Date _____

11509 Hardin Valley Rd
Knoxville, TN 37932

Primary Care of Tennesse
Patient Registration Form

Patient Information

First Name _____ MI ___ Last Name _____ M☐ F☐

DOB _____ SSN _____ Marital Status ☐ Single ☐ Married ☐ Widow ☐ Divorced ☐ Separated

Address/Apt # _____

City _____ State _____ Zip _____

Home No. Cell No. Email Address:

Emergency Contact

First Name _____ Last Name _____ Relationship _____

Address _____

City _____ State _____ Zip _____

Ph No. 1 Ph No. 2

Employer Information

Employer Name _____

Employer Address _____

City State: Zip Phone No.

Insurance Information

Primary Insurance Name _____

Name of Policy Holder _____ DOB (if not self) _____

Relationship to Patient _____ SSN (if not self) _____

Patient's Policy ID No. _____ Policy Start Date _____

Secondary Insurance information

Secondary Insurance Name (if applicable): _____

Name of Policy Holder _____ DOB (if not self) _____

Relationship to Patient _____

Patient's Policy ID No. Policy Start Date

Pharmacy Information

Pharmacy Name _____

Address _____

City _____ State _____ Zip _____

Phone # _____ Fax # _____

PERSONAL EMAIL (if you want access to your online medical record): _____

Mail Order Pharmacy Name: (if applicable): _____

Address _____

City: _____ State _____ Zip _____

Ph No. Fax No.

Authorization Information

Race: (circle): American Indian/Alaskan Native, Asian, Black/African American, Native Hawaiian/other Pacific Islander

Ethnicity: (circle): Hispanic or Latino, White

Language: (circle): English, Spanish, Other:_____

I hereby assign to **Primary Care of TN** any insurance or other third-party benefits available for health care services provided to me. I also understand that if benefits are assigned, or if by contractual arrangement, payment to the practice will be made by my insurance, that I am responsible for any co-payments and deductibles and that these amounts are due at the time services are rendered. I also understand that in the event that services rendered are not covered by my "insurance," I will accept financial responsibility for all services provided to me. If benefits are not assigned to this practice, I agree to forward to the practice, all "insurance" payments that I received for the services rendered to me immediately upon receipt and/or to make payment, in full, for the services rendered to me(depending upon the agreement) at this time.

Signature of Patient/Legal Guardian: Date:

RELEASE OF INFORMATION

I authorize the release of any medical or other information as is necessary to process this claim based upon the "HIPAA Notice of Privacy Practices" information provided to me under separate cover. This information is on file as a permanent record and may be amended as is necessary.

Signature of Patient/Legal Guardian: Date

*ADVANCED DIRECTIVE? ☐YES ☐NO Consent to Telehealth/Telemedicine ☐YES ☐NO

Telehealth/Telemedicine Consent Form

By signing this form, I understand and agree with the following:

Telehealth/Telemedicine involves the use of electronic communications to enable healthcare providers at different locations to share individual patient medical information to improve patient care. Providers may include primary care practitioners, specialists and/or subspecialists, nurse practitioners, registered nurses, medical assistants, and other healthcare providers who are part of my clinical care team. In addition to myself and the members of my clinical care team, my family members, caregivers, or other legal representatives or guardians may join and participate in the telehealth/telemedicine service, and I agree to share my personal information with such family members, caregivers, legal representatives or guardians. The information may be used for diagnosis, therapy, follow-up, and/or education.

Telehealth/Telemedicine requires transmission, via the Internet or telecommunication device, of health information, which may include:

- Progress reports, assessments, or other intervention-related documents
- Bio-physiological data transmitted electronically
- Videos, pictures, text messages, audio, and any digital form of data

The laws that protect the privacy and confidentiality of health and care information also apply to telehealth/telemedicine. Information obtained during telehealth/telemedicine that identifies me will not be given to anyone without my consent except for the purposes of treatment, education, billing, and healthcare operations. By agreeing to use the telehealth/telemedicine services, I consent to Primary Care of Tennessee's sharing of my protected health information with certain third parties as more fully described in [NAME] Privacy Policy. I understand, agree, and expressly consent to Primary Care of Tennessee obtaining, using, storing, and disseminating to necessary third parties. information about me, including my image, as necessary to provide telehealth/telemedicine services.

As with any Internet-based communication, I understand there is a security breach risk. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data. They will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Individuals other than my clinical care team or consulting providers may also be present and have access to any information for the telehealth/telemedicine session. This is so they can operate or repair the video or audio equipment used. These persons will adhere to applicable privacy and security policies.

Telehealth/telemedicine sessions may not always be possible. Disruptions of signals or problems with the Internet's infrastructure may cause broadcast and reception problems (e.g., poor picture or sound quality, dropped connections, audio interference) that prevent effective interaction between consulting clinician(s), participant, patient, or care team.

I hereby release and hold harmless INAMEI and all members of my care team from any loss of data or information due to technical failures associated with the telehealth/telemedicine service.

I understand and agree that the health information I provide at the time of my Telehealth/Telemedicine service may be the only source of health information used by the medical professionals during the course of my evaluation and treatment at the time of my telehealth/telemedicine visit, and that such professionals may not have access to any full medical record or information held at Primary Care of Tennessee.

I understand that I will be given information about test(s), treatment (s), and procedures(s), as applicable. including the benefits. risks. possible problems or complications. and alternate choices for my medical care through the telehealth/telemedicine visit.

I have the right to or withdraw consent to the use of telehealth/telemedicine services at any time and return to traditional in-person clinic services. I understand that if I withdraw my consent for telehealth/telemedicine. it will not affect any future services or care benefits to which I am entitled.

All my questions have been answered to my satisfaction.

I hereby consent to the use of telehealth/telemedicine in the provision of care and the above terms and conditions.

By signing below, I certify that I am the legal representative of the participant or that I am the patient and am 1 8 years of age or older or otherwise legally authorized to consent. I have carefully read and understand the above statements. I have had all my questions answered. I understand that this informed consent will become a part of the Medical record.

Signature of Patient or Patient's Legal Representative Date and Time

Printed Name of Patient or Patient's Legal Representative Relationship to the Patient

INTERPRETER'S ATTESTATION (if applicable):
I certify that I am fluent in the language of the person providing consent. I certify that I have accurately and completely interpreted the contents of this form and that the person giving consent has indicated their understanding of the contents.

Signature of Interpreter Date and Time

Primary Care of Tennessee

11509 Hardin Valley Rd.
Knoxville, TN 37932
Office (865) 200-4101 Fax (865) 200-4039
Diane B. Knights, FNP-BC

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Please fill in each section in its entirety. You must have the full address for the facilities listed, please do not submit this form if you are unable to complete it fully.

Patients Name:_____

Social Security Number:_____

Date of Birth:_____

Physician to PROVIDE records, include name and address:

_____

_____

_____

_____

Facility to RECEIVE records, include name and address:
Primary Care of Tennessee
11509 Hardin Valley Rd.
Knoxville, TN 37932

This request and authorization applies to:

☐ **All healthcare information, including office notes, labs, radiology reports, emergency room**

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

I understand that: I may inspect or copy the protected health information to be used or disclosed. I may receive this authorization in writing by contacting your office at the above address. I understand, unless limited below, this release also pertains to records whose confidentiality is protected by either Federal Regulations (42 CFR part 2) or State Law (IC 16-39-2) concerning hospitalization or treatment, including but not limited to, information regarding alcohol abuse, substance abuse, communicable disease documentation, human immunodeficiency virus (HIV), or mental health treatment or counseling.

Attention Privacy Officer: Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPPA. I may refuse to sign this authorization and that you will not condition treatment or research-related treatment, in which case you may refuse to provide that research-related treatment.

Signature_____ Date_____

Primary Care of Tennessee

11509 Hardin Valley Rd.
Knoxville, TN 37932
Office (865) 200-4101 Fax (865) 200-4039
Diane B. Knights, FNP-BC

Phone and Medical Information Contact(s)

Our facility requires you to have a working phone number that we may leave a message on if you do not answer. This phone must have a voicemail or answering machine and must be private enough that sensitive information may be relayed on it. **You may list contact(s) below that you would like for us to speak to on your behalf about your medical information if you cannot be reached or are unable to speak on the phone due to medical impairments or other reasons.** If we call your home and someone other than you or the contacts you list below answers, the only information we will leave is our name, the facility name and our phone number and a message for you to return our call.

We can contact the following person(s) in your behalf about your medical information

Name of Person_____
Phone Number_____
Relationship:_____

Name of Person_____
Phone Number_____
Relationship:_____

You have been made aware of the following notices are available to you – Notice of the Privacy Practices of Protected Health Information and the Notice of Financial Policy. If you would like to take a copy home with you please ask us.

I understand the above phone numbers and answering machines/voicemails WILL be used to leave potentially sensitive medical information and will possibly be used to leave messages concerning results of other medical treatment. I hereby give the above facility consent for the use of these number(s) to call and leave messages concerning all of the above mentioned information. I also give my consent for the above facility to leave my medical information with the names I have listed above.

Signature_____ Date_____

Save Form Print Form Email Form