

## COLLECTION POLICY

### PROMISE TO PAY Arthritis Associates of Kingsport

#### Installment note

#### I PROMISE TO PAY Arthritis Associates:

1. Collection policy: Co-pays are due at time of service. If unable to pay all other estimated charges at time of service *25% down payment* and minimum monthly payments of *25% due by the end of each month*. Account balances of *\$100 or less* require minimum payment of *\$25 per month*.

2. Uninsured Policy: Payment made in full at time of service receives a *25% discount*. If unable to pay in full *25% down* and minimum monthly payments of *25% due by end of each Month*.

3. 24-hour cancellation policy – If you no show for your appointment you will be charged \$25. This policy is in place out of respect for our physicians and their patients. Cancellation without *24 hours' notice* is difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule. By initialing you acknowledge you have read and understand the cancellation policy as described above. \_\_\_\_\_

4. Collection Agency- If you fail to make any of the *agreed payments* our pre-collection department will submit *all unpaid balances* to an outside collection agency and any future scheduled *appointments* will be *cancelled*. By initialing you acknowledge you have read and understand the cancellation policy as described above. \_\_\_\_\_

\_\_\_\_\_  
(Printed) Patient – Last Name, First Name, MI

\_\_\_\_\_  
Signature of patient or person authorized by law

\_\_\_\_\_  
DOB: \_\_\_\_\_

\_\_\_\_\_  
Street Address, City, State, Zip Code

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date Signed

## Patient Privacy Notice

### Arthritis Associates of Kingsport

#### PHI- Protected Health Information

We are required by law to protect the privacy of your medical information and to provide you with written Notice describing:

#### **HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.**

**Please initial you have read and understand the information below:**

\_\_\_\_\_ We may use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

\_\_\_\_\_ We may be required or permitted by certain laws, regulations, or circumstances to use and disclose your medical information for certain purposes without your authorization. Under other circumstances we may need your written authorization (that you may later revoke) to use or disclose your medical information.

\_\_\_\_\_ As our patient, you have important rights relating to inspecting and copying your medical information that we maintain. This includes amending or correcting that information, obtaining any disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

\_\_\_\_\_ You have the right to receive a copy of our most current NOTICE in effect. If you have not yet received a copy of our current NOTICE, please ask at the front desk and we will provide you with a copy.

\_\_\_\_\_ Upon a written request copies of your medical records will be made available in a timely manner. There will be a fee associated with this service.

\_\_\_\_\_ Under this law, we have the right to refuse to treat you should you refuse all or part of your PHI.

*The misuse of PHI has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know our employees, managers, and providers undergo training so that they may understand and comply with government rules and regulations regarding PHI and HIPPA compliance regarding privacy of our patients. We will listen to our employees and patients without any thought of penalization if they feel an event in any way compromises our policy of integrity. If you have any questions, concerns or complaints about the NOTICE or your medical information, please contact the HIPPA Compliance Officer.*

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

**Our office utilizes an electronic prescription service. Your signature allows Arthritis Associates of Kingsport to verify your prescription history electronically:**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Arthritis Assoc Of Kingsport PLLC**

Three Sheridan Square  
 Kingsport, TN 37600-7390  
 (423) 392-6840

PATIENT INFORMATION						
NAME (Last, First Middle)		MRN	SSN#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS		SECONDARY/BILLING ADDRESS (if Applicable)			ETHNICITY	
CITY, STATE ZIP		HOME PHONE	CITY, STATE ZIP		HOME PHONE	RACE
PRIMARY CARE PHYSICIAN		REFERRING PHYSICIAN		CONTACT NAME		CONTACT HOME PHONE
PRIMARY EMPLOYER		SECONDARY EMPLOYER (if Applicable)				
ADDRESS		ADDRESS				
CITY, STATE ZIP		CITY, STATE ZIP				
WORK PHONE		WORK PHONE				

RESPONSIBLE PARTY INFORMATION (if Different than above)					
NAME (Last, First Middle)		SSN#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS		SECONDARY/BILLING ADDRESS (if Applicable)			
CITY, STATE ZIP		CITY, STATE ZIP			
HOME PHONE		HOME PHONE			
RELATIONSHIP TO PATIENT					

PRIMARY INSURANCE			
NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED		GROUP#	
ADDRESS OF INSURANCE COMPANY		COPAY AMT	
CITY, STATE ZIP		\$	
RELATIONSHIP TO PATIENT		DEDUCTIBLE	\$
		EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)			
NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED		SSN#	BIRTHDATE
ADDRESS OF INSURANCE COMPANY		GROUP#	
CITY, STATE ZIP		COPAY AMT	
		\$	
RELATIONSHIP TO PATIENT		DEDUCTIBLE	\$
		EFFECTIVE DATE	EXPIRATION DATE

Insurance authorization: I authorize AAK to file insurance for services performed in their office and that payment be made to the providers of service. I authorize the above to contact and/or release my health information to Social Security or other insurance carriers regarding payment for services received at AAK. I am responsible for all financial obligations of health services. If for any reason the account should become delinquent, I agree to pay charges, interest or collection costs and reasonable fees.

SIGNATURE OF PATIENT/GUARDIAN

DATE



Name: \_\_\_\_\_ DOB: \_\_\_\_\_

### PAST MEDICAL HISTORY

Please check all that apply

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Abnormal Bleeding<br><input type="checkbox"/> Acid Reflux<br><input type="checkbox"/> Alzheimer's Disease<br><input type="checkbox"/> Anemia<br><input type="checkbox"/> Aneurysm<br><input type="checkbox"/> Anxiety<br><input type="checkbox"/> Arthritis<br>(Rheumatoid/Osteoarthritis)<br><input type="checkbox"/> Asthma<br><input type="checkbox"/> Barrett's Esophagus<br><input type="checkbox"/> Bleeding Ulcers<br><input type="checkbox"/> Blood Clots<br><input type="checkbox"/> Cancer _____<br><input type="checkbox"/> Cirrhosis of the Liver<br><input type="checkbox"/> Colitis<br><input type="checkbox"/> Congestive Heart Failure<br><input type="checkbox"/> COPD/Lung Disease<br><input type="checkbox"/> Crohn's Disease<br><input type="checkbox"/> Dementia<br><input type="checkbox"/> Depression<br><input type="checkbox"/> Diabetes | <input type="checkbox"/> Diverticulosis<br><input type="checkbox"/> Elevated Cholesterol<br><input type="checkbox"/> Fatty Liver<br><input type="checkbox"/> Fibromyalgia<br><input type="checkbox"/> Glaucoma<br><input type="checkbox"/> Gout<br><input type="checkbox"/> History of Head Injury<br><input type="checkbox"/> Heart Attack<br><input type="checkbox"/> Heart Disease<br><input type="checkbox"/> Heart Murmur<br><input type="checkbox"/> Hepatitis<br><input type="checkbox"/> Hiatal Hernia<br><input type="checkbox"/> Hypertension<br><input type="checkbox"/> History of Suicide Attempts<br><input type="checkbox"/> HIV/AIDS<br><input type="checkbox"/> Irregular Heartbeat<br><input type="checkbox"/> Irritable Bowel Syndrome<br><input type="checkbox"/> Kidney Disease<br><input type="checkbox"/> Kidney Failure<br><input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Lupus<br><input type="checkbox"/> Migraines<br><input type="checkbox"/> Mini Stroke/Stroke<br><input type="checkbox"/> Neuropathy<br><input type="checkbox"/> Osteopenia/Osteoporosis<br><input type="checkbox"/> Pancreatitis<br><input type="checkbox"/> Parkinson's Disease<br><input type="checkbox"/> Peripheral Vascular Disease<br><input type="checkbox"/> Pneumonia<br><input type="checkbox"/> Prostate Problems<br><input type="checkbox"/> Restless Leg Syndrome<br><input type="checkbox"/> Rheumatic Fever<br><input type="checkbox"/> Seizures<br><input type="checkbox"/> Sjogren's Syndrome<br><input type="checkbox"/> Sleep Apnea<br><input type="checkbox"/> Positive TB Skin Test/<br>History of TB<br><input type="checkbox"/> Thyroid Disease<br>(Under/Over Active)<br><input type="checkbox"/> Urinary Tract Infections<br><input type="checkbox"/> Vitamin B12 Deficiency<br><input type="checkbox"/> Vitamin D Deficiency |
|--|---|---|

### SURGICAL HISTORY

(Please include biopsies, eye surgeries, stent placements, etc.)

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE

Arthritis Assoc of Kingsport PLLC

Three Sheridan Square Kingsport, TN 37660 | Phone: 423-392-6840

## Medical Information Release Form (HIPAA Release Form)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

### Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Spouse \_\_\_\_\_

Child(ren) \_\_\_\_\_

Other \_\_\_\_\_

Information is not to be released to anyone.

*This Release of Information will remain in effect until terminated by me in writing.*

### Messages

Please call  my home  my work  my cell Number: \_\_\_\_\_

If unable to reach me:

you may leave a detailed message

please leave a message asking me to return your call

The best time to reach me is (day) \_\_\_\_\_ (time) \_\_\_\_\_.

Signed: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

***Directions to Arthritis Associates of Kingsport***

3 Sheridan Square  
Kingsport, TN 37660  
43-392-6840

**From Gate City**

Via Interstate: Drive in to Weber City towards I-26 on route 36. Merge right onto I-26 towards Kingsport. Take Meadowview Parkway exit and turn left at the bottom of the ramp. Go approximately 0.5 miles towards Wilcox Drive. Proceed through the intersection up the hill towards the rear of Sheridan Square complex. Arthritis Associates of Kingsport is building #3.

**Directions from Bristol**

Via Interstate: Take I-81 South into Tennessee to exit 57B (Kingsport exit), onto I-26 towards Kingsport. Take exit 4 (Wilcox Drive) and proceed through the first traffic light on Wilcox Drive. Turn right at the next traffic light (Meadowview Parkway) into Sheridan Square. Drive up the hill towards the rear of the complex. Arthritis Associates of Kingsport is building #3.

**Directions from Church Hill/Rogersville**

Via Interstate: Take 11W east through Kingsport. Proceed on I-26 towards Johnson City for approximately 4 miles. Take exit 3 (Meadowview Parkway) and turn left at the bottom of the ramp. Go approximately 0.5 miles towards Wilcox Drive. Proceed through the intersection up the hill towards the rear of Sheridan Square complex. Arthritis Associates of Kingsport is building #3.

**Directions from Johnson City/Gray**

Via Interstate: Take I-26 West towards Kingsport. Take exit number 4 (Wilcox Drive) and proceed through the first traffic light on Wilcox Drive. Turn right at the next traffic light (Meadowview Parkway) into Sheridan Square. Drive up the hill towards the rear of the complex. Arthritis Associates of Kingsport is building #3.

PLEASE ARRIVE 15 MINUTES PRIOR TO YOUR APPOINTMENT TIME.

IF YOU ARE 15 MINUTES LATE FOR YOUR APPOINTMENT, YOU WILL BE RESCHEDULED.

PLEASE BRING A MEDICATION LIST AND/OR MEDICATION BOTTLES TO EACH APPOINTMENT.