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

Email Address Race ______ Ethnicity ____________

Gender (Circle as many as are appropriate)

Birth Sex: Male Female Transgender Other

Current Sex: Male Female Transgender Other

Marital Status (Circle One) Married Single Divorced Widowed

Home Phone ( )

Cell Phone ( )

(Circle One) Employed Retired Disabled F/T Student Other

Work Phone ( )

Employer Referring Physician

How did you hear of us?

PRIMARY INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

Insurance ID # GR #

Name of Insured DOB SS#

SECONDARY INSURANCE INFORMATION

Insurance ID# GR #

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

Employer Address

City State Zip

AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS TO PHYSICIAN: I hereby authorize the physician to release any information acquired in the course of 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

UNIVERSAL MEDICATION FORM

Name:	Address:
Phone Number:	
Birthdate:	
Emergency Contact/Phone:	

IMMUNIZATION RECORD

Tetanus:	Flu Vaccine:
Pneumonia Vaccine:	Hepatitis Vaccine:
Other:	

ALLERGIES

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING TO INCLUDE: Prescription medications and over the counter medications. Please include any medications you make take on an as needed basis.

Date Started	Name of Medication/ dosage	Directions (how much and when)	Date Stopped If applicable	Reason for taking this medication

University Vascular & Transplant Surgery
1940 Alcoa Hwy., Suite E-120
Knoxville, TN 37920
(865) 305-8040 or Fax (865) 305-8041

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(All sections must be completed)

Patient Name: ______________________ **Date of birth:** __________

SSN: __________ Address: ______________________________

____

I hereby authorize the release of medical records to UT Vascular and Transplant Surgeons

Records to be released from: ______________________________

For the following purpose: Medical Treatment

The authorization will expire on: ______________________
Date or Event may not exceed one year

This request and authorization applies to:

_____ All medical records

_____ Health care information relating to the following treatment,
Condition or dates of treatment: ______________________

____

_____ Specific records to be released (eg. Labs, imaging reports, other):

____

____

I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance and thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.

______________________________ ______________

Signature of Patient **Date**

UNIVERSITY MEDICAL GROUP

Patient Privacy Questionnaire and Notification

Patient Name:____ Date of Birth:__________________

I give permission to the physicians and their staff at University Medical Group to leave messages regarding my healthcare in the following manner when I am not available:

Contact Information:

I would prefer to be contacted at*: _______Home #___________________________________

_______Cell #_____________________________________

_______Work #____________________________________

_______Other #____________________________________

______May ONLY leave information with me. (If you check here, no other choice should be marked).

______May leave appointment reminders on my answering machine/voicemail.

______May leave lab results on my answering machine/voicemail.

______May leave general questions/information on my answering machine/voicemail.

______May leave a message with a call back number only.

Please list the name of the individual and relationship of anyone we may give information to:

Name:___________________________________Relationship:___________________Contact#:___________________

Name:___________________________________Relationship:___________________Contact#:___________________

______May leave appointment reminders with the above listed person

______May leave lab results with the above listed person

______May leave general questions/information with the above listed person

______May discuss billing information with the above listed person

______I prefer that all healthcare messages be given to the above listed person

*If we are unable to reach you by another means, we will send information through the U.S. Postal Service to your home address. We keep a record of each visit. This record may include your test results, diagnosis, medications, and your response to medications or other therapies. This allows your physicians and other clinical staff to provide appropriate care to meet your medical needs. The information in your record is called protected health information. We may disclose your protected health information to other healthcare providers or entities involved in your care.

I understand that my protected health information may be used to coordinate my treatment as described above. I have been offered a copy of the University Health System, Inc. (UHS) Notice of Information Practices. I understand that this Notice describes how my health information may be used or disclosed by this practice, UHS, UHS Ventures Inc., Physicians, and other providers practicing at UHS or UHSV facilities and that I should read it carefully. I am aware that the Notice may be changed at any time.

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to contact me or to employ a third-party automated outreach and messaging system to use my contact information, the name of my care provider, and other limited information, for the purpose of notifying me of balances due, when necessary. I authorize my health care provider or its agents to call my cell phone either manually or by auto dialer to collect any amount I owe. I understand that if any fees are incurred in the collection of my account, I will be responsible for any interest, court costs, and reasonable attorney's fee allowed by Tennessee Law.

Signature of Patient____ Date_____________________

University Vascular & Transplant Surgery Insurance Payment Policy

Thank you for choosing UT Vascular and Transplant Surgeons. We are committed to providing you with quality and affordable healthcare. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy for you to review. Please read it, ask us questions you may have and sign in the space provided below. A copy of this can be provided to you upon request.

1. Insurance Plans. We are providers with Medicare, most Aetna plans, Blue Cross, Blue Care, Cigna, Humana, Amerigroup, United Healthcare and most Medicare Advantage plans. If you are not insured by a plan that we do business with, you may be expected to pay in full for your visit. Please provide us with any updated insurance information. If you do not provide up to date insurance information, you may be responsible for your visit in full. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions regarding your coverage.
2. Co-payments. All co-payments must be paid in full at the time of service. This arrangement is part of your contract with your insurance company. Please be prepared to make all payments at the time of your visits.
3. Non-covered Services. Please be aware that some of the services you receive may be non-covered or not considered reasonable or necessary by your insurance. Our office will file each visit to your insurance. If they deem that something is not reasonable or necessary, we ask that you submit payment for that service within a reasonable time frame.
4. Proof of Insurance. All patients must complete our patient information form before seeing a physician. We also ask that you complete this form once a year. We must obtain a copy of your current valid insurance card to provide proof of insurance. If you fail to provide us with the correct information in a timely manner, you may be responsible for the balance of the claim.
5. Claim Submission. We will submit your claims and assist you in any way we can to help get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their requests. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim. Your insurance benefits is a contract between you and your insurance company. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you. If you have Medicare, we will bill you any monies owed after we have received payment from Medicare and/or a secondary policy that you might have.
6. Coverage Changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. We will also need to have a copy of your new insurance card(s).
7. Non-Payment. If your account is over 90 days past due, you will receive a letter from our billing office. Partial payments are accepted as long as you call them directly to set up the necessary payment plan. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency.

Our practice is committed to providing the best treatment to our patients. Thank you for understanding our payment policies. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by all guidelines.

______________________________	______________
Signature of Patient or Responsible Party	**Date**