Campbell Station Primary Care Associates
Caring for Our Community

Family Practice ♦ Primary Care
Board Certified Family Nurse Practitioner
FED ID# 62-1864574

Robert M. Martin, MS, CFNP
J.K. Buchanan, MD – Consultant Physician

(865) 675-7522 PH
(865) 671-3196 FAX

PATIENT INFORMATION

PLEASE PRINT

LAST NAME	FIRST	MIDDLE	DATE

STREET	HOME PHONE	MARITAL STATUS

CITY / STATE　　ZIP CODE　　BIRTHDATE　　SOCIAL SECURITY

PERSON RESPONSIBLE FOR PAYMENT　**Insurance Carrier:**

Pharmacy:

LAST NAME　　FIRST　　MI　　RELATIONSHIP TO PATIENT

ADDRESS　　CITY　　STATE　　ZIPCODE

SOCIAL SECURITY NO.　　HOME PHONE　　BUS. PHONE　　DATE OF BIRTH
SEX

EMPLOYER NAME　　EMPLOYER ADDRESS　　EMP PHONE

EMERGENCY CONTACT

NAME　　HOME PHONE　　BUSINESS PHONE　　RELATIONSHIP TO PATIENT

DO YOU HAVE A LIVING WILL?　　Are your Immunizations up to date?

PRESCRIPTION, REFERRAL, LABORATORY, AND DIAGNOSTIC POLICY

In order to provide all patients with the same standard of quality care, it is the policy of this office to

1. Return Telephone calls within 24 hours. For Emergencies, Please present to the ER or call 911.
2. Call-in prescription requests will be approved or denied within 48 hours - Because of liability: **Controlled Medications Can Not Be Called In.**
3. All health care is rendered by the Board Certified Primary Care Family Nurse Practitioner.
4. Labs and Diagnostic results in most cases will be ready within 5 working days. Please call for followup.

Please Sign indicating that you have read this policy __________

Campbell Station Primary Care, 11541 Kingston Pike, Suite 101, Knoxville, TN 37934
(865) 675-7522 Phone
(865) 671-3196 FAX

Robert M. Martin, MS, CFNP
J.K. Buchanan, MD –
Consulting Physician

Authorization to Release Medical Records

PATIENT INFORMATION			
LAST NAME	FIRST	MIDDLE	DATE
STREET			HOME PHONE
CITY / STATE		ZIP CODE	BIRTHDATE

ADDRESSED TO HEALTH CARE PROVIDER:			
DR.			
ADDRESS	CITY	STATE	ZIPCODE
BUSINESS PHONE	BUSINESS FAX		

AUTHORIZATION

I authorize the release of any and all of my medical records (including labs, progress notes, x-ray reports, and all correspondence) to :

Campbell Station Primary Care Associates
Advantage Family Healthcare, PLLC
Robert M. Martin, MS, CFNP

Please Fax, Mail, or Email Medical Records to:

Campbell Station Primary Care
11541 Kingston Pike, Ste 101
Knoxville, TN 37934

(865) 675-7522
(865) 671-3196 FAX
campbellstation@hotmail.com

SIGNATURE: ______________________ **DATE:** encdate

Campbell Station Primary Care Associates
Pre-Office Visit Information

Name: ____________ Date: ____________

We will bill your insurance if your coverage can be verified, if it cannot, payment for the visit is due in full at the time of service.

If your insurance coverage cannot be verified, and you cannot pay for the cost of the office visit, then unfortunately you will not be seen and you will have to re-schedule your appointment.

Note to Patient and Third Party Payors:
Acquisition and processing charges are billed if laboratory services are performed. The clinician is entitled to fair compensation for whatever costs are incurred for specimen preparation and handling as well as costs associated with billing and receiving payment for laboratory services that are referred out and for whatever unforeseen services (that are otherwise not reimbursable) might be necessary as a result of the specimen interpretation including, but not limited to, incorporation of the specimen result into the patients file, interpretation results and other contingent factors, notification of the patient of the result and potential changes in treatment plans that require additional clinician time outside of the normal office visit. The additional costs, are acquisition or processing charges the clinician may ethically add to the cost charged by the pathologist, but will not exceed contracted rates. Tennessee Board of Medical Examiners Private Advisory Ruling MD-04-01

The cost of the office visit is $75.00. When lab analysis is medically necessary, these charges will be added at the end of the visit. We will make every effort to keep the cost to a minimum, including providing cash client discounts when possible. At the same time, we serve our patients according to AHRQ / US Department of Health and Human Services Guidelines

Please Sign indicating that you have read this policy ________

BILLING POLICY AND CREDIT CARD AUTHORIZATION

To decrease billing expenses for the cost of collections and to facilitate payments for our patients, your balance after insurance payment will be automatically charged to a credit or debit card. You will see a debit on your card statement from Advantage Family Healthcare, PLLC. If your insurance does make additional payments on your account creating a credit in your favor, your card will be refunded immediately.

Please be assured that we protect all of your personal information.

Patient Name: ____________________ Name as Printed on Credit Card: ____________________________________

Home Phone: ____________________ Work or Cell Phone: ____________________

Credit Card Information:
Visa _______ Mastercard ______ Discover _______ American Express _____

Billing Address for the Card --

Card Number ___________________________ Expiration Date: ________________
CVC Number ________

I authorize Advantage Family Healthcare to automatically bill the card listed above for any personal balance I incur after insurance payment has been made.

Signature _______________________ Date ______________________

Name:
SS #
DOB: Age:
Address:
Marital Status:
Telephone #
Email:
Insurance:
Member #

Physicians / Specialists
Primary Care: **Martin, CFNP**

Other MD'S: ____

Other PCP

HISTORIAN
Who is filling out this form?
Patient ☐ Spouse ☐
Child ☐ Parent ☐
Other:
Pharmacy:

Personal Health History

- ☐ Kidney or bladder disease
- ☐ Hypertension
- ☐ Heart or Cardiovascular disease
- ☐ Lung Disease ☐COPD, ☐Asthma, ☐Emphysema
- ☐ Stroke
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Hepatitis
- ☐ Liver or Pancreatic disease
- ☐ Stomach disease or colon disease
- ☐ Frequent Urination, Urgency, or Accidents
- ☐ Cancer -> TYPE:

- ☐ Depression ☐ Anxiety
- ☐ Emotional or Psychiatric illness
- ☐ Victim of Physical or Sexual Abuse
- ☐ Substance abuse
- ☐ Alcohol, ☐Tobacco, or ☐ Drugs
- ☐ Fractures
- ☐ Arthritis
- ☐ Frequent Headaches
- ☐ Problems with eyes, ears, throat
- ☐ Ever been in hospital isolation
- ☐ Back pain
- ☐ Seizures

Any Other Problems We Have Not Mentioned:

Notes:

Past Medical History

Acute Health Problems:

Chronic Health Problems

1. ________________
2. ________________
3. __________
4. __________
5. ________________

Surgeries / Hospitalizations / ER with Date (s)

1. __________
2. __________
3. __________
4. __________
5.
6.

Family Health History **Health Problems?**

Mother: living ☐ deceased ☐
Father: living ☐ deceased ☐
Siblings: __
Children: ____

Social History

1. Living Arrangements:
2. Alcohol ☐ How many drinks per week?
3. Tobacco ☐ How many packs per day?
4. Recreational Drug use ☐ ______________

Health Maintenance:

Last PAP/Pelvic ________________

Last Mammogram: __________

Immunizations: _________Tetanus:
Other

Provider Signature: ____________________

Drug Allergies: ____ ; ______ ; __ **No Known Drug Allergy** ☐
Seasonal Allergies: Yes ☐ No ☐ **Food Allergies:** Yes ☐ No ☐ __

⇐ Patient Signature: ________________

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FINANCIAL RESPONSIBILITY

LAST NAME	FIRST NAME	DOB

INSURANCE INFORMATION (Please allow us to make a copy of your insurance card)

PRIMARY INSURANCE		**SECONDARY INSURANCE**	
INSURANCE NAME		INSURANCE NAME	
CLAIMS ADDRESS		CLAIMS ADDRESS	
INSURANCE PHONE NO.		INSURANCE PHONE NUMBER	
ID NUMBER:		ID NUMBER	
GROUP NUMBER:		GROUP NUMBER	
SUBSCRIBER'S NAME:		SUBSCRIBER'S NAME	
SUBSCRIBER'S SS #		SUBSCRIBER'S SS #	
SUBSCRIBER DATE OF BIRTH	SEX	SUBSCRIBER DATE OF BIRTH	SEX
PATIENT'S RELATIONSHIP TO SUBSCRIBER:		PATIENT'S RELATIONSHIP TO SUBSCRIBER	
EFFECTIVE DATE		EFFECTIVE DATE	

IMPORTANT! **PLEASE READ**

The patient (or guardian) is ultimately responsible for all fees, regardless of insurance coverage or pending litigation. If you have insurance coverage, a claim will be filed, however, the patient (or guardian) is responsible for all fees. It is the patient's (or guardian's responsibility to assure that the provide is a member of your insurance plan and inform our office, prior to being seen, or if you have been scheduled with a non-provider. It is also your primary responsibility to inform our office of any needed prior authorizations.

AUTHORIZATION and ASSIGNMENT of BENEFITS

I hereby authorize Advantage Family Healthcare, PLLC, to furnish information to my insurance carrier concerning my illness and treatment and to request additional medical information from any hospital or provider who has cared for me.

I hereby assign Advantage Family Healthcare, PLLC, all payments for medical services rendered to my dependents or myself. I understand that in the event that the signee defaults or becomes delinquent on the terms of this agreement, a finance charge of 1.5% per month will be added to the balance from the date of service. Should the provider of service be required to employ an Attorney or a collection service to collect the balance, a fee of 50% shall be added to the amount due, plus any court costs and attorney fees if necessary to enforce this agreement.

⇐Patient Signature (or guardian): ______________________________ Date: encdate

PATIENT CONSENT FORM

The Department of health and Human Services has established a “Privacy Rule” to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients’ consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of our health dare information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use of disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already taken been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you

have reviewed our privacy notice. ⇐

Print Name: ________________________ Signature: ________________________ Date: encdate 4:30 PM

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENT

To our Valued Patients:
The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers, and providers continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPPA) with particular emphasis on the “Privacy Rule”. We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes n any way to the growing problem of improper disclosure of PHI. As par of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. Moreover, we welcome your input regarding any service problem so that we may remedy the situation promptly. Thank you for being one of our highly valued patients.

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COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To our Valued Patients:
The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers, and providers continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPPA) with particular emphasis on the “Privacy Rule”. We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

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PATIENT TESTING AFTER HEALTHCARE WORKER EXPOSURE

PLEASE PRINT			
LAST NAME	FIRST	MIDDLE	DATE

POLICY

Advantage Family Healthcare and other health care workers handle blood and other body fluids for many reasons, such as when performing lab tests, inserting tubing, and cleaning equipment. It is the policy of Advantage Family Healthcare, PLLC to test a patient for Hepatitis B, Hepatitis C, and HIV (the virus that causes AIDS) if any employee or other health care worker is exposed to a patient's blood or other body fluids in such a way that transmission of these infections could occur. An example of an accidental exposure is a needle stick with a needle that has been used on you. Should an accidental exposure occur, the tests would be at no cost to you. We are requesting that you sign this consent form prior to treatment, but you are not required to do so.

AUTHORIZATION FOR TESTING

If any employee or other health care worker is exposed to my blood or body fluids, I hereby authorize Advantage Family Healthcare, PLLC to test my blood for Hepatitis B, Hepatitis C, and HIV.

______________________________ ____________________

Patient's Signature Date

I decline to authorize the above testing.

______________________________ ____________________

Patient's Signature Date

Campbell Station Primary Care Associates

Caring for Our Community

Payment Plan Agreement

I, _____________________agree to pay Advantage Family Healthcare, PLLC the balance of incurred charges for my account according to the payment schedule set out below. I understand that I am responsible for all fees and agree to stated payment policies, including collection fees and/or legal fees should I default on repayment.

Name:
Advantage Family Healthcare Payment Plan:

Balance	Repayment Period to be Paid In Full by:
$ 1 - $99	3 months from date of Service
$100 - $499	6 months from date of Service
$500 and Greater	9 months from date of Service

I understand that at the time of service, I will be responsible for my co-pay, if applicable, plus 1/2 the outstanding balance or $50 whichever is less.

Name:

⇐ Patient Signature (or Guardian) ________________________________ Date: ___________

Payment may be in the form of Cash, Check, Visa, or Mastercard paid in person or by US Mail payable to:

AFHC
Campbell Station Primary Care Associates
11541 Kingston Pike, Suite 101
Knoxville, TN 37922

Reminders will be sent out on the 1st of each month whenever the account maintains an indebted balance. This payment plan has been made available to help you the patient continue to receive quality health care when full payment at the time of service is not financially possible. AFHC reserves the right to request payment in full should the account remain delinquent beyond the stated time periods.
Thank you for your cooperation.

MEDICATION HISTORY

PATIENT NAME:

PHARMACY:

PLEASE LIST ALL MEDS THAT YOU ARE CURRENTLY TAKING

Medical Condition______________________________

Drug Name____________________**Dosage**__________

Medical Condition______________________________

Drug Name____________________**Dosage**__________

Medical Condition______________________________

Drug Name____________________**Dosage**__________

Medical Condition______________________________

Drug Name____________________**Dosage**__________

Medical Condition______________________________

Drug Name____________________**Dosage**__________

Medical Condition______________________________

Drug Name____________________**Dosage**__________

Medical Condition______________________________

Drug Name____________________**Dosage**__________

Medical Condition______________________________

Drug Name____________________**Dosage**__________

Medical Condition______________________________

Drug Name____________________**Dosage**__________