ETSUHealth

REGISTRATION FORM

SECTION 1: PATIENT INFORMATION			
Full Legal Name (First)	**(Middle)**	**(Last)**	**Preferred Name**
Date of Birth	**Social Security No.**	**Marital Status** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered ☐_____	
Address (Number and Street, Apt. No.)			
City	**State**	**Zip**	
Home Phone (include area code)	**Cell Phone (include area code)**		
Sex at Birth ☐ Male ☐ Female	**Preferred Pronouns** ☐ Male ☐ Female ☐ Gender Neutral		
Gender Identity w/ Insurance Company ☐ Male ☐ Female ☐_____			
Ethnicity ☐ Non-Hispanic or Non-Latino ☐ Hispanic or Latino	**Race** ☐ American Indian or Alaska Native ☐ Asian ☐ African American/Black ☐ Caucasian/White ☐ Native Hawaiian or Other Pacific Islander ☐_____	**Primary Language** ☐ English ☐ Spanish ☐_____	
Occupation	**If student, name of school** ☐ Full-time Student ☐ Part-time Student		
Employer Name	**Employer Phone (include area code)**		
Employer Address (Number and Street)			
City	**State**	**Zip**	
Do you need interpreter services? ☐ **Yes** ☐ **No**	**Have you executed an Advanced Directive such as a Living Will or Power of Attorney?** ☐ Yes ☐ No If yes, please provide a copy.		
Who is your Primary Care Provider?	**What is your Preferred Pharmacy?**		

SECTION 2: INSURANCE INFORMATION		
Primary Insurance Company Name	**Effective Date**	
Subscriber Name	**Date of Birth of Subscriber**	**Social Security No. of Subscriber**
Relationship to Patient ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Child ☐_____		
Secondary Insurance Company Name	**Effective Date**	
Subscriber Name	**Date of Birth of Subscriber**	**Social Security No. of Subscriber**
Relationship to Patient ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Child ☐_____		

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SECTION 3: RESPONSIBLE PARTY			
***** ☐ CHECK HERE IF PATIENT IS ALSO THE RESPONSIBLE PARTY AND SKIP THIS SECTION. *****			
Full Legal Name (First)	**(Middle)**	**(Last)**	
Date of Birth	**Social Security No.**	**Marital Status** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered ☐_____	
Address (Number and Street, Apt No.)			
City	**State**	**Zip**	
Home Phone (include area code)		**Cell Phone (include area code)**	
Employer Name		**Employer Phone (include area code)**	
Employer Address (Number and Street)			
City	**State**	**Zip**	
Relationship to Patient ☐ Spouse ☐ Parent/Guardian ☐ Child ☐_____			

I certify that the information provided is true and complete to the best of my knowledge.

_____ _____

Signature of Patient or Legally Authorized Representative Date

If this document is signed by someone other than the Patient, such as a person holding a Durable Power of Attorney for Healthcare, the signer must state his/her relationship to the Patient, describe his/her authority to act on the Patient's behalf, and provide a copy of the Durable Power document:

_____

Please present all insurance cards and information to the receptionist for registration.

Please initial below.

Acknowledgment of Corporate Relationship

_____
Patient Initials

ETSU Health is the new outward-facing brand that includes the educational, clinical, and research pursuits of ETSU's thriving Academic Health Sciences Center and the clinical components of ETSU Physicians and Associates and Northeast Tennessee Community Health Centers, Inc. ETSU Health is not a legal entity.

Teaching Clinics

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Patient Initials

As a patient of East Tennessee State University, Medical Education Assistance Corporation, or the Northeast Tennessee Community Health Centers, Inc. (hereinafter referred to collectively as "ETSU Health"), students (in medical school and health-related studies) and resident physicians (hereinafter referred to collectively as "Trainees") may participate in your care as part of the educational programming. Our mission is a dual one: caring for patients and educating Trainees. As such, faculty supervisors and Trainees work as a team to provide your care. Trainees, depending on their levels of experience, may observe or participate in the care provided to you. We believe this adds to the depth and level of care you receive. Trainees are supervised by faculty supervisors licensed in the State of Tennessee.

Thousands of patients receive medical, behavioral, and mental health treatment at ETSU Health, and enjoy our team-based approach to care. We are grateful for the opportunity to be of service to you and appreciate your willingness to participate in training healthcare providers of the future.

Insurance Authorization and Assignment

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Patient Initials

I hereby authorize East Tennessee State University, Medical Education Assistance Corporation, and the Northeast Tennessee Community Health Centers, Inc. (hereinafter referred to collectively as "ETSU Health") to provide any necessary medical or other information about me or my dependent to my insurance company, and/or its designated representatives, for the purpose of obtaining payment. This authorization is valid as long as I am a patient of any ETSU Health facility.

I hereby assign to the provider all payments for healthcare services, including behavioral and mental health treatment, rendered to myself or my dependent. I also assign and/or convey to ETSU Health any legal or administrative claim arising under any group health plan, employee benefits plan, health insurance or other managed care company concerning the treatment I or my dependent received from ETSU Health including any right to pursue those legal or administrative claims. This is an express and knowing assignment of my ERISA claims, including any claim for benefits, breach of fiduciary duty, breach of duty good faith, penalties, and other legal and administrative claims. This assignment is valid as long as I am a patient of any ETSU Health facility.

I understand that my insurance company may only cover a portion of my total bill, or may cover nothing at all. I understand I am responsible for all bills related to the provision of healthcare services and will be responsible for payment of any charges not covered under this assignment. If for any reason my or my dependent's account becomes delinquent, I agree to pay for any and all charges related to re-billing, cost of collections, reasonable legal fees, and any other charges permitted by law.

Medicare

One Time Authorization

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Patient Initials

If applicable, I hereby request that payment of authorized Medicare benefits be made on my behalf to East Tennessee State University, Medical Education Assistance Corporation, and the Northeast Tennessee Community Health Centers, Inc. (hereinafter referred to collectively as "ETSU Health") for any healthcare services provided to me or my dependent. I hereby authorize ETSU Health to provide any necessary medical or other information about me or my dependent to the Health Care Financing Administration and its agents as needed to determine these benefits or the benefits payable for related services.

Medigap Assignment Authorization

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Patient Initials

If applicable, I request that payment of authorized Medigap benefits be made to ETSU Health for any healthcare services provided to me or my dependent by ETSU Health. I hereby authorize ETSU Health to provide any necessary medical or other information about me or my dependent to the Medigap carrier as needed to determine these benefits or the benefits payable for related services.

ETSUHealth

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

By signing below, I acknowledge that I have received the HIPAA Notice of Privacy Practices of East Tennessee State University, Medical Education Assistance Corporation, and the Northeast Tennessee Community Health Centers, Inc. (hereinafter referred to collectively as "ETSU Health"). I understand that my health information is protected under state and federal law, and that the HIPAA Notice of Privacy Practices describes how my protected health information may be used and shared with others. If I have any questions about the HIPAA Notice of Privacy Practices, I will let staff know.

_____ _____

Signature of Patient or Legally Authorized Representative Date

ETSU Health is committed to protecting the privacy and security of your health information. If you wish for us to be able to *discuss* your protected health information with family or close friends, please list those individuals here:

Printed Name: _____	Relationship to Patient: _____	Telephone (include area code): _____
Printed Name: _____	Relationship to Patient: _____	Telephone (include area code): _____
Printed Name: _____	Relationship to Patient: _____	Telephone (include area code): _____

ETSU Health reserves the right to otherwise share your information as permitted or required by law.

EMERGENCY CONTACT		
Person to Notify in Case of Emergency	**Relationship to Patient**	**Phone Number (include area code)**

Electronic Communication Authorization

As a patient of ETSU Health, you may request that we communicate with you via unencrypted electronic mail ("email"). If you choose to provide ETSU Health with an email address, we may use this email address to communicate with you about your healthcare or payment for your healthcare, to respond to your requests for information, and for other legitimate purposes related to the healthcare services you receive from ETSU Health. Your healthcare is important to us, and we will make every effort to reasonably comply with your request to receive communications via email; however, we reserve the right to deny any request when it is determined that granting such a request would not be in your best interest.

Before providing your email address, please know there are certain risks and limitations associated with email communications. These risks may include but are not limited to: breaches of your privacy and confidentiality, difficulty ensuring the email we receive is really from you and not someone else, and delayed response times. Providers and staff will make every reasonable effort to protect your information and to promptly respond to your requests for information via email. *If you are experiencing an emergency, you should never rely on email communications and should seek immediate medical attention.*

Patient Email Address:

If at any time you change your email address or wish to discontinue email communications altogether, you must provide written notification to a representative of ETSU Health.

By providing your email address and signing below, you acknowledge your understanding of the inherent risks of communicating health information via unencrypted email and hereby request and authorize ETSU Health to communicate with you via unencrypted email despite those risks. By signing below, you also acknowledge that you have the choice to receive communications via other more secure means such as by telephone, in-person, or through the patient portal instead of via unencrypted email. By signing below, you agree to hold ETSU Health harmless for any unauthorized use or disclosure of your protected health information as a result of a communication sent to the email address you provide.

_____ _____

Signature of Patient or Legally Authorized Representative Date

ETSUHealth

Integrated Care Consent to Treat

Thank you for choosing East Tennessee State University, Medical Education Assistance Corporation, and the Northeast Tennessee Community Health Centers, Inc. (hereinafter referred to collectively as "ETSU Health") for your care. This consent form provides ETSU Health, its physicians, associates, assistants, affiliates, and other healthcare providers, with your permission to provide medical, behavioral, and mental health treatment. Please read and sign below. If you have any questions, please let our staff know.

General Consent for Care and Treatment

By signing this form, I am requesting that healthcare services be provided to me by ETSU Health. This includes examinations, diagnostic procedures and imaging, laboratory services and testing, medical treatment, behavioral and mental health services, and all other healthcare-related treatment, care, and services ("Healthcare Services") that I may receive. I voluntarily consent to any and all Healthcare Services that providers at ETSU Health consider to be necessary. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees or assurances have been made to me about the results or effectiveness of medical treatment or other Healthcare Services. I intend this general consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. I consent to receiving Healthcare Services at this office or at any other office of the organization. I understand that I may discuss any treatment plan with my provider, including the purpose of any treatment and its potential risks

If you have any concerns regarding any service or treatment recommended by ETSU Health, w*e encourage you to ask questions.*

Integrated Healthcare Services

I understand this clinic is a participant of an integrated care organization, which means the clinic may work together with mental health and behavioral health providers when appropriate to give me the best care possible. This organization is also a teaching clinic where students (in medical school and health-related studies) and resident physicians (hereinafter referred to collectively as "Trainees") may participate in my care as part of the educational programming. As such, I understand and agree that Trainees, depending upon their levels of experience, may observe or participate in my care.

Behavioral and Mental Health Treatment

If applicable, I understand and acknowledge there are risks and benefits associated with behavioral and mental health treatment. Additionally, with any clinical treatment, there is no guarantee that these services will help. I acknowledge there may be certain risks associated with medications which could be prescribed as part of behavioral and mental health treatment. I understand the benefits of behavioral and mental health treatment can include feeling less distressed, finding solutions to problems, feeling better physically, and building more positive relationships.

Telehealth

Telehealth involves the use of technology to enable your provider to connect with you without an in-person office visit. Some problems and conditions cannot be treated via telehealth. If your provider determines they are unable to treat you via telehealth, you may have to come to a clinic for a face-to-face appointment. *You* may decide telehealth is not a good fit for you. If at any time during a telehealth session you decide you would like to stop the session for any reason, you may do so. Just let your provider know. You have the right to receive services in person.

As with any technology, telehealth has limitations. There is no guarantee that your telehealth session will eliminate the need for you to see a provider in person. There are benefits and risks associated with the use of telehealth. Benefits may include improved access to healthcare and the ability to see different healthcare providers without having to travel. Risks may include delayed treatment due to technology failures or loss of confidentiality as a result of failed security protocols. If a disruption in service occurs, your provider will try reconnecting through telehealth or by telephone. Telehealth sessions will not be recorded or kept as part of your clinical record.

If applicable, by choosing to receive services via telehealth: I agree to have the knowledge and skills needed to use the technology; I understand the benefits and risks of telehealth; and I will be physically located in Tennessee in a private location with internet/telephone service at the time of my visit. In case of emergency, I know where my nearest hospital is and I agree to go there or call 911 or call a local crisis line. I understand that my provider may also reach out to my emergency contact to coordinate care in emergency situations. I understand that minors receiving telehealth must have a parent or legal guardian available during the telehealth session.

Patient Portal

If you have signed up for the patient portal, please be aware it may take up to 48 business hours for someone to respond. Do not use the patient portal for emergencies.

Confidentiality

In general, your health information is protected by law, and your providers will not share this information without your written permission. There may be times, however, in which we are permitted or required under the law to share your health information, and we will do so. Because multiple providers work as a team, they may share information about you with each other that is important for your care. Your treatment may also be discussed in individual and/or group educational consultations between the Trainees and faculty supervisors licensed in the State of Tennessee. All participants in these educational consultations are held to the same professional standards as your provider to ensure your health information is kept

confidential. Your care may benefit from this supervision and consultation. If applicable, I understand minor patients may benefit from having a confidential relationship with their behavioral or mental health provider. Health information shared by minors with their behavioral or mental health provider will generally not be discussed with the parent or legal guardian unless the provider, in their professional judgment, feels sharing is necessary.

ETSU Health utilizes a single electronic medical record that can be accessed by all participating practices for purposes such as treatment and payment for your healthcare. This means health information created by one clinic may be viewed by other providers at participating clinics as permitted or required by law for your healthcare.

Patient's Rights and Responsibilities
I understand that I have the right to take part in my medical care and treatment plan.

By signing below, I hereby confirm that I have read and understand this information, and I consent to the treatment and integrated healthcare services to be provided. I understand that, although healthcare services may be discontinued at any time, my consent will remain fully effective until it is revoked in writing and delivered to a representative of ETSU Health.

_____ _____
Signature of Patient or Legally Authorized Representative Date

If this document is signed by someone other than the Patient, such as a person holding a Durable Power of Attorney for Healthcare, the signer must state his/her relationship to the Patient, describe his/her authority to act on the Patient's behalf, and provide a copy of the Durable Power document:

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