**Middle Tennessee Family Medicine (MTFM)**

Preferred Name/Nick Name _____

NAME First_____Middle_____Last_____Suffix_____

Social Security # _____ Date of Birth _____ Gender: ☐Female ☐Male

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Street: _____ Apt/Suite _____

City: _____ State _____ Zip Code _____

*Response to this section is optional, but requested by Insurance Companies* ____ Patient/Representative Refused to answer
**Race**: ___ American Indian or Alaskan Native ____Caucasian ___ Hispanic ___ Black or African American ___Asian ___Native Hawaiian or Other Pacific Islander ___Other
**Ethnicity**: ___Hispanic or Latino ___Not Hispanic or Latino
**Language**: ___English ___Spanish ___Korean ___ Japanese ___Laotian ___Indian ___Russian ___Other

**Contact Information**

Home Phone: _____ Cell: _____ Work: _____ ext.:_____

Email_____ (In providing Email - you agree to participate with our secure on-line patient portal)

Preference for appointment reminders: ☐ Home ☐Cell ☐Work ☐Text Msg (cell only) ☐Voice Message

Preferred time to receive voice message: _____Morning (8-12) _____Afternoon (12-5) _____Evening (6-8)

Can we leave x-ray and/or laboratory information on your Cell Phone or Home Phone? ___Yes ___No

**Release of Information Authorization & HIPAA Notification**

I hereby authorize MTFM health care providers, their agents or affiliates, by signing this form, to release such patient-identifiable medical information (which may include drug/alcohol abuse, HIV status or psychiatric treatment) to my insurance companies and managed care organizations, TennCare, Medicaid, and other federal programs as necessary to perform administrative functions and to bill for and verify my treatment.

I Authorize MTFM, its employee my physicians and other providers to release to the Social Security Administration or its intermediaries any information needed for processing any Medicare claim.

I authorize disclosures and communications, including general medical condition, plan, treatment or payment with: ___Pharmacies ___Referring Specialists ___Hospital Staff and ____ Family members listed:

1._____
Name Phone Number Relationship

2._____
Name Phone Number Relationship

3._____
Name Phone Number Relationship

Emergency Contact: _____
Name Phone Number Relationship

I authorize the above named person to be my emergency contact. In the event of a medical emergency situation, this person may receive my PHI (protected Health Information) related to the emergency for which they were contacted.

I have received a copy of my rights under HIPAA (Health Information Portability and Accountability Act) or have been given access to a copy of such. **(Copies of the privacy notice are available at the front desk. Please feel free request one.)** ____Initial

I may revoke this authorization at any time by notifying MTFM in writing. If I do not revoke it earlier, my authorization will expire twelve months after the date I signed this form. _____Initial

**Assignment of Benefits**

I hereby authorize and request all insurance carriers, HMOs or managed care organizations with which I have coverage, including, if applicable, Medicare and Medicaid, to pay directly to MTFM any and all benefits due under the terms of my policy for services provided by MTFM, including any settlements or judgments for such services. If my health insurance will not allow direct payment MTFM, I agree to immediately forward to MTFM all health insurance payments I receive for my care and treatment at MTFM. ** Due to our office policy, we do not file tertiary insurance. ____Initial

**Advance Directive / Living Will/ POA**

I have an advance directive such as a living will or durable power of attorney for my healthcare in the event I am unable to make my own medical decisions? ____Yes ____No -If yes, please provide copy for your chart-

**Agreement to Pay**

I acknowledge and agree that I am financially responsible and will pay for any deductible or co-payment for all services and treatment provided to me, including any amount not paid by my insurance plan, to the extent legally permissible, at time of service.

I understand that I am responsible for any non-covered Medicare services, deductibles and co-insurance.

I hereby agree that if MTFM or its agents has agreed to bill my insurance, MTFM has agreed to do as a courtesy, and that MTFM has the right, should MTFM deem it advisable, to demand payment in full from me at any time prior to full payment from any insurance company, unless MTFM and my insurance company have agreed that I will not be billed.

I hereby acknowledge having been told that I may be billed by MTFM and that this payment agreement shall cover any and all providers and outpatient accounts. If a delinquent account is referred for collection, I agree to pay reasonable attorney's fees, court cost and/or collection agency fees associated with the collection process.

I understand that there is a $39.00 returned check charge fee.

I have read this agreement or have had it read to me. The information which I have provided is accurate, by voluntarily signing this agreement, I accept and agree to comply with its terms.

_____ _____ _____

Name of Patient (Print) Signature of Patient or Guardian (If Minor) Date