PATIENT REGISTRATION

Date	For Internal Use Only	Patient Number

PATIENT INFORMATION

Social Security #: **Date of Birth:**

First Name: **Middle:** **Last Name:**

Home Address: **City:** **State:** **Zip:**

Home Phone: (_____)_____ **Work Phone:** (_____)_____
Cell Phone: (_____)_____ **Email Address:**

Race: **Ethnicity:** (Please Circle) Hispanic/Latino Not Hispanic/ Latino Declined

Gender (Circle as many as are appropriate):
Birth Sex: Male Female Transgender Other
Current Sex: Male Female Transgender Other

Employment Status: **Employed** **Disabled** **F/T Student** **Retired** **Other**
(Circle One) Employer: _____ Retirement Date:_____
Marital Status (Circle One) **Married** **Single** **Divorced** **Widowed**

Referring Physician:

PRIMARY INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

Insurance: **ID #:** **Group #:**

Name of the Insured: **DOB:** **SS #:**

SECONDARY INSURANCE INFORMATION

Insurance: **ID #:** **Group #:**

Name of the Insured: **DOB:** **SS #:**

EMERGENCY CONTACT

Relationship:

First Name: **Middle:** **Last:**

Home Phone: (____)_____ **Work Phone:** (____)_____ **Cell:** (____)_____

SPOUSE/GUARANTOR/RESPONSIBLE PARTY

Social Security #: **Sex:** **Date of Birth:**

Relationship: **Daytime Phone: ( )**

First Name: **Middle:** **Last Name:**

Address: **City:** **State:** **Zip:**

Employment Status: **Employer:** **Retirement Date:**

Address: **City:** **State:** **Zip:**

AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS TO PHYSICIAN: I hereby authorize the physician to release any information acquired during my treatment necessary to process insurance claims. I also authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

SIGNATURE (Patient or Parent if Minor): _____ DATE/TIME: _____

UNIVERSITY OF TENNESSEE MEDICAL CENTER
1924 Alcoa Highway ♦ Knoxville, TN 37920
(865) 305-9000

5001

LABEL

CONDITIONS OF ADMISSION/TREATMENT

NAME:_____ MR#:_____ ENCOUNTER#:_____ DATE:_____

MEDICAL AND SURGICAL CONSENT

I consent to the care and treatment, including any X-ray examination, laboratory procedures, anesthesia, medical or surgical treatment and any and all hospital services which my physician(s), their designee(s), or others of the University of Tennessee Medical Center ("UTMC") staff consider to be necessary or appropriate. I understand that my physician(s) or their designee(s) will explain the need for, risk of, and alternatives to blood transfusion when blood may be needed, and my physician(s) or their designees will explain alternative options in treatment when they are available. **I understand that the majority of the Medical Staff (physicians) and other practitioners working under their supervision who furnish services to me, including emergency room doctors, radiologists, pathologists, anesthesiologists/anesthetists, physician assistants, advance practice nurses and the like, are independent contractors and are not employees or agents of UTMC. I understand and agree that any residents and fellows furnishing medical services to me are not employees or agents of UTMC but are employees or agents of the State of Tennessee.**
X_____

NO GUARANTEE AS TO RESULTS

I understand that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of treatments and examination in UTMC.

RELEASE OF INFORMATION

I authorize UTMC and/or physicians to disclose all or any part of my patient record to any person or organization which is or may be liable or responsible for payment of all or part of the hospital charges, including, but not limited to, hospital or medical services companies, insurance companies, workers' compensation carriers, or welfare funds. I further authorize the release of all or any part of my medical record to any physician, hospital, or other health care provider giving me past, present or future care and treatment.

PERSONAL VALUABLES

I acknowledge that I have been asked to send money and valuables home. I understand that UTMC maintains a safe for money and valuables, and that UTMC will not be liable for the loss or damage to any money, jewelry, documents, or any other personal property, including glasses, contact lenses, dentures, hearing aids, or prosthesis, unless deposited with UTMC for safekeeping.

ADVANCE DIRECTIVES

I understand that information will be made available explaining my right to prepare an Advance Directive for Health Care. I understand that UTMC cannot honor any such document unless it has been legally executed and made a part of my medical record. I understand that under Tennessee Law, the medical center may refuse to implement an advance directive that conflicts with institutional policy or that is medical inappropriate.

HIV/HEPATITIS TESTING

If an employee, student, or other health care provider is exposed to my blood or other body fluids, I authorize UTMC to perform confidential blood tests for HIV (the virus that causes AIDS) and hepatitis. I understand that I will not be charged for these tests. I also understand that under Tennessee law this test may be performed without my consent.

PHOTOGRAPHY

I understand that UTMC may photograph me, including appropriate portions of my body, for clinical and treatment purposes to be included in my medical record. I authorize UTMC to photograph me or portions of my body for scientific or educational purposes, provided my identity is not revealed by the pictures or any descriptive text accompanying them. I understand that I can withdraw my authorization by sending a written request to: UTMC, Medical Records – Box 110, 1924 Alcoa Highway, Knoxville, TN 37920-6999.

EDUCATION AND RESEARCH

I understand that UTMC participates in education and research activities and understand and agree that faculty, residents and students in these programs may be involved in my care. I authorize UTMC to retain, preserve and use for scientific, teaching, educational and research purposes specimens or tissues taken from my body as well as medical information contained in my medical record. I agree that any tissue or specimens may be disposed of by UTMC at its convenience.

The undersigned certifies that he/she has read the foregoing, or has had the foregoing read to him/her, and that he/she understands and fully accepts its terms.

X_____
(Patient Signature)

Date of signing_____Time of signing_____

_____
(Closest relative or legal guardian)

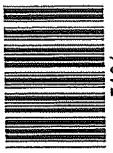
_____Date_____Time_____
(Witness)

_____
(Relationship)

Patient is a minor_____years of age.

Patient is unable to consent because:

_____



University of Tennessee Medical Center
1924 Alcoa Highway Knoxville, TN 37920
(865)305- 9000

LABEL

RELEASE AUTHORIZATION

PATIENT NAME_____DATE OF SERVICE_____

1) PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAY REQUEST FOR MEDICARE AND MEDICAID / TENNCARE BENEFITS

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act and Medicaid/TennCare is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare or Medicaid/TennCare claim. I request that payment of authorized benefits be made on my behalf. This authorization and assignment shall be valid for one year. I request that the payment of authorized Medigap benefits be made on my behalf to University of Tennessee Emergency Group for any services furnished me by that physician/supplier.

2) AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize the University of Tennessee Medical Center (UTMC) and other healthcare providers or suppliers providing service to me during this hospitalization to release information requested by my insurance carrier completed on the attached form. I assign UTMC the insurance benefits herein specified and otherwise payable to me, but not to exceed UTMC's regular charges for this period of hospitalization, and I authorize and direct my insurance carrier to make payment of said benefits directly to UTMC. I understand I am financially responsible to UTMC for charges not covered and paid by reason of this assignment. It is further agreed that any credit balance resulting from payment of the insurance or other sources may be applied on any other account owed UTMC by me or my family.

3) PROMISE TO PAY ACCOUNT

For and in consideration of services rendered and to be rendered by UTMC, I/we jointly and severally promise to pay all charges incurred for the account of the above named patient from admission to discharge. I will be responsible for any court costs, reasonable attorney fees and interest, as allowed by Tennessee law, incurred in the collection of my account. I authorize UTMC or its agents to check my credit and employment history and by this authorization expressly permit sources and employers to provide UTMC with the information requested. If I provide my cell phone number, I authorize UTMC or its agents to call my cell phone either manually or by auto-dialer in order to collect any amount I owe. If I provide my email or text number, I authorize UTMC or its agents to contact me at that email address or text number.

4) UTMC STAFF PHYSICIAN ASSIGNMENT

To facilitate paperless insurance claim processing, I assign my insurance benefits to any physician providing service to me during this hospitalization at UTMC. I understand that I am financially responsible for charges not covered and paid by reason of this assignment. I understand that medical care may be provided by a non-participating facility based physician (i.e. University Anesthesiology, University Pathology, University Radiology, Team Health Emergency Physician's, etc.), that a separate billing may be received from these physicians for services provided, and that I will be responsible for any court costs, reasonable attorney fees and interest, as allowed by Tennessee law, incurred by such physicians in the collections of my account.

5) DME NOTIFICATION

Your physician may order durable medical equipment (DME), such as wheelchairs, walkers, and crutches, to be used by you following discharge from the hospital. **You have the right to obtain the DME from a supplier or vendor of your choice.** You are financially responsible for the DME you receive. Contact your insurance company if you have any questions about coverage or payment for these supplies.

6) UHS NOTICE OF INFORMATION PRACTICES

I have received a copy of the University Health Systems, Inc. (UHS) Notice of Information Practices. I understand that this Notice describes how my health information may be used or disclosed by UHS and physicians and other providers at UHS and its facilities, and that I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling (865) 305-9118, on the UTMC website at www.utmedicalcenter.org, or by requesting one at a UHS office.

7) PATIENT INSURANCE IDENTIFICATION RESPONSIBILITY

I understand if I have insurance coverage not presented by me at registration/admission, my bill may not be processed timely and the appropriate authorization may not be obtained from the insurance company. In this circumstance, I agree to be responsible for charges not reimbursed by the insurance plans indicated above or insurance plans I have not divulged.

Signature X _____ Signature X _____ _____
Responsible Party Authorization to Release Information Date/Time

Signature _____Date/Time_____ Relation to Patient _____
Release Autho/Assignment

Witness_____Date/Time_____

UNIVERSITY OF TENNESSEE MEDICAL CENTER
1926 ALCOA HWY BUILDING F
KNOXVILLE, TN 37920 (865) 305-9000

LABEL

INDIVIDUAL AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize The University of Tennessee Medical Center Cancer Institute to release, use, request, or disclose from the health records of:

Patient name:_____ Date of Birth:_____

Address:_____ Telephone No:_____

Purpose of Release/Request: _____

INFORMATION TO BE RELEASED/REQUESTED

The following information:

☐ Pertinent Medical Records

☐ Exclude: _____

You have a right to revoke this authorization by doing so in writing. Such revocation will be effective to the extent that action has not been taken in reliance on the authorization or, if the authorization was obtained as a condition of obtaining insurance coverage, only to the extent that other law provides the insurer with the right to contest a claim under the policy.

I understand that this authorization is voluntary and that I may refuse to sign this authorization, and that my refusal will not affect my eligibility for benefits, payment for coverage of services, or ability to obtain treatment.

I understand the information to be released may include records related to behavior and/or mental health care, alcohol, and drug abuse treatment, HIV/AIDS, and genetics. This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it. Revocation must made in writing to the provider/facility releasing the information. The provider will not condition treatment on whether I sign the authorization.

The information used or disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by the regulations that protect individually identifiable health information from use or disclosure by health care providers.

_____ _____ _____

Date/Time Signature Print Name

_____

Authority of Personal Representative
If Signing for the Individual

PowerChart Scan Location Type: HIPAA Privacy Form

This authorization expires in 12 months

University of Tennessee Medical Center Cancer Institute
1926 Alcoa Highway Knoxville TN, 37920
(865) 305-9000

LABEL

Patient Privacy Questionnaire

I, ______________________________(Please Print Patient Name), give permission to the physicians and their staff at the University of Tennessee Medical Center Cancer Institute to leave messages regarding my healthcare in the following manner when I am not available:

I would prefer to be contacted regarding healthcare information at:

□ Work #: ________________________ □ Cell #: ________________________

□ Home #: ________________________ □ Other #: ________________________

Please list what person(s) can receive your personal health information

Name:______________________ Relationship: ______________________ Phone: ____________________

☐ May leave appointment reminder with the above listed person ☐ Other:

☐ May leave lab results with the above listed person

☐ May discuss billing information with the above listed person

☐ I prefer that all healthcare message be given to the above listed person

Name:______________________ Relationship: ______________________ Phone: ____________________

☐ May leave appointment reminder with the above listed person ☐ Other:

☐ May leave lab results with the above listed person

☐ May discuss billing information with the above listed person

☐ I prefer that all healthcare message be given to the above listed person

Name:______________________ Relationship: ______________________ Phone: ____________________

☐ May leave appointment reminder with the above listed person ☐ Other:

☐ May leave lab results with the above listed person

☐ May discuss billing information with the above listed person

☐ I prefer that all healthcare message be given to the above listed person

I understand that this notice describes how my health information may be used or disclosed by UHS, UPA, UHSV facilities and that I should read it carefully. I have been offered a copy of the University Health System, Inc. (UHS) notice of information practices. If we are unable to reach you by another means, we will send information through the U.S Postal Service to your home address. This includes test results, diagnosis, medication, and your response to medication or other therapies. By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system. They will be able to use my contact information, the name of my care provider, and other limited information, for the purpose of notifying me, when necessary.

______________________________ ____________________ ____________________

Signature of Patient or Authorized Representative | Relation to Patient if Authorized Representative | Date/Time

PowerChart Scan Location Type: HIPAA Privacy Form