CLEVELAND MEDICAL ASSOCIATES, PLLC.

1060 WILLIAM WAY NW CLEVELAND, TN 37312 | Phone: (423) 478-1050 | Fax: (888) 853-7312

PATIENT DEMOGRAPHICS

FULL NAME: _____ DATE OF BIRTH: _____

GENDER (Circle One): **FEMALE** **MALE** DO YOU HAVE AN ADVANCED DIRECTIVE (LIVING WILL)? **YES** **NO**

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

EMAIL: _____ SOCIAL SECURITY #: _____

PRIMARY PHONE: _____ SECONDARY PHONE: _____

MARITAL STATUS: **SINGLE** **MARRIED** **DIVORCED** **WIDOWED** **OTHER**: _____

Pharmacy Name & Location: _____

EMERGENCY CONTACT

NAME:_____ RELATIONSHIP: _____ PHONE: _____

ADDRESS: _____

INSURANCE INFORMATION

PRIMARY NAME: _____ SUBSCRIBER ID: _____ GROUP: _____

SECONDARY NAME: _____ SUBSCRIBER ID: _____ GROUP: _____

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits, including major medical benefits and Medicare benefits, to which I am entitled to **Cleveland Medical Associates.** This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I understand that I am financially responsible for all charges whether or not paid by my insurance carrier. I understand that I will be responsible for any court costs or collection fees should it become necessary to take action to collect for services/supplies rendered.

I hereby authorize **Cleveland Medical Associates** to release all medical information necessary to secure payment on my account.

Patient Name (Printed): _____**Signature:**_____

Date: _____

AUTHORIZATION FOR TREATMENT

Your signature below indicates that your consent for treatment of/as patient and responsibility for paying the bill. Please ensure that the physician listed on your card is the doctor you are seeing in our office before your appointment date.

I hereby authorize the release of any information acquired during my examination or treatment to my insurance company and authorize the payment of medical benefits directly to my physician.

Patient Signature: _____ **Date:** _____

CONSENT OF INFORMATION DISCLOSURE

This form is necessary for us to release medical information to your family or friends. If their name is not on this list, we cannot release any information about you to them. If you do not want anyone to know this information, just strike a line through the blanks and sign the form. **THIS FORM MUST BE SIGNED AND DATED**.

I give **Cleveland Medical Associates** consent to give personal, financial, and medical information to the follow persons.

Name: _____Phone: _____ Relationship: _____

Name: _____Phone: _____ Relationship: _____

Name: _____Phone: _____ Relationship: _____

I consent to the use or disclosure of my protected health information by this facility, including its employees, physicians, and agents, for the purposes of diagnosing or providing treatment, obtaining payment for my health care bills or to conduct health care operations of this facility. I understand that diagnosis or treatment of me by this facility may be conditioned upon my consent as evidenced by my signature of this document.

I understand that I have the right to request restriction as to how my protected health information used or disclosed to carry out treatment, payment, or health care operations of this facility, its employees, physicians, or agents. However, I understand that this facility is not required to agree to the restrictions that I may request. If the facility agrees to the restriction that I request, the restriction is binding on the facility.

I have the right to revoke this consent, in writing, at any time, except to the extent that the facility has taken action on this consent.

My protected health information means health information, including my demographic information collected from me and created or received by this facility, my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information may relate to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe that the information may identify me. It may also refer to alcohol, drug abuse, communicable disease including HIV status, and/or psychiatric diagnosis complied during my visit, encounter, or hospitalization.

I understand that state law requires the facility to report certain positive test results, such as hepatitis and the antibody for HIV/AIDS virus to the health department. My medical information described above, and appropriate records as permitted by law may be disclosed and released to any such persons or organizations upon their request both during and after my facility stay. I understand and agree that federal and state entities, including but not limited to , the Centers for Medicare and Medicaid Services, the state Department of Health and Joint Commission on the Accreditation of Healthcare Organizations, may have access to my medical records.

I discharge and release the facility and its employees from any responsibility and liability arising out of the disclosure or use of such information by such persons and organizations. I also authorize the release of my medical information to the physician(s) listed as my personal or family physician(s) upon registration and to any referral physician

By signing this consent form, you are agreeing that your provider at Cleveland Medical Associates may receive and use your prescription medication history automatically through channels in our EMR from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

Patient Signature: _____ **Date**: _____

By signing this consent form, you are agreeing that your provider at Cleveland Medical Associates may receive and use your medical history, hospital records, or consult notes automatically through channels in our EMR from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

Patient Signature: _____ **Date**: _____

NOTICE OF PRIVACY PRACTICES:

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

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

Patient Signature: _____ **Date**: _____

PRACTICE USE ONLY

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

Date: _____ Initials: _____

FINANCIAL POLICY

Welcome to our practice. We ask that all our patients read, understand, and accept our financial policy as described below.

For your convenience, we accept all the following methods of payment:

Cash

Check (with photo identification)

Visa

Mastercard

Discover

American Express

Full payment is due at the time of service unless we have pre-approved your insurance coverage and accepted assignment. Any required co-pays or deductibles owed by you will be collected at the time of service. If your insurance plan determines a service is not covered, we will bill you for that charge.

If we do not have a contract with your insurance carrier, we cannot accept assignment to be reimburse by your carrier. Therefore, charges are due and payable by you at the time of service. As a courtesy, we will bill your insurance plan on your behalf for any service that we provide with instructions to reimburse you directly.

We will bill your health plan for any hospital services that we provide.

You will be responsible to pay any billed amounts upon receipt of a statement from our billing office.

For medical care provide to a minor child, the guardian or chaperone of that patient is financially responsible for those charges.

If you need to cancel your appointment, we must have a 24-hour notice, or you will be charged a fee of $25.00. (This will not be billed to your insurance)

If assistance is needed in collecting for these services, you may be responsible for attorney or collection fees.

I have read and agree to the terms of the financial policy described above.

Patient Signature: _____ **Date**: _____

Medicare beneficiaries are responsible for paying an annual deductible and 20% coinsurance.

We are dedicated to providing you with the best care and services possible. Thank you for accepting responsibility for prompt payment.

NAME: _____ DOB: _____

CURRENT MEDICAL PROBLEMS OR CHRONIC ILLNESSES

EYE PROBLEMS:

Glaucoma

Macular Degeneration

EAR PROBLEMS:

Hearing Loss/ Hearing Aid

HEART PROBLEMS:

Heart Attack

Heart Failure

High Blood Pressure

Irregular Heartbeat (Arrhythmia)

High Cholesterol

BONE & JOINT PROBLEMS:

Arthritis

Osteoporosis

Fractured Hip, Wrist, or Spine

Gout

GI PROBLEMS:

Ulcers

Heartburn

Hiatal Hernia

Diverticulitis

Liver Disease

Cirrhosis

Colon Polyps

LUNG PROBLEMS:

Asthma

COPD

KIDNEY & URINARY TRACT:

Kidney Disease

Prostate Disease

Bladder or Kidney Infections

Urinary Incontinence

GLAND PROBLEMS:

Diabetes

Hypothyroidism

Hyperthyroidism

NERVOUS SYSTEM PROBLEMS:

Stroke/TIA

Dementia or Alzheimer's

Epilepsy or Seizures

OTHER PROBLEMS:

Allergies

Anemia

Hernia

Thrombosis (blood clot)

Cancer

- What kind? _____

OTHER: _____

LIST ANY PHYSICIANS AND/OR PRACTIONERS YOU CURRENTLY SEE

NAME:_____ SPECIALTY: _____

NAME: _____ SPECIALTY: _____

NAME: _____ SPECIALTY: _____

NAME: _____ SPECIALTY:_____

LIST ANY ALLERGIES TO MEDICATION, DYES, OR FOOD

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

LIST ANY PAST SURGERIES OR HOSPITALIZATIONS (INCLUDE YEAR)

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

LIST ANY MEDICATIONS THAT YOU CURRENTLY TAKE (INCLUDING OVER THE COUNTER)		
NAME	STRENGTH	DIRECTION

RECORD THE LAST YEAR YOU HAD THE FOLLOWING: (IF YOU DO NOT KNOW, LEAVE BLANK)

GLAUCOMA/EYE EXAM: _____

COLON CANCER SCREEN: _____

MAMMOGRAM: _____

BONE DENSITY SCAN: _____

PAP SMEAR: _____

PSA TEST: _____

COVID VACCINE: _____

FLU VACCINE: _____

HEPATITIS B SHOT: _____

SHINGLES SHOT: _____

PNEUMONIA VACCINE: _____

ABDOMINAL AORTIC ANEURYSM SCREENING: _____

TETANUS DIPHTHERIA VACCINE: _____

SOCIAL HISTORY

DO YOU DRINK ALCOHOL? **YES** **NO** IF **YES**, HOW MUCH? _____

HAVE YOU EVER SMOKED OR CHEWED TOBACCO? **YES** **NO** IF **YES**, HOW MUCH? _____

DO YOU DRINK CAFFEINE? **YES** **NO** IF **YES**, HOW MUCH? _____

DO YOU DO ANY FORM OF REGULAR EXERCISE EVERY DAY? **YES** **NO** IF **YES**, HOW MUCH? _____

MARITAL STATUS: **MARRIED** **SINGLE** **DIVORCED** **WIDOWED** **OTHER**: _____

LIST HEALTH PROBLEMS AND CAUSES OF DEATH IF APPLICABLE

LIVING/DECEASED	**AGE**	**MEDICAL PROBLEMS**
FATHER: _____	_____	_____
MOTHER: _____	_____	_____
BROTHER(S): _____	_____	_____
SISTER(S): _____	_____	_____
CHILDREN: _____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any other health problems that you would like your doctor to know about before your visit?

_____

_____

_____