Robert Elder, MD
1930 Alcoa Hwy., Suite A-235
Knoxville, TN 37920
(P) (865) 305-5940
(F) (865) 305-5941

THE UNIVERSITY OF TENNESSEE MEDICAL CENTER

Date: _____

Dear: _____

We would like to welcome you to University Urogynecology. We appreciate the trust you have placed in us. You are scheduled to see Dr. Robert Elder on _____ at _____ EST. Please arrive 30 minutes prior to your appointment to allow us to complete your registration. **If you should arrive 10 minutes after your scheduled appointment time listed above, you will be asked to reschedule to a later date!**

Enclosed is the new patient paperwork for your initial visit. **It is imperative that you return the completed packet in the provided pre-paid self-addressed stamped envelope immediately so that we can request the proper records prior to your appointment. Include the name of the physician, along with their contact information and dates pertaining to any surgeries, studies, or procedures related to your diagnosis.** We will require your current insurance card(s) and co-payment.

Parking is available in parking garage H and located across from the fountain circle. Campus parking is $2.00 and is paid as you exit the premises. Enclosed is a map to help you find the correct parking area. We are in Building A on the 2nd floor. We are located in Suite 235 across from the elevators. Please allow 15 minutes for commuting from the parking lot to our office.

If you have any questions, please contact us during our business hours Monday - Friday 8:00 am - 4:30 pm.

Thank you,

UT Urogynecology

UT UROGYNECOLOGY
PATIENT REGISTRATION

Date:	For Internal Use Only:	MRN:
PATIENT INFORMATION		
First Name:	Middle:	Last:
Social Security Number:		Date of Birth:
Home Address:		
City:	State:	Zip:
Home Phone:		Cell Phone:
Email Address:	Race:	Ethnicity:
Employment Status (Circle One):	Employed Retired Disabled Student Other	
Employer:		Work Phone:
Marital Status (Circle One):	Married Single Divorced Widowed	
Referring Physician:		Phone:
How Did You Hear About Our Office:		
PREFERRED PHARMACY		
Pharmacy Name:		Phone:
PRIMARY INSURANCE INFORMATION		
Insurance:	ID:	Group:
Name of Insured:	DOB:	SSN:
SECONDARY INSURANCE INFORMATION		
Insurance:	ID:	Group:
Name of Insured:	DOB:	SSN:
EMERGENCY CONTACT (List TWO)		
First Name:	Middle:	Last:
Relationship:		
Home Phone:	Cell Phone:	Work Phone:
First Name:	Middle:	Last:
Relationship:		
Home Phone:	Cell Phone:	Work Phone:
SPOUSE/GUARANTOR/RESPONSIBLE PARTY		
First Name:	Middle:	Last:
Home Address:		
City:	State:	Zip:
Social Security Number:		Date of Birth:
Relationship:		
Employer:		
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 any non-covered services.

SIGNATURE (Patient or Parent if minor) DATE

UT Urogynecology Insurance Payment Policy

Thank you for choosing UT Urogynecology. 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. Please read it, ask us any questions you may have, and sign in the space provided. A copy of this can be provided to you upon request.

1. **Insurance Plans.** We are providers with Medicare, most Aetna plans, Beech Street, Blue Cross/Blue Shield, Blue Care, Champus-military only, Cigna, the Initial Group, Humana, Americhoice Tenncare, and United Health. We are **not** insured with UHC Secure Horizon. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but do not have an up to date insurance card, payment in full is required until we are provided with a current copy of your insurance information. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions that you may have 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 help us in upholding your agreement by paying your co-payment at each visit.
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, even though your physician feels that it is necessary. Our office will file each visit to your insurance company. If they deem that something is not reasonable or necessary, we ask that you submit payment for that item immediately.
4. **Proof of Insurance.** All patients must complete our patient information form before seeing a physician. We will 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 request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. We will pre-collect any expected coinsurance or deductibles prior to scheduling surgeries and procedures. Your insurance benefit 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 money's 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.
7. **Non-Payment.** If your account is over 90 days past due, you will receive a letter from our billing department. 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 policy. 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**

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 send confidential messages regarding appointments, lab results, or general messages to your patient portal account

_____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:_____

Name:_____Relationship:_____

_____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.

Signature of Patient_____ Date_____

UT UROGYNECOLOGY

C. Bryce Bowling, MD
Robert Elder, MD
Michael Polin, MD
Jessica Dove, FNP-BC

1930 Alcoa Hwy, Suite A-235
Knoxville, TN 37920
(P) 865-305-5940 (F) 865-305-5941

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 Urogynecology for the purpose of Medical Treatment.

Records to be released from: _____

_____

_____

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 (example: labs, imaging reports, operative reports):

_____

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**

Patient Intake Form

Name			
Birthdate		Age	

Reason for Visit Today

Allergies

GYN History

Last menstrual period		
Age of first period		
Number of days between periods		
Length of period (days)		
Describe periods (heave, clots, irreg, etc.)		
Method of birth control		
Have you ever used birth control pills? Y N	IUD? Y N	DepoProvera? Y N
Last pap smear	Result	
Ever had abnormal pap smear? Y N	Result	
Last Mammogram	Result	
Last Colonoscopy/Barium enema/Sigmoidoscopy		
Last Bone Density scan/DEXA		
Ever had sexually transmitted disease (gonorrhea, chlamydia, syphilis, herpes, genital warts?) Y N		
Ever had problems with infertility? Y N		
Ever had Endometriosis? Y N		
Ever had Fibroids? Y N		
Would you take blood or blood products in an emergency? Y N		

Obstetric History

	Number		Number		Number
Pregnancies		Abortions		Miscarriages	
Premature Births (<37 wk)		Live Births		Living Children	

Birth Date	Birth Weight	Gender	Weeks Preg.	Delivery Type	Notes

Current Medications

Name	Dose	Frequency	Who prescribed

Social History			
	Yes	No	Explain
Smoking			
Alcohol			
Drug Use			
Regular Exercise			
Physical or sexual abuse			
Advanced directive of living will			
Organ donor			

Past Medical and Family History						
Do you or anyone in your family have..	Yes	No	Explain			
Asthma/Bronchitis						
Emphysema/COPD						
High cholesterol/Lipids						
Heart defects/Arrhythmias						
Heart attack/Disease						
Diabetes						
High Blood Pressure						
Stroke						
Blood Clots/Bleeding Disorders						
Depression/Anxiety						
Psychiatric Disorders						
Anemia/Blood Transfusion						
Seizures/Epilepsy						
Intestinal/Bowel/Colon Disorders						
Hepatitis/Liver Disease						
Thyroid Disease						
Gallbladder Disease						
Alzheimer's Disease/Dementia						
Migraines/Headaches						
Cancer						
Other						

Operations/Hospitalizations		
Reason	Date	Hospital

Immunizations		
	Date	Reactions
Tetanus		
MMR		
Influenza		
Pneumovax		
PPD		
Hepatitis B		

Review of Symptoms			
	Yes	No	Notes
Chest pain/pressure			
Shortness of breath			
Swelling in legs			
Palpitations			
Rapid heartrate			
Weight loss/gain			
Fever/Chills/Night Sweats			
Fatigue			
Rash			
Abnormal moles			
Heat/Cold Intolerance			
Frequent bruising			
Uncontrolled thirst			
Hearing loss/deafness			
Mouth sores			
Diarrhea			
Constipation			
Nausea/Vomiting			
Bloody stool			
Bloody urine			
Painful urination			
Strong urgency to urinate			
Frequent urination			
Involuntary urine loss			
Muscle or joint pain			
Dizziness			
Numbness			
Trouble walking			
Abnormal bleeding			
Painful periods			
Hot flashes			
Painful intercourse			
Pain in breast			
Nipple discharge			
Lumps in breast			
Blurred/spotty vision			
Depression			
Anxiety			
Difficulty breathing			
Wheezing			
Coughing up blood			
Chronic cough			

Medication List

Patient Name:_____DOB_____

Allergies

Medication Name	Directions