

INTAKE FORM UPDATES

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 *

Gender Identity:

Gender Pronoun:

He

She

Patient Ethnicity *

Patient Race: *

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:

Emergency Contact *
First Name Last Name

Phone * Relationship

Agricultural Work Status:
*

Veteran Status: * Yes
 No
 N/A

Referral Source:

Insurance Information

Insurance *

<input type="text"/>	<input type="text"/>
Insurance Company	Phone Number
<input type="text"/>	<input type="text"/>
Name on Card	Co-pay Amount
<input type="text"/>	<input type="text"/>
Subscriber ID (Policy Number)	Group ID
<input type="text"/>	<input type="text"/>
Coverage Start Date	Coverage End Date
<input type="text"/>	<input type="text"/>
Name of Insured	Relationship to Insured
<input type="text"/>	
Plan	

SIGNATURE PAGES

PATIENT FINANCIAL & 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