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THE UNIVERSITY OF TENNESSEE MEDICAL CENTER

Wisdom for Your Life.

University Gynecologic Oncology

Cancer Institute, Suite 410
1926 Alcoa Highway
Knoxville, TN 37920

865.305.5622
fax 865.305.4580
universitygynoncology.org

Welcome to The University of Tennessee Medical Center

You are scheduled for an upcoming office appointment and consultation with University Gynecologic Oncology at The University of Tennessee Medical Center, Cancer Institute. The physicians, nurse practitioners and staff look forward to meeting you and promise to make your visit helpful and efficient.

Women may be referred to Gynecologic Oncologists for suspected or known female malignancy (cancer) **OR** for complex but benign gynecologic conditions. Other women may be referred to determine the risk of developing female cancer later in life, and in some cases, determine how to reduce that risk.

Enclosed are a few forms for your upcoming visit and some information you may find helpful. Feel free to complete any or all of the forms and bring them along for your visit. Please bring a list of your medications, allergies and previous surgeries if possible. We also ask that you bring your insurance card and a photo ID.

Don't hesitate to contact our office at 865.305.5622 should you need additional information or have questions about your appointment.

Larry C. Kilgore, M.D.

Kristopher J. Kimball, M.D.

Amanda W. Berry, NP

Shelly B. Foust, NP

Amanda O. Cameron, NP

DATE _____

PATIENT REGISTRATION

FOR INTERNAL USE ONLY
PATIENT NUMBER _____

PATIENT INFORMATION

SOCIAL SECURITY # _____ HOME ADDRESS _____

FIRST NAME _____ MIDDLE _____ _____

LAST NAME _____ CITY _____ STATE _____ ZIP _____

SEX _____ DATE OF BIRTH _____ EMAIL _____

MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED

(CHECK ONE)
☐ EMPLOYED ☐ RETIRED
☐ FULL TIME STUDENT ☐ OTHER

HOME PHONE (_____) _____

WORK PHONE (_____) _____

CELL # (_____) _____

REFERRING PHYSICIAN _____

EMPLOYER _____ HOW DID YOU HEAR OF US? _____

PRIMARY INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

INSURED / CARD HOLDER'S NAME _____

RELATIONSHIP _____ DOB _____ SOC. SEC. # _____

SECONDARY INSURANCE INFORMATION

INSURED / CARD HOLDER'S NAME _____

RELATIONSHIP _____ DOB _____ SOC. SEC. # _____

EMERGENCY CONTACT

RELATIONSHIP _____ SEX _____

FIRST NAME _____ MIDDLE _____ HOME PHONE (_____) _____

LAST NAME _____ WORK PHONE (_____) _____

SPOUSE / GUARANTOR / RESPONSIBLE PARTY

SOCIAL SECURITY # _____ SEX _____ DATE OF BIRTH _____

RELATIONSHIP _____ DAYTIME PHONE (_____) _____

FIRST NAME _____ MIDDLE _____ EMPLOYER _____

LAST NAME _____ ADDRESS _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

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

University Health System, Inc.
University Gynecologic Oncology
Larry Kilgore, M.D. & Kristopher Kimball, M.D.

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I, _____, hereby authorize the use or disclosure of my identifiable health information as described below.

Person(s)/Organization(s) Authorized to Provide Health Information:

All Medical Providers are authorized to release or disclose all of my health records, whether past or current, including but not limited to medical offices, hospitals and clinics.

Specific Description of Information to be Disclosed:
Any and all medical records, including but not limited to complete medical records, admission, discharge summaries, histories and physical exams, consultation reports, orders and progress notes, operative reports, x-ray reports, radiology/CT films, pathology reports, pathology samples/slides, laboratory tests, all medical tests, descriptions of treatment, diagnoses, prognoses, opinions and recommendations, including but not limited to all materials, records, notes, raw data, objective test results, pharmacy information or prescriptions written and dispensed, and reports used in the evaluation, care and treatment.

Purpose of the Request
I Understand and Acknowledge:

1. that this authorization is voluntary;
2. that if the organization or individuals authorized to receive the information are not a health plan or health care provider, the released information may no longer be protected by the federal privacy regulations that became effective in April 2003
3. that all or part of the disclosed information may be used or redisclosed as exhibits at judicial or administrative filings, hearings or proceedings;
4. that my health care and payment for my health care will not be affected if I do not sign this form;
5. that the health care provider may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization, except as permitted by law;
6. that this authorization shall remain in effect for a period of ***five (5) years*** from the date that I sign this authorization or until I have otherwise notified said providers this authorization is withdrawn;
7. that I may revoke this authorization at any time by notifying the providing organization in writing, but that if I do, it will not have any effect on any actions the organization takes before they receive the revocation;
8. that I may receive a copy of this form after I sign it if I request it; and
9. that a copy of the this authorization shall be as valid as the original; and
10. that I consent to release of medical information, including medications, that may relate to HIV, AIDs, STD, communicable disease, mental health, genetic, or alcohol/substance abuse treatment information.

Signature of Patient: _____ Date: _____

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

5101

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) HIV/HEPATITIS TESTING

In the event of an employee, student, or other healthcare provider exposure to my blood/body fluids, I hereby give permission for confidential HIV (AIDS) and hepatitis testing (at no charge to patient).

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 _____

Witness_____ 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 (Advance Care Plan or Appointment of Health Care Agent). I understand that UTMC cannot honor any such document unless it has been legally executed and made a part of my medical record.

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:

_____

Date _____

CONSENT TO PHOTOGRAPH

I HEREBY AUTHORIZE THE UNIVERSITY GYN ONCOLOGY STAFF MEMBER TO PHOTOGRAPH (NAME OF PATIENT _____) WHILE UNDER THE CARE OF THE ABOVE INSTITUTION FOR PATIENT IDENTIFICATION PURPOSES ONLY.

_____ (signature of patient)

_____ (GYN ONC staff initials)

University Gyn Oncology

Larry C. Kilgore, M.D.

Kristopher J. Kimball, M.D.

You have been given a copy or a copy has been made available to you of the HIPAA Notice of Privacy Practices.

May we leave a message for you on your voice mail/answering machine?

YES____ NO____

List anyone that may call and get health information on your behalf.

_____Relationship_____

_____Relationship_____

_____Relationship_____

_____Relationship_____

_____Relationship_____

Our Mission

To serve through healing, education, and discovery

THE UNIVERSITY OF TENNESSEE MEDICAL CENTER

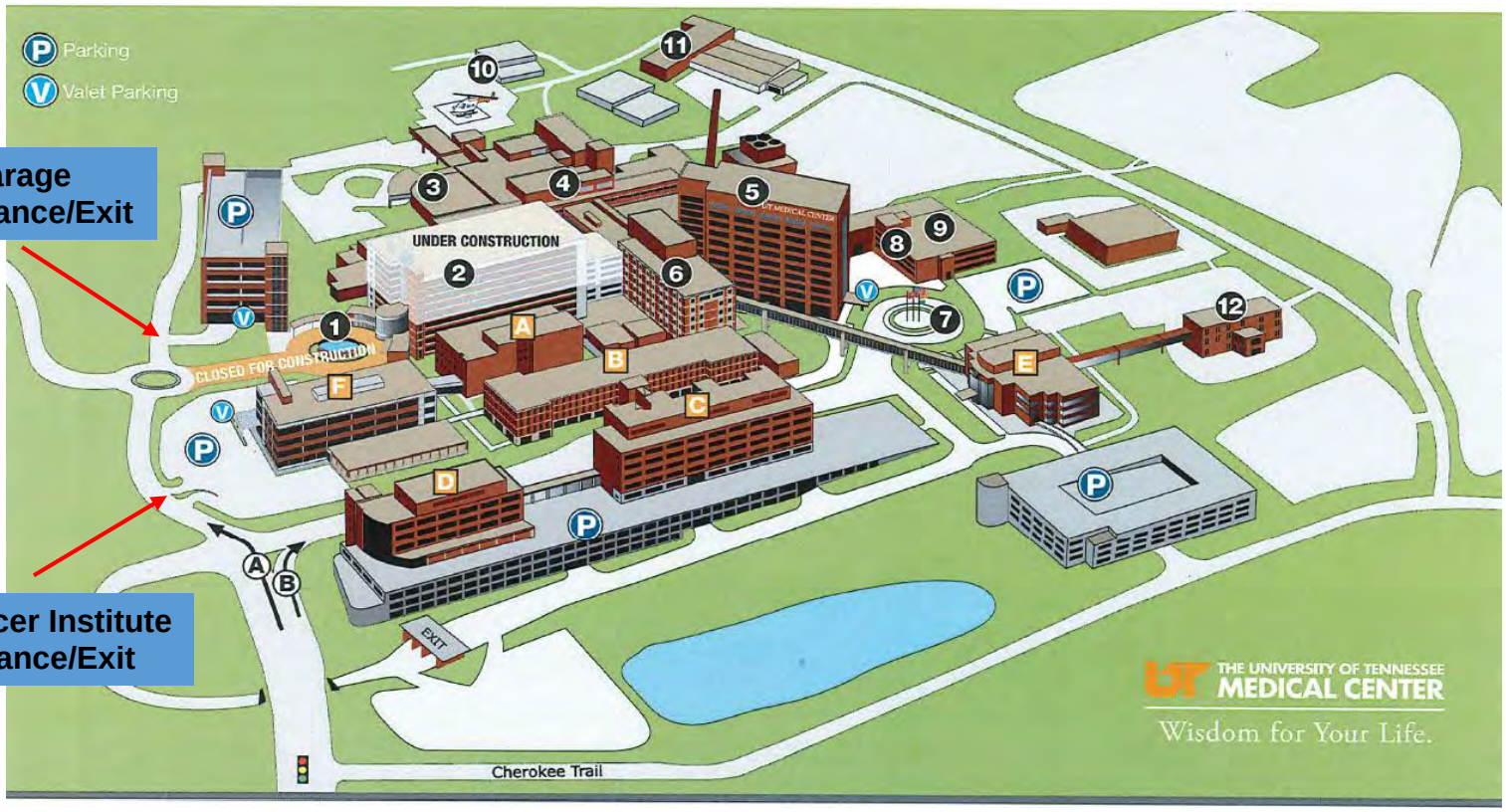
CANCER INSTITUTE

PARKING INSTRUCTIONS

Please park in the Cancer Institute parking lot. If the Cancer Institute lot is full, it may be necessary to park in H Garage and walk across the street, or if necessary, valet parking is offered at the Cancer Institute entrance. Due to construction around the Cancer Institute, please allow extra time to park. Upon entering the Cancer Institute, please take the elevators to the 4th floor. Please see the map below for an overview of the hospital campus.

H Garage Entrance/Exit

Cancer Institute Entrance/Exit



UT Medical Center Campus

Route A: Parking Garage H, Emergency Dept, MRI, Endoscopy and Cancer Institute

Route B: To Hospital/Main Entrance, To Medical Offices and Parking Garage

1. Fountain Circle-**Closed for Construction**
2. Heart Hospital, Endoscopy Center, MRI
3. Emergency/Trauma
4. North Tower
5. East Boling Patient Pavilion
6. South Pavilion
7. Flag Circle-Patient Drop-Off/Pick-Up
8. UT Graduate School of Medicine
   University Family Medicine
9. UT College of Pharmacy
10. UT LIFESTAR
11. Human Resources/
    Facilities Planning
12. Cherokee Trail Building

Medical Office Buildings

- A Medical Building A
- B Medical Building B
- C Medical Building C-*Brain and Spine Institute*
- D Medical Building D-*UT Day Surgery*
- E Medical Building E-*Heart Lung Vascular Institute*
- F Medical Building F-*Cancer Institute*
  Advanced Orthopaedic Center