

**Where did you hear about us?**

- ☐ Yellow Pages (YP) ☐ Newspaper (NP) ☐ Website (WS)  
☐ Friend or Family (FF) ☐ Physician Referral (PR)  
☐ Other (OT) \_\_\_\_\_

**OFFICE USE ONLY**

Physician: \_\_\_\_\_  
Approved by: \_\_\_\_\_  
Date: \_\_\_\_\_

**Welcome  
to our office**

**NEW PATIENT INFORMATION (Complete if different from billing party)**

Name \_\_\_\_\_  
First Middle Last  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_ Zip \_\_\_\_\_ Phone # ( ) \_\_\_\_\_  
Birthdate \_\_\_\_\_ Sex M or F Race \_\_\_\_\_ Marital Status S M W D  
Social Security # \_\_\_\_\_ Employer \_\_\_\_\_  
Address of Employer \_\_\_\_\_ Work Phone # \_\_\_\_\_  
May we contact you at work? Y N By E-Mail Y N E-Mail Address \_\_\_\_\_  
Emergency Contact Name \_\_\_\_\_ Emerg. Phone # ( ) \_\_\_\_\_  
Relationship to billing party \_\_\_\_\_

**Guarantor/Responsible Party**

Name \_\_\_\_\_  
First Middle Last  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone # \_\_\_\_\_  
Birthdate \_\_\_\_\_ Sex M or F Marital Status S M W D  
Social Security # \_\_\_\_\_ Driver's License # \_\_\_\_\_  
Place of employment \_\_\_\_\_ Work Phone # \_\_\_\_\_

**OTHER INFORMATION**

Name and address of nearest relative not living with you \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone # \_\_\_\_\_

**If you are currently under another physician's care, please list:**

Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Whom may we thank for referring you to us?** \_\_\_\_\_

**INSURANCE**

**1. Primary Insurance Company Name** \_\_\_\_\_  
Group # \_\_\_\_\_ Policy Member # \_\_\_\_\_  
Subscriber Name \_\_\_\_\_ Subscriber Birthdate \_\_\_\_\_ Sex M or F Social Security # \_\_\_\_\_  
Subscriber Employer and Address \_\_\_\_\_  
**2. Secondary/Supplemental Insurance Name** \_\_\_\_\_  
Group # \_\_\_\_\_ Policy/Member # \_\_\_\_\_  
Subscriber Name \_\_\_\_\_ Subscriber Birthdate \_\_\_\_\_ Sex M or F Social Security # \_\_\_\_\_  
Subscriber Employer and Address \_\_\_\_\_

**Please note whomever brings a child in to be seen is responsible for payment at time of service unless prior arrangements have been made.  
It is the custodial parent's responsibility to arrange reimbursement from a non-custodial parent.**

**By signing below I hereby give my consent for Holston Medical Group to treat my minor child, under 18 years of age**

**INSURANCE AUTHORIZATION AND ASSIGNMENT:**

I understand that I am financially responsible for any medical service at time of service. I authorize my insurance carrier to pay to Holston Medical Group any assigned claims filed by them and authorization for release of medical information requested by my insurance company. For Medicare beneficiaries: I request payment of authorized Medigap benefits be made to me or on my behalf to Holston Medical Group and medical information about me to be released to my Medigap insurer.

Date \_\_\_\_\_ Signature \_\_\_\_\_

# PEDIATRIC HISTORY FORM

Date \_\_\_\_\_

MRN \_\_\_\_\_

Patient Name \_\_\_\_\_ ☐ Male ☐ Female Birth Date \_\_\_\_\_

Today's Date \_\_\_\_\_

Parent's Name \_\_\_\_\_ Age \_\_\_\_\_ Occupation \_\_\_\_\_

Parent's Name \_\_\_\_\_ Age \_\_\_\_\_ Occupation \_\_\_\_\_

Mark appropriate box for parents:

Married ☐ Single ☐ Separated ☐Divorced ☐ Widowed ☐

Child lives with: \_\_\_\_\_

Number of people in Household: \_\_\_\_\_

How many children has the mother had: \_\_\_\_\_

Which number is this one: \_\_\_\_\_

## BIRTH HISTORY

During the mother's pregnancy with this child, did she:

(Circle yes or no)

- |   |     |    |
|---|-----|----|
| 1. Have high blood pressure?                                    | Yes | No |
| 2. Have sugar in your urine?                                    | Yes | No |
| 3. Have a Kidney or bladder infection?                          | Yes | No |
| 4. Take medicines prescribed by her doctor or over the counter? | Yes | No |
| If yes, what? _____   |     |    |

5. Consume Alcohol? If yes, amount \_\_\_\_\_ Yes No

6. Use any tobacco products? If yes, amount \_\_\_\_\_ Yes No

7. Have a dependency on drugs? Yes No

8. Was this child premature: Yes No

If yes, number of weeks at birth \_\_\_\_\_

9. Did you have a difficult delivery? Yes No

10. Was the birth:

Normal Vaginal \_\_\_\_\_ Breech \_\_\_\_\_ Cesarean \_\_\_\_\_

11. Child's weight at birth \_\_\_\_\_

12. Was there a jaundice problem? Yes No

13. Did the child have any of the following while in the nursery:

Breathing difficulty Yes No

Low blood sugar Yes No

Seizures Yes No

NICU Stay Yes No

14. Did the mother have any maternal history of the following?

HSV Yes No

Hep C Yes No

Hep B Yes No

## DIET HISTORY

Has this child been:

Breast fed \_\_\_\_\_ Bottle fed \_\_\_\_\_

Would you describe your child's eating habits as

Excellent \_\_\_\_\_

Good \_\_\_\_\_

Fair \_\_\_\_\_

Poor \_\_\_\_\_

Has your child taken Vitamins: Yes No

## FAMILY HISTORY

Does the Mother or Father have any chronic illnesses?

Yes No

If Yes, what? \_\_\_\_\_

Do any of your other children have any chronic illnesses?

Yes No

If yes, what? \_\_\_\_\_

Have any of your child's family (include siblings, parents, grandparents, uncle or aunts) had any of the following illnesses or disorders:

(Mark an X in appropriate box)

Allergies		Diabetes	
Birth Defects		Hypertension	
Anemia		Heart Disease	
Arthritis		Kidney Disease	
Cancer		Intellectual Disability	
Breast		Muscular Dystrophy	
Lung		Cerebral Palsy	
Colon		Psychiatric Problem	
Asthma		Rheumatic Fever	
Chronic Bronchitis		Tuberculosis	
ADHD		Unexpected death of a child	
Ear / Eye Disease		Autism	

Does your child have any known allergies to medicines, food or pollen? Yes No

If yes, what \_\_\_\_\_

## PAST MEDICAL HISTORY

Surgeries \_\_\_\_\_

Hospitalizations \_\_\_\_\_

List any medicines which your child takes:

Past Chronic Diagnoses: (ADHA, Asthma)

MRN: \_\_\_\_\_

Date Received: \_\_\_\_\_

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have reviewed and/or received a copy of the *Notice of Privacy Practices*, which provides a more complete description of how my protected health information (PHI) may be used or disclosed. I understand that Holston Medical Group (HMG) reserves the right to change their notice and information practices and that I may view a copy of the current *Notice* on HMG's website, [www.holstonmedicalgroup.com/hipaa](http://www.holstonmedicalgroup.com/hipaa), in any of their offices, or by a request in writing.

I also understand that Holston Medical Group participates in the OnePartner Health Information Exchange (OnePartner HIE) and may make my medical information available electronically or may electronically transmit my medical information to a third party, in order to fulfill provider obligations to release my medical information in the future.

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Patient Date of Birth

\_\_\_\_\_  
Patient Signature (if applicable)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authorized Representative Signature

\_\_\_\_\_  
Relationship to Patient

I understand that my Protected Health Information (PHI) will only be verbally communicated to those individuals listed below and no paper copies of my PHI will be provided without my signature on an *Authorization for Release of Individually Identifiable Health Information* form. I understand that some information may be considered sensitive, including but not limited to pregnancy test results, testing for sexually transmitted infections, Urine Drug Screen results, laboratory test results, medication, or information discussed during an office visit. The individuals listed below, will be required to provide the last four (4) digits of my Social Security Number, along with my date-of-birth, before any information will be discussed with them.

List the individual(s) that you want protected health information verbally discussed with:

Name	Phone Number	Name	Phone Number

### FOR INTERNAL USE ONLY:

Reason Acknowledgement Could Not Be Obtained: \_\_\_\_\_

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

Holston Medical Group complies with applicable Federal civil laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Holston Medical Group does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Attention: If you need language or translation services, please ask to speak with the Office Manager.

Atención: Si necesita servicios de idioma o traducción, solicite hablar con el Gerente de Oficina



## NO SHOW POLICY

Welcome to Holston Medical Group. Please take time to review the following information pertaining to our policy for no show appointments.

We understand that scheduling conflicts occur from time to time. However, we request at least two hours advance notice if you are unable to keep your scheduled appointment(s). Two or more missed appointments may result in your family being dismissed from Holston Medical Group. Patients that fail to show up for a scheduled appointment **may be charged a fee** for not providing the office with prior notice of cancellation.

Holston Medical Group physicians have developed our No Show policy in an effort to better serve our patients by providing same day appointments to those who are sick and need to be seen. If someone schedules an appointment and does not show for the visit, we have lost an available time that could have been used for a sick patient.

We look forward to providing your health care needs. Your understanding and cooperation helps us to provide available appointments for patients who urgently need them.

Please sign below as confirmation that you have read, acknowledge and understand our policy regarding no show appointments.

\_\_\_\_\_  
Please Print Patient Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Account Number

\_\_\_\_\_  
Please Sign Authorized Representative

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date



## Parental Pre-Authorization for Minors

It is the policy of Holston Medical Group to comply with state and federal laws that govern the treatment of children under the age of 18. Under this law, it is necessary to have the presence of a parent or legal guardian or a signed document giving consent before evaluation and/or treatment can be rendered to children under the age of 18.

I (we) request and authorize Holston Medical Group and its personnel to provide medical care to my child:

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

List any individuals other than the legal guardians to whom you give permission to bring your child in for medical treatment during your absence.

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Note: If there is any special parental or custodial relationship (such as custody with one parent only, legal custody/guardians with no-parent, etc. ) Please explain in the space below with your signature, printed name and phone number at which you may be reached. A copy of the legal document will need to be obtained.

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Legal Guardian/Parent's Signature \_\_\_\_\_

Printed Name \_\_\_\_\_ Phone \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

## FINANCIAL POLICY

***Holston Medical Group believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to have an understanding of our financial policy.***

1. **PAYMENT** is expected at the time of your visit. Just as we make every effort to accommodate you when you are in need of medical care, we expect that you will make every effort to pay your bill promptly. Payment is due at the time services are provided or upon receipt of a statement from our billing office. ***We will accept cash, check, debit, credit or health savings accounts.*** You may also make a payment online through our patient portal, FollowMyHealth®.

Payment will include any unmet deductible, co-insurance, co-payment amount or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause payment in full is expected at the time of your visit. For visits under a "global" or a follow up trauma visit (from a procedure performed by an HMG physician) or for ongoing rehabilitation treatment plans, you will only be responsible for your co-payment if applicable based on your insurance. We do ask for a ***copy of your current insurance card*** at the time of your visit to ensure we properly file your claim.

2. **SURGERY PATIENTS:** You may be responsible or required to pay a percentage of surgery charges prior to any surgeries or procedures. This will be determined by information given to us by your insurance company in regard to patient percent responsibility.
3. **INSURANCE:** We participate with several insurance plans and will file your claims on your behalf. It is your responsibility to ensure coverage for services prior to your visit. You will be responsible for the complete charges for any non-covered services provided. In addition, all co-payments, deductibles or non-covered charges will be due at the time of service. You must provide proof of insurance at each visit so we can ensure proper billing to your benefit plan. If there is an overpayment on your account, we will refund any overpayment to you after overpayment credit is applied to any outstanding account balance(s). We do not bill third party payors, but will be happy to provide a copy of the original claim if requested.
4. **HIGH-DEDUCTIBLE PLANS:** Under these plans, your insurance company will provide you a discount off our billed charges, but you are responsible for the entire amount due until you meet your deductible. ***We will accept cash, check, debit, credit or you may use your health savings account.***
5. **RETURNED CHECKS** will incur a \$30.00 service charge.
6. **ACCOUNTING PRINCIPLES:** If there is an overpayment on your account, we will refund any overpayment to you after overpayment credit is applied to any outstanding account balance (s). Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding date of service
7. **FORMS FEES:** Medical records, except those involving worker's compensation cases, will be billed at the rates listed below:

**Simple Forms (completed within 2 business days)**

DURING an office visit: No Charge

AFTER an office visit: \$5 / form

Examples of Simple Forms: Handicap tag/sticker, work re-entry forms, immunization, medication, sports, concussion clearance, WIC, Home Bound Status Short form, Disability Short Form, Bank Loan Form, Foster Parent Health Form, College & Camp Forms

**Complex Forms: \$25 (completed within 10 business days)**

Examples of Complex Forms: FMLA (per illness per year), Disability Long Form, Home Bound Status Long Form.

## FINANCIAL POLICY



- 8. MISSED APPOINTMENTS:** If you fail to cancel a previously scheduled appointment at least 24 hours in advance, you may be charged a fee as outlined below:

- Established office visit: \$20
- Allergy Testing: \$75
- New patient visit or consultation: \$100
- GI Procedure: \$250

This charge cannot be billed to the insurance company. Failure to pay a no show fee will be treated according to our policy on unpaid balances, with the exception of collection accounts. This charge is not applicable to patients with Medicaid/TennCare insurance coverage.

After 2 no-show appointments in a rolling calendar year, you may be discharged from the practice, at the discretion of the responsible provider and management. Medical care will not be withheld for a medical emergency for thirty days from date of dismissal.

- 9. UNPAID BALANCES:** All outstanding balances shall be due within 30 days of the date of service. At that time, all past due balances in their entirety must be paid prior to the time of your next visit. Balances that remain outstanding for a period of 90 days or more may be referred to a collection agency and could affect your credit.

- 10. FINANCIAL DISMISSAL:** Patients who do not make payment arrangements risk being dismissed from the practice. Holston Medical Group reserves the right to dismiss patients for delinquent financial accounts on personal balances. If dismissed, medical care will not be withheld for a medical emergency for thirty days from date of dismissal.

- 11. BILLING QUESTIONS:** We will be happy to help you resolve your balance and can be reached at  
**(423) 578-1802, Monday – Friday 8:00AM – 5:00PM.**
-



## FINANCIAL POLICY

MRN#: \_\_\_\_\_

Date Received: \_\_\_\_\_

***Holston Medical Group believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to have an understanding of our financial policy.***

*I have read, understand and agree to the Financial Policy as provided to me. I understand that charges not covered by my insurance company, as well as applicable co-payments, deductibles and any charges older than 30 days from the date of service are my responsibility.*

*I authorize Holston Medical Group to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim. I authorize my insurance benefits be paid directly to Holston Medical Group.*

*By signing below, I indicate my agreement with the policy as provided to me.*

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name





Patient: \_\_\_\_\_

MRN: \_\_\_\_\_

## Communicating with Your Primary Care Office

### Access to Your Physician and Staff

Your Holston Medical Group (HMG) health care team can be reached either by telephone or electronically through our patient portal, FollowMyHealth®. If you wish to communicate electronically, you may sign up at any office location on our website at your convenience. Please remember, electronic communication is for routine matters and never should be used for emergencies.

It **is not** appropriate to communicate with your health care team through social media, such as **Facebook**, or **texting**. Your privacy is important to us and these are not secure methods of communication. Any questions or concerns should be directed to the patient portal or office during normal business hours.

### After Hours Care

HMG is dedicated to serving our patients 24 hours a day, 7 days a week. The most effective way to serve you is during regular clinic hours, but we understand acute illnesses can occur at any time. Your Primary Care Provider's telephone message will direct you on how to contact the HMG Physician on Call.

### HMG Urgent Care

Please use the Emergency Room only in a true emergency (i.e. chest pain, shortness of breath, stroke-like symptoms).

To avoid long wait times in the ER, come to our Urgent Care clinics for routine health concerns such as colds, ear aches, flu symptoms, sprains and strains, etc. We have two locations conveniently located in Bristol and Kingsport. For hours and specific information call (423) 230-2420 (Kingsport) or (423) 990-2466 (Bristol).

### Prescription Refills

To avoid delays and busy phone lines, the best time to obtain your medication refills is at your office visit. While we realize there may be a need to request a refill via telephone or patient portal, please allow at least 48 hours for all refill request before checking with your pharmacy.

Sample medication will only be distributed during normal business hours.

Monthly refills of any controlled medications (pain medication, anxiety, etc) will only be given during an office visit within regular business hours.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_

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تأب ك م رمدي مع تخدمت ال تأب طت أن رجی ی، ترجمتة ال أو عة ل ال خدمات ی ال حاجة ب ت ت ك اذا : تأب ت ان