.
If no, do you want information on a Living Will: ___ Yes ___ No

Signature Verifying Accuracy of Information: ____________________________ Date: ______________________

Financial Policy

Please note that all insurance providers have different coverage and benefit levels depending on what you have chosen to purchase or what your employer has chosen for you. Some plans require that you pay a deductible for labs and diagnostic testing in addition to your visit copay. You should check with your insurance provider to see what your plan covers and what you will be responsible to pay for labs, x-rays and other diagnostic tests. We use an outside reference lab (Labcorp) for labs that we do not perform here in our office. They are participating on most plans, however, you may be billed by them for any balance not covered by your insurance.

We participate with most insurance plans. If you are an HMO patient, you must choose one of our doctors for your primary care physician. This can be done by calling your insurance company and having them list our physician as the PCP. You will be responsible for the visit if we are not listed as the PCP with your plan.

As a courtesy, we will submit your claim for all services to your insurance company. Please remember your individual health insurance policy is a contract between you and your insurance company and we are not a party to that contract. Be aware that some of your services may not be covered by your insurance policy. By presenting for care, you agree that you are responsible for all services and charges regardless of your insurance status. Should any provided services not be covered by your insurance, we will not alter your claim, change your diagnosis, or report a different service than what was performed in order that your insurance will cover the charge. You will be responsible for the balance.

All balances including deductibles and copays are due at the time of service. We file your insurance and then any balances that are due by you must be paid within 30 days unless prior arrangements are made with the billing office. If you have a billing or insurance question, please contact our billing office (865) 288-1541 and they will be happy to assist you. We ask patients to refrain from discussing billing questions with the physicians as they devote their time and expertise to your health care and cannot answer billing questions.

Additional Practice Related Fees:

- $25.00 Fee = Request to complete Life, Disability, FMLA, & various other types of independent health forms.
- $30.00 Fee = Returned checks for non-sufficient funds will have a processing fee that will be charged back to the patient. We will be unable to accept any personal checks after the first occurrence.
- $25.00 Fee = After hour phone calls to the physician may be charged a fee.

By signing below, I acknowledge and understand the Financial Policy of Faculty Internal Medicine and accept all payment terms under this Policy as well as my responsibilities as a patient to know and understand my health insurance benefits for services provided.

______________________________	________________________
Signature of Patient or Guardian	Date
______________________________	________________________
Patient Name (Print)	Date of Birth