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| **PATIENT INFORMATION** | | | |
| **Last Name** | **First Name** | | **Middle Name** |
| **Name you like to be called (*Nickname*)** | **Date of Birth** | | **Social Security No.** |
| **Address** | **City / State/ Zip Code** | | **Gender**    **( ) Male ( ) Female** |
| **Phone:**  **Home**  **Cell**  **Work** | **Email** | | **Mother’s Maiden Name**  *(ID Purpose Only****)*** |
| **Emergency Contact Name** | **Emergency Contact Number Relationship to Patient**  **( )** | | |
| **Language Spoken (mark all that apply)**  **[ ] English**  **[ ] Spanish**  **[ ] Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Marital Status**  **[ ] Single**  **[ ] Married**  **[ ] Widowed**  **[ ] Divorced** | | **Contact Preference**  **[ ] Ok to leave confidential message**  **[ ] Do not leave confidential**  **message** |
| **Homeless Status**  **[ ] Not Homeless [ ] Doubling up [ ] Shelter [ ] Street**  **[ ] Transitional Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Housing Status**  **[ ] Public Housing**  **[ ] Not in Public Housing** | | **Student Status**  **[ ] Full Time**  **[ ] Part Time**  **[ ] Not a Student** |
| **Employer Address Phone Number**  **Migrant\Seasonal Status**  **[ ] Migrant *(A person\dependent whose principle employment has been in agriculture within the last 24 months and has had to establish a temporary home for the purpose of such employment)***  **[ ] Seasonal *(A person\dependent whose principle employment has been in agriculture on a seasonal basis and has not had to establish a temporary home for the purpose of such employment)***  **[ ] Not a Farm Worker** | | | |
| **Race**  **[ ] Asian [ ] American Indian**  **[ ] Black\African-American [ ] Native-Hawaiian**  **[ ] More than one race [ ] White**  **[ ] Other Pacific Islander [ ] Other \_\_\_\_\_\_\_\_\_\_\_\_** | | **Ethnicity Interpreter Status**  **[ ] Hispanic or Latino [ ] Yes**  **[ ] Not Hispanic or Latino [ ] No** | |
| **Veteran Status**  **[ ] YES**  **[ ] NO**  **[ ] N\A** | | **Referred By**  **[ ] Relative\Friend [ ] Church**  **[ ] Health Fair [ ] Hospital**  **[ ] Newspaper [ ] Other \_\_\_\_\_\_\_\_** | |
| **Do you have an Advance Directive? *(Living Will*)**  **[ ] YES [ ] NO** | | **Smoker**  **[ ] YES [ ] NO** | |
| **SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |

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| **RESPONSIBLE PARTY INFORMATION** | | | |
| **Person to be billed, if other than the patient** | | | |
| **RELATIONSHIP TO PATIENT [ ] Self (skip to next section) [ ] Spouse [ ] Parent [ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |
| **Last Name** | **First Name** | | **Middle Name** |
| **SSN** | **Date of Birth** | | **Gender**  **[ ] Male [ ] Female** |
| **Address (if different from above)** | **City State** | | **Zip Code** |
| **Home Phone**  **( )** | **Cell Phone**  **( )** | | **Work Phone**  **( )** |
| **Employer** | **Employer Name** | | **Employer Phone** |
| **INCOME INFORMATION** | | | |
| **State your household income in one of the following categories listed below**  **Weekly \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Monthly \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yearly/Annual \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **[ ] Decline to provide household income Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |
| **OFFICE USE ONLY**  **Qualify for sliding fee discounts? [ ] YES [ ] NO**  **[ ] 100% & below [ ] 101-133% [ ] 134-175% [ ] 176-200%** | | | |
| **INSURANCE INFORMATION** | | | |
| **PLEASE PRESENT ALL ACTIVE INSURANCE INFORMATION & A COPY OF INSURANCE CARDS** | | | |
| **PRIMARY INSURANCE**  **[ ] No Insurance [ ]Medicaid\TennCare [ ] Medicare [ ] Other (Employer\Private\Commercial)** | | | |
| **PATIENTS RELATIONSHIP TO INSURED PARTY**  **[ ] Self [ ] Spouse [ ] Child [ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |
| **Plan Name** | **Policy Number** | | **Group Number** |
| **Insured Name** | **Insured SSN** | | **Insured Date of Birth** |
| **Effective Date (if known)** | | **Co-Pay Amount $** | |
| **Employer** | **Employer Address** | | **Employer Phone**  **( )** |
| **SECONDARY INSURANCE**  **[ ]Medicaid\TennCare [ ] Medicare [ ] Other (Employer\Private\Commercial)** | | | |
| **PATIENTS RELATIONSHIP TO INSURED PARTY**  **[ ] Self [ ] Spouse [ ] Child [ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |
| **Plan Name** | **Policy Number** | | **Group Number** |
| **INSURED NAME** | **Insured SSN** | | **Insured Date of Birth** |
| **Employer** | **Employer Address** | | **Employer Phone**  **( )** |

**PATIENT FINANCIAL & INSURANCE AGREEMENT**

**PLEASE READ THOROUGHLY AND SIGN BELOW**

**In consideration of receiving services from the ETSU College of Nursing, Community Health Centers, you agree:**

1. All services are provided to you with the understanding that you are responsible for the charges regardless of your insurance coverage. If you would like to know the charge of a service, please inquire prior to treatment. Please be aware that not all services are a covered benefit with different insurance companies. You are responsible for knowing what services are or are not covered. **KNOW YOUR BENEFITS.**

2. At check-in, we will collect your co-pay, deductible, and payment for uncovered services as well as the patient’s portion as determined by insurance or sliding fee scale. We accept cash, check, and credit card of Master Card, Visa, and Discover.

3. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. **It is the patient’s responsibility to inform our office immediately of insurance coverage or insurance company changes**.

4. You are responsible for knowing if a referral is required. Make sure you know what providers are in your plan, what facilities are covered and what ancillary services you must use. (Such as laboratory, hospitals, etc.) If we can be of assistance, please let us know.

5. We will bill your insurance company as a courtesy, but you are still ultimately responsible for payment of all services you receive. If your insurance company does not respond within 30 days we will follow up with an inquiry on your behalf. If, however, your insurance does not respond within 60 days of claim submission, a statement will be sent to you. You should call your insurance company to question why the claim is not paid. Our office will assist you only after you have contacted your insurance company.

6. If your medical claim has not been paid and your insurance company has not resolved your dispute, you may register a complaint with the Tennessee Department of Commerce and Insurance. Our office will do everything we can to assist you; however, you must understand you cannot delay payment while you are awaiting the outcome of your complaint.

7. Any unpaid charges over 90 days old will be sent to an outside collection agency with an additional agency fee. **You are responsible** **for any collection fees, legal fees, or court costs incurred in the collection process**. This agency will report your failure to pay to the THREE (3) national credit reporting agencies.

8. Returned checks are subject to a $40.00 return check fee.

We do understand that temporary financial problems may affect timely payment. We encourage you to communicate any such problems so that we can assist you in the management of your account.

I authorize the East Tennessee State University (ETSU) College of Nursing (CON) Community Health Center (CHC) to examine, evaluate, and treat me, and/or my child, or ward. I authorize the CHC to release any\all clinical information necessary in order to submit my insurance claims to my insurance companies. I also request that my insurance companies pay benefits directly to the CHC for services rendered. I understand that the CHC will refund any overpayments on my account, in a timely manner.

Your signature below forms a binding agreement between the CHC (the provider of service) and the Patient who is receiving services or the Responsible Party for minor patients (those patients under 18 years old). Responsible Party is the individual who is financially responsible for payment of any charges

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Patient Printed Name**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CHC Staff Signature**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Patient/Guardian Signature**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date**

**HEALTH HISTORY**

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| **PATIENT NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **FAMILY**  **Is the child yours by □ Birth □Adoption □ Stepchild □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Who lives in the home? Parent/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Brothers /Step # \_\_\_\_\_ Sisters/Step # \_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **TOBACCO Is there tobacco use in/around your household? □ Yes □ No** |
| **ALLERGIES List any allergies *(Medications, Vaccinations, Food, Animals/Insects*, *Environmental*)**  **Please list nature of reaction \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **MEDICATIONS List any Medications/Vitamins/Herbs/Home Remedies your child takes on a regular basis. Please state the reason for the medication.** |
| **MEDICAL HISTORY**  **Past Medical History: Please describe any major medical problems *(Asthma, Seizures, Heart Problems, Skin, Hearing/Vision, Seizure, Depression, Thyroid, Hyperlipidemia, Diabetes, etc.)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SURGICAL HISTORY Has your child had any operations such as ear tubes, hernia repair, tonsillectomy? □ YES □ NO If yes, please explain – type of surgery, location, dates** |
| **PSYCHOSOCIAL – Please list any Learning Disabilities, Psychological, Emotional, or Behavioral Problems** |
| **IMMUNIZATIONS Up to date □ YES □ No**  **Please state where your child receives immunizations \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\*\*\* (Please attach a copy of your child’s immunization record)** |
| **INFECTIOUS DISEASE Has your child had any of the following: If yes, please indicate type and date: Chicken Pox, Measles, Mumps, Rubella, Meningitis, Tuberculosis, Pertussin/Whopping, Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **FAMILY HISTORY: Have you or any of your child’s blood relatives *(parents, grandparents, aunts, uncles, brothers or sister)* had any of the following problems: ADD/ADHD, Alcoholism, Allergies, Alzheimer’s disease, Asthma, Blood Disease, CAD, Cancer, CVA *(Stroke*), Depression, Developmental Delay, Diabetes, Eczema, Hearing Deficiency, Hyperlipidemia, Hypertension, Irritable Bowel Disease, Learning Disability, Menal Illness, Migraines, Obesity, Osteoarthritis, Osteoporosis, PVD, Renal Disease, Seizure Disorder, Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**    **CONDITION WHO AGE OF ONSET** |
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