
# PATIENT INFORMATION

Patient Name:_____
Last First Middle

Mailing Address:_____

City:_____State:_____Zip Code:_____

Home Phone:_____Cell Phone:_____

___Male ___Female Marital Status:_____

E-Mail Address:_____

Social Security #:_____ Date of Birth: _____

Drivers License #:_____Expiration:_____State:_____

Employed:____Full-Time ____Part-Time Student: ____Full-Time ____Part-Time

Employer:_____ Phone:_____

# EMERGENCY CONTACT INFORMATION

NAME:_____PHONE:_____

# GUARDIAN/SPOUSE INFORMATION

Name:_____ ____Parent/Guardian ____Spouse

Home Phone:_____ Cell Phone: _____

Employer:_____ Work Phone: _____

_I would like to receive information concerning a Living Will ___I would not like to receive information concerning a Living Will

# RESPONSIBLE PARTY INFORMATION

**(If the person that is the carrier of the insurance card is the same as the patient, you do not have to fill this section out. Please read the Payment Policy below, sign and date it.)**

**INSURED NAME:** _____
Last First Middle

**RELATIONSHIP TO PATIENT:** _____

**MAILING ADDRESS:** _____

**CITY:** _____ **STATE:** _____ **ZIP CODE:** _____

**HOME PHONE:** _____ **CELL PHONE:** _____

**SOCIAL SECURITY NO:** _____ **DATE OF BIRTH:** _____

**EMPLOYER:** _____ **PHONE:** _____

# NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights regarding my protected health information. I understand the information below can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers
3. Conduct normal healthcare operations such as quality assessment and physician certification.

I have read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at one of the above to obtain a copy of the Notice of Privacy Practices.

I understand I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions , but if you do agree then you are bound to abide by such restrictions.

**PATIENT NAME:** _____

Last First Middle

**RELATIONSHIP TO PATIENT (if other than patient):** _____

**SIGNATURE:** _____

**DATE:** _____

If you would like tests results given to someone other than yourself if you are unavailable, please list that person below and their relationship to you. If no one is listed, you will be the only one able to receive the test results and no results will be left on answering machine or voicemail.

**NAME:**_____ **RELATIONSHIP:**_____

**OFFICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

_____ _____ _____

Date Initials Reason

## Health Questionnaire

**In order to provide you with quality health care, please fill out the following questions as thoroughly as possible.**

**1 - Please circle any health problems you have or have been diagnosed with.**

| | | |
|---|---|---|
| High Blood Pressure | COPD | Blood Clots in Legs/Lungs |
| Diabetes | Emphysema | Cancer: type_____ |
| High Cholesterol | Anemia | Other:_____ |
| Heart Attack | Kidney Stones | _____ |
| Stroke/Mini-Strokes | Migraines | _____ |
| Gout | Low/Upper Back Pain | _____ |
| Hypothyroidism | Seizures | _____ |

**2 - Please list surgeries/date or year.**

_____ _____ _____
_____ _____ _____
_____ _____ _____

**3 - Please list all medicines, herbals, and vitamins. Please also state how many times a day you take the medicine. (Example: Lotrel 5/20 - twice a day).**

_____ _____ _____
_____ _____ _____
_____ _____ _____

**Pharmacy**_____

**4 - Please list any allergies.**

_____ _____ _____

**5 - Please circle any health problems your parents or your siblings have.**

| | |
|---|---|
| High Blood Pressure | Father/Mother/Brother/Sister |
| Diabetes | Father/Mother/Brother/Sister |
| High Cholesterol | Father/Mother/Brother/Sister |
| Stroke | Father/Mother/Brother/Sister |
| Heart Attack | Father/Mother/Brother/Sister |
| COPD/Emphysema | Father/Mother/Brother/Sister |
| Cancer - What Type_____ | Father/Mother/Brother/Sister |

**6 - Family History**

| | |
|---|---|
| Father | Living/Deceased/Cause of Death/Age_____ |
| Mother | Living/Deceased/Cause of Death/Age_____ |
| Brother | Living/Deceased/Cause of Death/Age_____ |
| Sister | Living/Deceased/Cause of Death/Age_____ |

**7 - Children** Boys #_____ Girl's #_____

**8 - Do you use tobacco____ alcohol____**

**Sale Creek - Soddy Family Practice**
12820 Dayton Pike
Soddy Daisy, TN 37379
Phone 423-332-1813  Fax 423-332-7732

Dear Patient,

I would like to take this time to thank you for choosing Sale Creek – Soddy Family Practice as your primary care practice. Due to the changes in health care and the laws that pertain to certain medication, there will be medications that I have never written or will no longer be writing. For your reference, if you are needing chronic pain, nerve/anxiety, sleep, or controlled medications, my practice will not be writing any of the medications. If there is a need for these medications, I will gladly set up a referral to a specialist to assist you with your need.

I appreciate the opportunity to serve you with your health care needs and look forward to our physician/patient relationship.

Thank you,

Dr. Daniel T. Black DO, FAAFP

## PAYMENT POLICY

Thank you for choosing Sale Creek-Soddy Family Practice as your primary care provider. I am committed to providing quality and affordable health care. I receive tremendous professional satisfaction from helping my patients improve their lives. In fact, it is the reason I entered medicine and the reason I will stay. At the same time, however, there are significant changes outside of my control that continually threaten the economic viability of my practice. Although quality care is my primary goal, reimbursement for my services is what keeps me in business. As insurance reimbursement decreases and patient responsibility for medical care increases, I must change my reimbursement practices. To ensure I am reimbursed for the services I provide, the provisions in this policy are effective January1, 2017. To make sure you are aware of my payment policies, please read and sign this document and return it to the receptionist. She will provide you a copy of this policy at your request. Feel free to ask any questions you may have.

**Cancellations.** If you schedule an appointment but are unable to keep it, please call the office to cancel your appointment. We understand the challenges you face with your schedule. We ask in turn that you respect our providers' time. If you do not show up for an appointment without notifying us that you are cancelling two times, you will be dismissed from the practice.

**Insurance.** Knowing your insurance benefits is your responsibility. It is very important that you know your copay, coinsurance and deductible amounts. Please contact your benefits administrator or your insurance company with any questions you may have regarding your coverage. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. We participate in most major insurance plans, including traditional Medicare in most cases, however, we do not accept TennCare or any commercial plan that uses the TennCare network. We do not accept new patients with Cigna, UnitedHealthCare or any Medicare Advantage Plan. However, if you change your insurance to a Cigna or UnitedHealthCare or Medicare Advantage Plan while you are a patient, you will remain a patient of the practice. Should a new or existing patient present an insurance company or plan we are not familiar with, the patient must obtain information about the plan's reimbursement rates before we decide to accept that insurance. If the patient is not able to obtain this information, we will not accept this insurance plan.

**Proof of insurance.** All patients must complete our patient information form prior to your first visit. At your first visit only we will make a copy of your driver's license. It is important to note that you must show your insurance card(s) at every visit and verify your current address and phone number(s). This practice will ensure the information we have on file is correct. If you are a new patient and do not have your insurance card, we will reschedule your appointment. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the entire balance of a claim.

**Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request.

**Co-payments.** All co-payments must be paid at the time of service. If you are not able to pay your copay at the time of service, we will reschedule your appointment.

**Payments and Billing.** Payments made at the office are posted upon receipt. Insurance payments are received approximately 2 to 4 weeks after your claim is filed. You will receive a statement from our office only if there is a balance on your account after your insurance payment(s) are received. The balance is due upon receipt of the statement. We accept cash, personal checks and Visa and MasterCard. In addition to paying at the office or mailing your payment, credit/debit card payments can be made by calling the Billing Department at 423-521-7492.

**Nonpayment.** It is important to note you will not be permitted to schedule an appointment if there is a balance on your account. For this reason, it is imperative that you pay your balance in full upon receipt of our statement. It is also important to note that after you receive three (3) statements from our office, we may refer your account to a collection agency. Please note that the collection agency will report activity on your account to all credit bureaus.

If your account is turned to a collection agency, you and your immediate family members may be discharged from this practice. If this occurs, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our practice will only be able to treat you on an emergency basis.
I have read and understand the above policy and agree to follow its requirements.

_____ _____

**Print Patient/Responsible Party Name**

_____

**Signature Patient/Responsible Party**

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## NO SHOW /NO CALL POLICY

What is a "No Show/No Call" patient? Simply a patient has an appointment but misses their appointment and does not call to let us know that he or she will not be able nor no longer needs the appointment.

____I have been informed that if I make an appointment and then do not show up for the visit that I will be charged $35.00.

____I have been informed that if I have an appointment and cancel within 30 minutes of the appointment I will be charged $35.00.

Every day I am blessed to have a full scheduled. I often work people in during lunch. When those work in slots are full then patients that need to be see are put on cancellations list. If someone cancels their appointment that day, then we all the first person on the cancellation list and offer then the open time slot.

Why $35.00? Just to emphasize the need for you to call us if you cannot come to your appointment.

Why do I require that you call us 30 minutes before you appointment? Most of my patients need 20-30 minutes to get to the office.

I understand things come up and appointments need to be rescheduled. We are glad to accommodate you. Just give us a call and let us know that you need to cancel you appointment.

Dr. Daniel T. Black, D.O., FAAFP

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Sale Creek – Soddy Family Practice is now offering a patient portal. I would like to introduce the portal and give you the information that will help you decide if it may be something you may want to use.

Our patient portal is a highly encrypted secure connection from your computer to my server. This allows direct communication from you to me and my staff. Previously a patient would come in and have blood drawn. We would then call the patient with the results. The portal allows me to improve the communication by sending a copy of the labs with my personal explanations of your labs.

Also - questions for Dr. Black can be sent through the portal. These inquires will be responded to in the same fashion as a phone call. Because of the encryption we can answer your specific question. For example, if you call to ask Dr. Black a question concerning a side effect of a medicine you just started, my staff will send me a the question and I will answer it. I then send the message back to the staff so they can call you and give you the answer. However, if you are not available when they call (because of strict laws concerning protection of a patient's medical information) we cannot leave information on your voice mail. Thus the game of "phone tag" begins. If that same patient uses the portal an email alert will notify you that you have a message on our portal. You can then log in and read the message and even send a message back if need be. The portal works with smart phones and computers

Do you have to use the portal? The answer is absolutely not. If you like using the phone then please continue to communicate via phone. If you don't mind computers then this may be an option. You may use both if you like.

Is it safe? Yes, it is fully encrypted according to highest standards set forth by US government concerning medical records.

What do I have to do to try it out? Simply give us your email. We will then send you a portal invitation to your email. Simply answer a few questions and make a password. We will not have a record of your password so please write it down for your safe keeping.

**If you want to try the portal please print your email**_____

IIMPORTANT: If we send a portal invitation to your email you must open it and complete the questions with 48 hours. If you forget to activate the invitation with 48 hours, call the office and we will send another invitation.

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**Dr. Black is requiring that you write what you are being seen for today.**
**Please be specific.**

_____

_____

**Patient's Name:** _____ **DOB:**_____

**Signature:**_____ **Date:**_____