HMG
HOLSTON MEDICAL GROUP

Welcome to our office

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: ____________________

NEW PATIENT INFORMATION (Complete in different from billing party)

Name ____
First Middle Last

Address ____

City ________________ State ________ Country ________ Zip ________ Phone # (_____)____________

Birthday ________________ 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 ____________________ Birthday ____________ Phone # (_____)____________

Relationship to billing party ____

Guarantor/Responsible Party

Name ____

Address ____

City ________________ State ________ Country ________ Zip ________ Phone # (_____)____________

Birthday ________________ Sex M or F Race ________________ 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 ________ Country ________ Zip ________ Phone # (_____)____________

If you are currently under another physicians' 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.
Is it 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 AURTHORIZATION 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 ______________________________

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, 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 will only be verbally communicated to those individuals listed below. Those individuals 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 individuals that you want protected health information verbally discussed with:

______________________________ ______________________________

______________________________ ______________________________

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.
La atención: Si usted necesita servicios de idiomas o traducción, pida hablar con el Gerente de la oficina.
ان ت باه : إذا ك نت ب حاجة إل ى خدمات ال ل غة أو ال ترجمة، ي رجى أن ت طلب ال تحدث مع مدي ر م ك تب .

Revised: 04/19/17

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**

MRN:

____

DATE RECEIVED:

____

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 24-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 who 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
______________________________	______________________________
Patient Signature / Authorized Representative	Relationship to Patient
______________________________	______________________________
Witness	Date

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Revised:

MRN: ______________________

Date: ______________________

Communicating with Your Specialist

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, Follow my Health. 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 provider's telephone message will direct you on how to contact the HMG Physician on Call.

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.

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

Printed Name: ______________________________

Signature: ______________________________ **Date:** ________________

Witness: ______________________________ **Date:** ________________

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Orthopaedic Department

MRN ____________________

Today's Date ____________________

Name ______________________________ Age ________ Date of Birth ____________________

Social Security Number ____________________ Family Dr. or Pediatrician ____________________

Why are you hear today? ____________________ Family Dr. or Pediatrician Address ____________________

When did problem begin? ____________________ Family Dr. or Pediatrician Phone # ____________________

Occupation ____________________ Hobbies ____________________

What hand do you eat/write with? (Circle one) R L School ____________________ Grade ________

MEDICAL HISTORY: Have you had any of these problems?			
PROBLEMS	YES	NO	COMMENTS:
High Blood Pressure			
Diabetes (Sugar)			Pill or Insulin?
Chest Pain (Angina)			
Shortness of Breath			
Stroke			
Chronic Bronchitis			
Emphysema			
Asthma			
Hepatitis			What type?
Stomach Ulcer			
Frequent Urinary Infections			
Cancer or Tumor			
Bone Infection (Osteomyelitis)			
Arthritis			Where?
Thyroid Problems			High or Low
Gout			
Anemia (Low Blood Count)			
High Cholesterol			
Depression			
Blood Clots			
Sickle Cell Disease			
Rheumatic Fever			
Kidney Problems			
Sleep Apnea			
Other Problems?			

PREVIEOUS SURGURY: