Healthstar Physicians, P.C.
Welcome to Our Office!

Where did you hear about us?

☐ Yellow Pages ☐ Newspaper ☐ Website
☐ Family or Friend ☐ Physician Referral
☐ Other _____

OFFICE USE ONLY

Physician_____
Approved By _____
Date _____

Identification

Name _____
Last First Middle

Previous Name _____ Legal Sex ☐ Male ☐ Female

Birthdate _____Social Security# _____ Usual Provider _____

Contact Information

Address _____

City _____ State _____ Zip _____ Country _____ Driver's License # _____

Home Phone# (_____)_____ Mobile Phone# (_____)_____

Work Phone# (_____)_____Patient Email _____

Emergency Contact

Name _____ Relationship _____

Home Phone# (_____)_____ Mobile Phone# (_____)_____

Demographics

Language ☐ English ☐ Spanish ☐ Other Race _____ Ethnicity _____

Marital Status ☐S ☐M ☐W ☐D Gender Identity _____ Preferred Pharmacy _____

Guarantor/Responsible Party

Name _____
First Middle Last
Address _____

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

Birthdate _____ Social Security# _____ Sex ☐ Male ☐ Female

Place of Employment _____ Work Phone# (_____) _____

Relationship to patient _____

Insurance Information

Primary Insurance Company Name _____

Subscriber Name _____ Group # _____ Policy # _____

Birthdate _____ Social Security# _____ Sex ☐ Male ☐ Female

Subscriber Employer and Address _____

Secondary Insurance Company Name _____

Subscriber Name _____ Group # _____ Policy # _____

Birthdate _____ Social Security# _____ Sex ☐ Male ☐ Female

Subscriber Employer and Address _____

Patient Name: _____
Date of Birth: _____

Other Information

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

Address _____

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

Whom may we thank for referring you to us? _____

Employer _____

Address of Employer _____ Work Phone# (_____) _____

Minor/Parental Consent

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 Healthstar Physicians, P.C. to treat my minor child, under 18 years of age.

Signature_____ Date _____

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 Healthstar Physicians, P.C. 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 Healthstar Physicians, P.C. and medical information about me to be released to my Medigap insurer.

Signature_____ Date _____

Authorizations

I, hereby authorize the following individuals, other than myself, to receive information regarding my healthcare, lab/diagnostic results, appointments and/or billing and collections. These individuals will be required to provide at least one of the following before any information will be discussed with them: last four (4) digits of my SSN#, my date of birth or my address.

_____	_____	_____
Name	Relationship	Phone
_____	_____	_____
Name	Relationship	Phone

Signature_____ Date _____

Authorizations

Please initial acknowledgement of the following authorizations:

_____ I authorize Healthstar Physicians, P.C. to submit a blood sample of HIV and HBV testing as deemed necessary by my physician.

_____ I authorize Healthstar Physicians, P.C. or any agents thereof, to notify me by telephone, answering machine, mail, voicemail, etc. regarding appointments, lab/diagnostics, billing and collection information.

_____ I authorize Healthstar Physicians, P.C. to download my prescription history from Surescripts/RxHub and CSMD. I understand the prescription history will solely be used for medical purposes.

_____ I authorize Healthstar Physicians, P.C. to download my immunization history from TennIIS, the Tennessee Immunization Information System. I understand the immunization history will solely be used for medical purposes.

_____ I consent to receive calls, emails and/or text from Healthstar Physicians, P.C. for my protected healthcare and other services at the phone numbers provided, including my wireless number. I understand I may be charged for any such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

No-Show Policy

Welcome to Healthstar Physicians, P.C… 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 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 Healthstar Physicians, P.C. A $25 fee may be incurred after the second missed appointment for not providing the office with prior notice of cancellation.

Healthstar Physicians, P.C. 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 help's 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

_____ _____

Signature of Patient or Authorized Representative | Relationship

_____ _____

Witness | Date

HEALTHSTAR PHYSICIANS, P.C. www.HealthStarTN.org

Financial Policy

Healthstar Physicians, P.C. 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.

   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. 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. 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 discounted amount due until you meet your deductible. ***We will accept cash, check, debit, credit*** *or* ***you may use your health savings account.***

5. **SELF-PAY:** Patients with no insurance will be asked for a $100-$500 deposit, depending on specialty, prior to the visit. At check-out the patient will be asked to pay the rest of the charges generated during the visit or will receive the difference back if total visit charges are less than the deposit amount.

6. **MOTOR VEHICLE ACCIDENTS**: MVA's and legal issues will be treated as self-pay visits**.**

7. **RETURNED CHECKS** will incur a service charge currently set at $30, which may vary from time to time as determined by our financial institution.

8. **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 other than copays are applied to the oldest charges first, except for insurance payments which are applied to the corresponding date of service.

9. **FORMS FEES:** Fees are to be paid when form is completed/picked up. Rates are as follows:

   DURING an office visit: No Charge

   AFTER an office visit: $5 / Simple form

   Examples of Simple Forms: Handicap tag/sticker, concussion clearance, WIC, Home Bound Status Short form, Bank Loan

   College & Camp Form.

   Complex Forms: $25 (completed within 10 business days)

   Examples of Complex Forms: Short Term Disability form, Long Term Disability form, FMLA paperwork

Financial Policy (Continued)

10. **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:

    - $25 after the second missed appointment.

    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. This charge is not applicable to patients with Medicaid/TennCare insurance coverage.
    After 3 no-show appointments in a 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.

11. **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 120 days or more may be referred to a collection agency and could affect your credit.

12. **FINANCIAL DISMISSAL:** Patients who do not make payment arrangements risk being dismissed from the practice. Healthstar Physicians, P.C. 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. If dismissed by one Healthstar provider due to a delinquent financial account, patient may not be able to establish with any other Healthstar provider.

13. **BILLING QUESTIONS:** We will be happy to help you resolve your balance and can be reached at **(423) 581-7177, Monday - Friday 8:00AM - 5:00PM**

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 Healthstar Physicians, P.C. 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 Healthstar Physicians, P.C.

I understand and acknowledge that I am financially responsible for services rendered by Healthstar Physicians, P.C. I agree to pay all reasonable attorney fees and court cost in the event of default on my account.

Signature_____ Date _____

Printed Name_____ Date of Birth _____

Patient Name: _____
Date of Birth: _____

Acknowledgement of Receipt of Notice of Privacy Practices & Patient Rights

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

I also understand that Healthstar Physicians, P.C. 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

_____	_____	_____
Please Print Patient Name	Date of Birth	Account Number
_____	_____	
Signature of Patient or Authorized Representative	Relationship	

Communicating with Your Healthstar Physician

Access to Your Physician and Staff

Your Healthstar Physicians, P.C. health care team can be reached either by telephone or electronically through our patient portal. 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 any provider or staff members personal number. 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

Healthstar Physicians, P.C. 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. Please contact your Primary Care Provider's office for after-hours instructions.

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 After-Hours clinics for routine health concerns such as colds, earaches, flu symptoms, sprains and strains, etc. We have three locations conveniently located in Morristown, Dandridge and Newport. For hours and specific information call Morristown - (423) 586-2410, Dandridge - (865) 475-6161 or Newport - (423) 623-6240.

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 _____

Adult Medical History

Patient Name: _____
Date of Birth: _____

Name: _____ Date of Birth: _____ Today's Date: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated Referred by: _____

Occupation or Job _____ Number of people in household _____

Chief Complaint/ Reason for visit: _____
General state of health? ☐ Excellent ☐ Good ☐Fair ☐ Poor

Have there been any changes to your health in the last year? ☐ Yes ☐ No

Your last physical examination was on: _____

Are you now under the care of a physician? ☐ Yes ☐ No

If so, what condition is being treated? _____

Is this visit a result of an injury? ☐ Yes ☐ No Did the injury occur at work? ☐ Yes ☐ No Date of Injury _____

Have you had any of the following related to the injury? ☐ Cast ☐ Cortisone Shots ☐ Physical Therapy ☐ Surgery ☐ Other

Do you have any environmental risk or exposures? ☐ Asbestos ☐ Chemicals ☐ Excessive Noise ☐ Radiation ☐ Other

Please mark any of the following that apply to you:

☐ Abnormal Bleeding
☐ Acid Reflux/GERD
☐ Amputations
☐ Anemia
☐ Angina/Chest Pain
☐ Angioplasty/Pacemaker
☐ Angioplasty Pacemaker
☐ Arthritis
☐ Birth Defects
☐ Cancer
☐ Chemotherapy/Radiation
☐ Circulatory Problems
☐ Congenital Heart Defects
☐ Coronary Artery Disease
☐ Depression
☐ Diabetes
☐ Diverticulitis/Diverticulosis
☐ Dizziness/Fainting Spells
☐ Glaucoma
☐ Hay Fever/Seasonal Allergies
☐ Headaches
☐ Heart Attack/Heart Failure
☐ Heart Murmur
☐ Heart/Valve Replacement
☐ Hepatitis/Jaundice
☐ High/Low Blood Pressure
☐ Hip/Other Joint Replacement
☐ Hives/Skin Rash
☐ Immune Suppression
☐ Kidney or Liver Disease
☐ Mitral Valve Prolapse
☐ Osteoporosis
☐ Persistent Cough /Asthma/Emphysema/COPD
☐ Psychiatric Disorder
☐ Seizures/Epilepsy
☐ Snoring/Sleep Apnea
☐ Stomach Ulcer/Colitis
☐ Stroke/TIA
☐ Thyroid Disease
☐ Tuberculosis
☐ Other

Have you had any of the following childhood illnesses?
☐ Chicken Pox ☐ Measles ☐ Meningitis ☐ Mumps ☐ Polio ☐ Rheumatic fever ☐ Rubella ☐ Scarlet Fever

Have you ever had any surgery, hospitalization, or serious illness of any kind? ☐ Yes ☐ No
If yes, what and when? _____

Do you smoke or use other tobacco products? ☐ Yes ☐ No
If yes, packs per day? _____

Do you consume alcohol? ☐ Yes ☐ No
If yes, how much per day? _____

Are you on any kind of diet? ☐ Yes ☐ No If yes, what kind of diet? _____

Have you had an allergy or have reacted adversely to any of the following:

☐ Aspirin
☐ Codeine or other Narcotics
☐ Egg/Egg Yolk
☐ Foods
☐ Iodine / X-Ray Dye
☐ Latex / Natural Rubber
☐ Local Anesthetics
☐ Penicillin
☐ Sedatives or Barbiturates
☐ Sulfa Drugs
☐ Other (please list)
_____

Patient Name: _____
Date of Birth: _____

Adult Medical History (Continued)

Do you take any medications? ☐ Yes ☐ No
Please list all medications, **including** over-the-counter medications
(such as vitamins, aspirin, Motrin or Tylenol)

Date of last immunization or booster for:
Diptheria _____
Influenza _____
Pneumonia_____
Polio_____
Tetanus_____

Is there a **family history** of the following?

☐ Acid Reflux/GERD
☐ Alcoholism
☐ Anemia
☐ Angioplasty/Pacemaker
☐ Bleeding Disorders
☐ Cancers
☐ Circulatory Problems
☐ Congenital Heart Defects
☐ Coronary Artery Disease
☐ Depression
☐ Diabetes
☐ Glaucoma
☐ Heart Attack/Heart Failure
☐ Heart Murmur
☐ Heart Valve Replacement
☐ High Cholesterol
☐ High/Low Blood Pressure
☐ Kidney or Liver Disease
☐ Lung Disease
☐ Osteoporosis
☐ Overweight
☐ Persistent Cough /Asthma/Emphysema/COPD
☐ Psychiatric Disorders
☐ Stroke/TIA
☐ Tuberculosis
☐ Other

Family History	Age	Present Illness	Cause of Death
Mother			
Father			
Siblings			

FOR WOMEN ONLY

Are you pregnant, or is there any chance that you might be pregnant? ☐ Yes ☐ No
Are you nursing? ☐ Yes ☐ No
Form of Birth Control _____
Do you have any problems associated with your menstrual period? ☐ Yes ☐ No
Are your periods regular? ☐ Yes ☐ No
Do you complete self-breast exams? ☐ Yes ☐ No

Number of Pregnancies _____
Number of miscarriages_____

Date of last menstrual cycle _____
Age at onset of menstrual cycle _____
Date of onset of menopause_____

Optional

Religious Preference: ☐ Baptist ☐ Catholic ☐ Protestant ☐ Other _____