INTAKE FORM

DEMOGRAPHIC/INSURANCE INFORMATION

Patient Name *

First Name * | Middle Name | Last Name *

Prior Last Name | Preferred Name

Patient Birth Date *

(MM/DD/YYYY)

Social Security Number:

ETSU Student ID: *

Patient Gender * Please select a choice

Gender Identity: Please select a choice

Gender Pronoun:
- He
- She

Sexual Orientation * Please select a choice

Marital Status * Please select a choice

Patient Ethnicity * Please select a choice

Patient Race: * Please select a choice

Patient Preferred Language *

Interpreter Needed: *
- Yes
- No

Patient Address *

Address Line 1 *

Address Line 2

City * | State *

Postal / Zip Code *

Patient Phone *

Home Phone *

Work Phone *

Mobile Phone

Email *

ETSU Email

Ok to call:
- Yes
- No

Ok to leave message:
- Yes
- No

Contact Preference: Please select a choice

Emergency Contact *

First Name

Last Name

Phone *

Relationship

Agricultural Work Status: * Please select a choice

Veteran Status:
- Yes
- No
- N/A

Referral Source: Please select a choice

Insurance Information

Insurance

Insurance Company

Phone Number

Name on Card

Co-pay Amount

Subscriber ID (Policy Number)

Group ID

Coverage Start Date

Coverage End Date

Name of Insured

Relationship to Insured

Plan

SIGNATURE PAGES

PATIENT FINANICIAL & INSURANCE AGREEMENT

Please read carefully and sign below

In consideration of receiving services from the ETSU College of Nursing, University Health Center, 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) University Health Center (UHC) to examine, evaluate, and treat me, and/or my child, or ward. I authorize the UHC 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 UHC for services rendered. I understand that the UHC will refund any overpayments on my account, in a timely manner.

Your signature below forms a binding agreement between the UHC (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

Signature * Type your name in lieu of a signature.

Date: 07/29/20

HIPAA AUTHORIZATION

I authorize East Tennessee State University (ETSU) College of Nursing (CON) Student/University Health Services (SUHS) to discuss and\or release my medical information including labs and test results, diagnosis, and treatment discussed to the following persons:

ACKNOWLEDGEMENT OF PATIENT RIGHTS AND RESPONSIBILITIES

&

NOTICE OF PRIVACY PRACTICES

I acknowledge that the East Tennessee State University (ETSU) College of Nursing (CON) Student/University Health Services (SUHS) has provided me with a written copy of Patient Rights and Responsibilities. This information clearly defines my rights and responsibilities as a patient receiving services by a SUHS associated provider.

I have also been given the opportunity to review the East Tennessee State University (ETSU) Notice of Privacy Practices and understand that the Notice indicates how my protected health information may be used and disclosed and how I gain access to this information. I have also been given the opportunity to receive a copy of the ETSU Notice of Privacy Practices for further review

AUTHORIZATION AND RELEASE

I understand that the ETSU CON SUHS serves as a training center for students majoring in, but not limited to, Nursing, Audiology, Dental Hygiene, Nutrition, Radiology, and Speech-Language Pathology at ETSU. For this reason, I authorize the use of student observation, video recording, audio recording, pictures, client data, and discussion for professional research or educational purposes. I understand that no names or identifying information will be used in any of these procedures.

By signing below, I agree to the above-mentioned statements.

Name: *

Name of authorized person

Phone Number:

Phone number of authorized person

Relationship to Patient:

Relationship of authorized person

Name:

Name of authorized person

Phone Number:

Phone number of authorized person

Relationship to Patient:

Relationship of authorized person

Name:

Name of authorized person

Phone Number:

Phone number of authorized person

Relationship to Patient:

Relationship of authorized person

Signature * Type your name in lieu of a signature.

Date: 07/29/20

PRIMARY CARE HEALTH HISTORY

Past Medical History

- [ ] [ ] [ ] [ ]
- [ ] [ ] [ ] [ ]
- [ ] [ ] [ ] [ ]
- [ ] [ ] [ ] [ ]
- [ ] [ ] [ ] [ ]

List any hospitalizations or surgeries you have had (including c-section):

List any medication or food allergies: *

Are you allergic to latex? *

Please select a choice

List all current medications (including vitamins, herbal supplements, and health food preparations): *

Preventative Care

When was your last:

Tetanus booster:

Flu shot:

Pneumonia vaccine:

GYN PAP smear (FEMALE):

Colonoscopy:

Bone density screening:

Mammogram (FEMALE):

PSA blood test (MALE):

Prostate/rectal exam (MALE):

SOCIAL AND FAMILY HISTORY

Social History Tobacco *

Smoker status:

Please select a choice

Amount per Day

Type

Years Using Tobacco

Quit Date

Quit Attempts

Second-Hand Smoke Exposure

Please select a choice

Social History Alcohol *

Do you currently drink alcohol?

Please select a choice

Please select a choice

Frequency

Amount per Day

Type

Start Age

Last alcohol use

Do you have a family history of alcoholism?

Social History General

Birthplace

Occupation

Please select a choice

Marital Status

Please select a choice

Education Level

Please select a choice

Retired

Please select a choice

Carbon Monoxide Detector

I don't have children

Number of Sons

Number of Daughters

Caffeine: Yes No

Type

Amount per Day

Social History Exercise *

Health club/fitness membership

Please select a choice

Please select a choice

Frequency

Hours/Week

Activity Level:

Please select a choice

1. Activity Description
2. Activity Description
3. Activity Description

Family History

Condition		Mother	Father	Gr. Mother	Gr. Father	Sister	Brother
	Has/Had Condition?						
	Cause of Death?						
	Has/Had Condition?						
	Cause of Death?						
	Has/Had Condition?						
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