the *Urology* clinic

A member of the HMG Family of Care

Your Urology Health History

Appointment Date: _____

Name: _____ Birth date: _____
Height: _____ Weight: _____
Primary Care Physician: _____ Pharmacy: _____
Why are you seeing the Urologist today? _____

List all allergies:

_____ _____ _____
_____ _____ _____

List all medications/vitamins and dosages:
Please remember to bring the actual bottles with you.

_____ _____ _____
_____ _____ _____
_____ _____ _____

List all previous surgeries:

_____ _____ _____
_____ _____ _____

Have you ever had a colonoscopy? _____ If yes, when? _____
Have you had a pneumonia vaccine? _____ If yes, when? _____

List all medical problems:

_____ _____ _____
_____ _____ _____

List all medical problems that run in your family and your relation to them:

_____ _____ _____
_____ _____ _____
_____ _____ _____

Does anyone in your family have prostate cancer? _____, If yes, who? _____

Do you smoke? _____ Do you use smokeless tobacco? _____ E cigarette? _____
How much? _____ Did you quit? _____ When? _____
How long did you smoke or use smokeless tobacco? _____

How much caffeine do you use per day? _____
Do you drink alcohol? ____ How much per week? _____ For how long? _____
Do you use recreational drugs? _____ If yes, what type _____

What is your occupation: _____?
What ethnicity are you? Caucasian African American Hispanic Other

Are you <u>currently</u> experiencing any of the following symptoms? (Circle all that apply):

Kidney stones	Urinary tract infections	Blood in urine	Painful urination
Fever	Chills	Blurry vision	Double vision
Nasal stuffiness	Sore throat	Chest pain	Swelling
Shortness of breath	Wheezing	Back pain	Bone pain
Rash	Itching	Numbness	Dizziness
Swollen glands	Abnormal bleeding	Nausea/vomiting	Abdominal pain
Blood in your stool			

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Welcome to our office

Where did you hear about us?
Yellow Pages (YP) Newspaper (NP) Website (WS)
Friend or Family (FF) Physician Referral (PR)
Other (OT) _____

OFFICE USE ONLY
Physician: _____
Approved by: _____
Date: _____

NEW PATIENT INFORMATION (Complete if different from billing party)

Name _____
First Middle Last

Address _____

City _____ State _____ Country _____ Zip _____ Phone # ( ) _____

Birthdate _____ Sex M or F Race _____ Marital Status S M W D

Social Security # _____ Employer _____

Address of Employer _____ Work Phone # _____

May we contact you at work? Y N By E-Mail Y N E-Mail Address _____

Emergency Contact Name _____ Emerg. Phone # ( ) _____

Relationship to billing party _____

Guarantor/Responsible Party

Name _____
First Middle Last

Address _____

City _____ State _____ Zip _____ Phone # _____

Birthdate _____ Sex M or F Marital Status S M W D

Social Security # _____ Driver's License # _____

Place of employment _____ Work Phone # _____

OTHER INFORMATION

Name and address of nearest relative not living with you _____

Address _____ City _____ State _____ Zip _____ Phone # _____

If you are currently under another physician's care, please list:

Name _____

Address _____ City _____ State _____ Zip _____

Whom may we thank for referring you to us ? _____

INSURANCE

1. Primary Insurance Company Name _____

Group # _____ Policy Member # _____

Subscriber Name _____ Subscriber Birthdate _____ Sex M or F Social Security # _____

Subscriber Employer and Address _____

2. Secondary/Supplemental Insurance Name _____

Group # _____ Policy/Member # _____

Subscriber Name _____ Subscriber Birthdate _____ Sex M or F Social Security # _____

Subscriber Employer and Address _____

Please note whomever brings a child in to be seen is responsible for payment at time of service unless prior arrangements have been made.
It is the custodial parent's responsibility to arrange reimbursement from a non-custodial parent.
By signing below I hereby give my consent for Holston Medical Group to treat my minor child, under 18 years of age

INSURANCE AUTHORIZATION AND ASSIGNMENT:

I understand that I am financially responsible for any medical service at time of service. I authorize my insurance carrier to pay to Holston Medical Group any assigned claims filed by them and authorization for release of medical information requested by my insurance company. For Medicare beneficiaries: I request payment of authorized Medigap benefits be made to me or on my behalf to Holston Medical Group and medical information about me to be released to my Medigap insurer.

Date _____ Signature _____

FINANCIAL POLICY

Holston Medical Group believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to have an understanding of our financial policy.

1. **PAYMENT** is expected at the time of your visit. Just as we make every effort to accommodate you when you are in need of medical care, we expect that you will make every effort to pay your bill promptly. Payment is due at the time services are provided or upon receipt of a statement from our billing office. ***We will accept cash, check, debit, credit or health savings accounts***. You may also make a payment online through our patient portal, ***myHMG***.

   Payment will include any unmet deductible, co-insurance, co-payment amount or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause payment in full is expected at the time of your visit. For visits under a "global" or a follow up trauma visit (from a procedure performed by an HMG physician) or for ongoing rehabilitation treatment plans, you will only be responsible for your co-payment if applicable based on your insurance. We do ask for a ***copy of your current insurance card*** at the time of your visit to ensure we properly file your claim.

2. **SURGERY PATIENTS:** You may be responsible or required to pay a percentage of surgery charges prior to any surgeries or procedures. This will be determined by information given to us by your insurance company in regard to patient percent responsibility.

3. **INSURANCE:** We participate with several insurance plans and will file your claims on your behalf. It is your responsibility to ensure coverage for services prior to your visit. You will be responsible for the complete charges for any non-covered services provided. In addition, all co-payments, deductibles or non-covered charges will be due at the time of service.You must provide proof of insurance at each visit so we can ensure proper billing to your benefit plan. If there is an overpayment on your account, we will refund any overpayment to you after overpayment credit is applied to any outstanding account balance(s). We do not bill third party payors, but will be happy to provide a copy of the original claim if requested.

4. **HIGH-DEDUCTIBLE PLANS:** Under these plans, your insurance company will provide you a discount off our billed charges, but you are responsible for the entire amount due until you meet your deductible. ***We will accept cash, check, debit, credit or you may use your health savings account***.

5. **RETURNED CHECKS** will incur a service charge which may vary from time to time as determined by our financial institution.

6. **ACCOUNTING PRINCIPLES:** If there is an overpayment on your account, we will refund any overpayment to you after overpayment credit is applied to any outstanding account balance (s). Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding date of service

7. **FORMS FEES:** Medical records, except those involving worker's compensation cases, will be billed at the rate of $25.00.

8. **MISSED APPOINTMENTS:** If you fail to cancel a previously scheduled appointment at least 24 hours in advance, you may be charged a fee as outlined below:

- Established office visit: $25
- New patient visit or consultation: $50
- Procedure visit: $100

This charge cannot be billed to the insurance company. Failure to pay a no-show fee will be treated according to our policy on unpaid balances, with the exception of collection accounts. This charge is not applicable to patients with Medicaid/TennCare insurance coverage.

After 2 no-show appointments in a rolling calendar year, you may be discharged from the practice, at the discretion of the responsible provider and management. Medical care will not be withheld for a medical emergency for thirty days from date of dismissal.

9. **UNPAID BALANCES:** All outstanding balances shall be due within 30 days of the date of service. At that time, all past due balances in their entirety must be paid prior to the time of your next visit. Balances that remain outstanding for a period of 90 days or more may be referred to a collection agency and could affect your credit.

10. **FINANCIAL DISMISSAL**: Patients who do not make payment arrangements risk being dismissed from the practice. Holston Medical Group reserves the right to dismiss patients for delinquent financial accounts on personal balances. If dismissed, medical care will not be withheld for a medical emergency for thirty days from date of dismissal.

11. **BILLING QUESTIONS:** We will be happy to help you resolve your balance and can be reached at **(423) 578-1802, Monday – Friday 8:00AM – 5:00PM.**

FINANCIAL POLICY

MRN#: _____

Date Received: _____

Holston Medical Group believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to have an understanding of our financial policy.

I have read, understand and agree to the Financial Policy as provided to me. I understand that charges not covered by my insurance company, as well as applicable co-payments, deductibles and any charges older than 30 days from the date of service are my responsibility.

I authorize Holston Medical Group to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim. I authorize my insurance benefits be paid directly to Holston Medical Group.

By signing below, I indicate my agreement with the policy as provided to me.

_____	_____	_____
Date	**Signature**	**Printed Name**

Holston Medical Group complies with applicable Federal civil laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Holston Medical Group does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Attention: If you need language or translation services, please ask to speak with the Office Manager.

La atención: Si usted necesita servicios de idiomas o traducción, pida hablar con el Gerente de la oficina.

انتباه :إذا كنت بحاجة إلى خدمات اللغة أو الترجمة، يرجى أن تطلب التحدث مع مدير مكتب.

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NO SHOW POLICY

Welcome to Holston Medical Group. Please take time to review the following information pertaining to our policy for no show appointments.

We understand that scheduling conflicts occur from time to time. However, we request at least 24 hours advance notice if you are unable to keep your scheduled appointment(s). Two or more missed appointments may result in your family being dismissed from Holston Medical Group. Patients that fail to show up for a scheduled appointment may be charged a fee for not providing the office with prior notice of cancellation.

Holston Medical Group physicians have developed our No Show policy in an effort to better serve our patients by providing same day appointments to those who are sick and need to be seen. If someone schedules an appointment and does not show for the visit, we have lost an available time that could have been used for a sick patient.

We look forward to providing your health care needs. Your understanding and cooperation helps us to provide available appointments for patients who urgently need them.

Please sign below as confirmation that you have read, acknowledge and understand our policy regarding no show appointments.

Please Print Patient Name	Date of Birth	Account Number

Please Sign Authorized Representative	Relationship to Patient

Witness	Date

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Seasons

MRN: _____

Date Received: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have reviewed and/or received a copy of the *Notice of Privacy Practices,* which provides a more complete description of how my protected health information (PHI) may be used or disclosed. I understand that Holston Medical Group (HMG) reserves the right to change their notice and information practices and that I may view a copy of the current *Notice* on HMG's website, www.holstonmedicalgroup.com/hipaa, in any of their offices, or by a request in writing.

I also understand that Holston Medical Group participates in the OnePartner Health Information Exchange (OnePartner HIE) and may make my medical information available electronically or may electronically transmit my medical information to a third party, in order to fulfill provider obligations to release my medical information in the future.

_____ _____

Print Patient Name | Patient Date of Birth

_____ _____

Patient Signature (if applicable) | Date

_____ _____

Authorized Representative Signature | Relationship to Patient

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I understand that my Protected Health Information (PHI) will only be <u>verbally</u> communicated to those individuals listed below and no paper copies of my PHI will be provided without my signature on an *Authorization for Release of Individually Identifiable Health Information* form. I understand that some information may be considered sensitive, including but not limited to pregnancy test results, testing for sexually transmitted infections, Urine Drug Screen results, laboratory test results, medication, or information discussed during an office visit. The individuals listed below, will be required to provide the last four (4) digits of my Social Security Number, along with my date-of-birth, before any information will be discussed with them.

List the individual(s) that you want protected health information verbally discussed with:

Name	Phone Number	Name	Phone Number

FOR INTERNAL USE ONLY:

Reason Acknowledgement Could Not Be Obtained: _____

_____ _____

Employee Signature | Date

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Atención: Si necesita servicios de idioma o traducción, solicite hablar con el Gerente de Oficina

نبيه: إذا كنت بحاجة إلى خدمات اللغة أو الترجمة، فيرجى طلب التحدث مع مدير المكتب

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Patient: _____

MRN: _____

Communicating with Your Specialist

Access to Your Physician and Staff

Your Holston Medical Group (HMG) health care team can be reached either by telephone or electronically through our patient portal, FollowMyHealth®. If you wish to communicate electronically, you may sign up at any office location on our website at your convenience. Please remember, electronic communication is for routine matters and never should be used for emergencies.

It **is not** appropriate to communicate with your health care team through social media, such as **Facebook**, or **texting**. Your privacy is important to us and these are not secure methods of communication. Any questions or concerns should be directed to the patient portal or office during normal business hours.

After Hours Care

HMG is dedicated to serving our patients 24 hours a day, 7 days a week. The most effective way to serve you is during regular clinic hours, but we understand acute illnesses can occur at any time. Your Primary Care Provider's telephone message will direct you on how to contact the HMG Physician on Call.

HMG Urgent Care

Please use the Emergency Room only in a true emergency (i.e. chest pain, shortness of breath, stroke-like symptoms).

To avoid long wait times in the ER, come to our Urgent Care clinics for routine health concerns such as colds, ear aches, flu symptoms, sprains and strains, etc. We have two locations conveniently located in Bristol and Kingsport. For hours and specific information call (423) 230-2420 (Kingsport) or (423) 990-2466 (Bristol).

Prescription Refills

To avoid delays and busy phone lines, the best time to obtain your medication refills is at your office visit. While we realize there may be a need to request a refill via telephone or patient portal, please allow at least 48 hours for all refill request before checking with your pharmacy.

Sample medication will only be distributed during normal business hours.

Monthly refills of any controlled medications (pain medication, anxiety, etc) will only be given during an office visit within regular business hours.

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

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