EAST TENNESSEE MEDICAL ASSOCIATES, PC

****PATIENT INFORMATION****

Last Name:__________________First Name______________________Middle Initial:_______
Mailing Address:____DOB:__________
City:____________State:_____Zip:________Social Security #:_______________ Sex:_______
Cell Phone:________________ Home Phone:_________________Email:_________________
Marital Status:___________________ Ethnicity:________________Race:_________________
Preferred Language:______________________________Employer:______________________
Primary Medical Doctor:____________________________________Phone:_________________

EMERGENCY CONTACT

If there is an emergency while you are at our office, who should we contact?

Name:________________________Phone:____________________Relation:_______________

INSURANCE INFORMATION

Primary Carrier:____________________Subscriber ID:________________
Secondary Carrier:__________________Subscriber ID:________________

If you did not provide copies of your insurance cards more information may be needed to file your insurance claims.

HEALTHCARE COMMUNICATION AUTHORIZATION

You may leave messages or discuss my treatment, appointments, or other scheduling that may occur and give other information as necessary with the following personal representatives.

Name:__________________________Phone:_______________Relationship:___________
Name:__________________________Phone:_______________Relationship:___________
Name:__________________________Phone:_______________Relationship:___________
Name:__________________________Phone:_______________Relationship:___________

I understand that East Tennessee Medical will NOT provide information to anyone not listed above.

Acknowledgment of Notice of Privacy

I understand that the practice will provide, at my request, a copy of the HIPAA Notice of Privacy, which is clearly posted in the lobby area.

Authorization To Treat

I hereby consent to evaluation, testing, and treatment as directed by my Physician or his or her designee.

Assignment of Benefits To Physician

I authorize the release of medical or other information necessary to process health insurance claims and request payment of benefits to East TN Medical Associates.

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Signature Printed Name Relationship if other than Self Date

East Tennessee Medical Associates Office Use Only		
Nephrologist	**MRN**	**Date**

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FINANCIAL POLICY

If you have insurance, we will file the claim for you. It is the responsibility of the patient to provide complete and accurate insurance information. If you have an office visit co-pay, it is due at the time of services. Once your insurance company processes your claim any amount applied to your deductible or coinsurance will be billed to you.

If you do not have insurance coverage, please arrange payment at the time of service.

Lab services are provided by LabCorp. Any lab work done while you are here will be filed to your insurance company by LabCorp or billed to you if you do not have insurance.

By signing you indicate you understand the above policy.

Signature Printed Name Relationship if other than Self Date

NO SHOW/CANCELLATION POLICY

East TN Medical Associates carefully schedules our appointments so that each patient receives the appropriate amount of time to be seen by our physicians and staff. Additionally, your physicians choose your follow up appointments based on the condition of your health. It is imperative to your care that you follow up with our clinic regularly. That's why it is very important that you keep your scheduled appointment and arrive on time.

We also understand there will be times when you must reschedule. If you cannot keep your appointment, please contact us as soon as possible and preferably the day before your appointment. This allows you to schedule another appointment that most closely aligns with your anticipated follow up date and provides an opportunity for those waiting for an appointment to be seen.

What does this mean for you?

- **Appointments cancelled on the day of the appointment will be treated as a No Show.**
- **If you are more than 15 minutes late for your appointment your physician may not be able to see you and will consider this a no show.**
- **You will get one warning letter from us if you have multiple cancellations or no shows to let you know that you are not in line with the policy.**
- **If you continue to miss appointments without notifying the clinic, East Tennessee Medical Associates may terminate its relationship with you. If that occurs, you will receive a Certified Dismissal Letter and our physicians will only be able to treat you in the hospital setting.**

By signing this policy, you confirm that you have read and understand our new no show and cancellation policy. A copy of this notice can be provided to you upon request.

Signature Printed Name Relationship if other than Self Date