SR Medical Services

2497 S. Roane Street, Suite 110
Harriman, TN 37748

Mobile Office
P: 865.599.0300
F: 865.321.8887

Harriman Office
P: 865.297.4499
F: 865.234.8924

Thank you for choosing SR Medical Services for your healthcare needs. Our services are different from your traditional primary care office so we hope to set expectations clearly.

Appointments:
With our chronic care program, our patients will typically be seen once a month. Appointments do need to be confirmed with our staff in order to keep the time reserved for you. We try our best to give a time frame window but that is subject to change as visit times, drive times, and other patient needs can vary each day. Monthly appointments need to be kept in order to maintain medication refills appropriately. We do ask that all pets are secured away during the visit for the safety of our providers. If there are any home conditions that may be hazardous for our providers, we ask that you notify us prior to the appointment so we can adjust the visit to telehealth if necessary. Since our schedules are organized ahead of time by geographic location, acute visits will need to be accommodated via telehealth or by a third party provider.

Insurance:
Insurance is filed as a courtesy to our patients but ultimately the policy is an agreement between you and the insurance company and you are responsible for the remainder that the insurance states you owe.

Refills:
Should you need refills, please call our office at least 3 days before you are scheduled to run out.

Labs/Imaging:
We partner with third party vendors to offer in-home labs and imaging services. Scheduling and billing must be coordinated directly with their offices as we do not have access to that information.

On Call:
Please note if you should have a healthcare need arise over the weekend, please call our main office line at 865-599-0300 to reach the on call provider as the specific provider lines are not monitored over the weekends. If you ever have a true medical emergency, please call 911.

Your provider's name is: _____
Their dedicated phone number/fax/text is: _____

SR Medical Services

Patient Information

Last Name:	First Name:		M.I.:
Mailing Address:			Apt#
City/State/Zip:			
Date of Birth:	S.S.#	Sex: Choose	Home phone:
Marital Status:	Language:	Race:	Cell Phone:
Emergency Contact:		Ethnicity:	Work Phone:
Relationship to Patient:			
Can we speak to this person regarding your health care?		Can we leave message regarding your health care?	
		Email:	

Responsible Party

Last Name:	First name:		
Mailing Address:			Apt#
City/State/Zip		Phone:	
Date of Birth:	Relationship to Patient:	S.S.#	

Insurance Information

Primary Insurance	Secondary Insurance
Ins. Co. Name:	Ins. Co. Name:
Policy Holder Name:	Policy Holder Name:
Policy Holder's DOB:	Policy Holder's DOB:
Policy Holder's ID #	Policy Holder's ID #
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

Preferred Pharmacy Name, Address, Phone #:

I certify that I have read and agree to SR Medical Group's (SMS) payment policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to SMS all money to which I am entitled for medical expenses related to the service performed from time to time by SMS, but not to exceed my indebtedness to SMS. I authorize SMS to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claim(s). I understand that failure to pay outstanding balances within 90 days of notification will result in submission to an outside collection agency. A $20.00 returned check fee will be charged for returned checks. I choose to receive communications from SMS by text or e-mail at the number or address stated above, including but not limited to communications about appointments, treatments, and payment. I understand that such e-mail and texts may not be secure and there is a risk that they may be read by a third party.
Medicare Beneficiaries: I request that payment of authorized Medicare benefits be made to SMS. I authorize any holder of medical information about me to release to CMS and its agents any information needed to obtain these benefits or the benefits payable for related services.

I have reviewed a copy of SR Medical Group's Privacy Notice ***(Initial)*** ☐

Print name: Date:

Signature: Date:

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Medical Information

Patient Name:_____
(Last) (First) (M)

List all current medications: *(If you do not know, please contact your pharmacy)*

_____
_____
_____
_____
_____

List all known allergies:

_____
_____

Pharmacy (Name, Address, Phone #): _____

Other medical providers involved in your health care :*(i.e. Cardiologist, Mental Health Provider, Kidney Doctor, etc)*

_____
_____
_____
_____

Please answer the following questions :

Are there any vision problems that affect your communication? *Yes* ☐ *No* ☐

Are there any hearing problems that affect your communication? *Yes* ☐ *No* ☐

Marital status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐

Current living situation *(check all that apply)*

Single Family home ☐ *Multi Family Household* ☐ *Homeless* ☐ *Shelter* ☐ *Assisted Living Facility* ☐

Other:_____

Smoking/Tobacco Use: Current ☐ Past ☐ Never ☐

*Type:*_____ *Amount:* _____ *Number of years:* _____

Alcohol Use: *Current* ☐ *Past* ☐ *Never* ☐ *Drinks per day:*

Recreational Drug Use*:* *Current* ☐ *Past* ☐ *Never* ☐ *Type:*

Are you sexually active? *Yes* ☐ *No* ☐

How often do you get the social and emotional support you need? *Always* ☐ *Usually* ☐ *Rarely* ☐ *Never* ☐

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Medical Information

Patient Name:_____
(Last) (First) (MI)

Personal Medical Information

(Check all that apply)

ADHD		Crohn's Disease		Hiatal Hernia		Osteopenia/Osteoporosis	
Alcoholism		COPD/Emphysema		High Blood Pressure		Parkinson's Disease	
Alzheimer's		Dementia		Kidney Stones		Peripheral Vascular Disease	
Anemia		Depression		Kidney Disease		Peptic Ulcer	
Anxiety		Diabetes 1 or 2		High Cholesterol		Psoriasis	
Abnormal heart beat		Diverticulitis		HIV		Pulmonary Embolism (PE)	
Arthritis		DVT (Blood Clot)		Hepatitis		Rheumatoid Arthritis	
Asthma		GERD (Acid Reflux)		Irritable Bowel (IBS)		Seizure Disorder	
Bipolar		Glaucoma		Lupus		Sleep Apnea	
Bladder Problems		Headaches		Liver Disease		Stroke	
Bleeding Problems		Heart Disease		Macular Degeneration		Thyroid Disorder	
Cancer (what type)		Heart Attack		Neuropathy		Ulcerative Colitis	

Family History

(Please check all that apply to immediate family. i.e. Mother, Father, Siblings, Grandparents)

Breast Cancer		If so, whom?
Colon Cancer		
Other types of cancer		
High Blood Pressure		
Stroke		
Heart Problems		
Diabetes		

Surgical History

Type of Surgery	Date of Surgery	Surgeon or Hospital

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Patient Name:_____
(Last) (FIRST) (MI)

Please sign at the bottom to acknowledge that you have read & understand the following statements.

Authorization to Treat

I have received all the information that I need to make an informed decision, and I consent to and authorize the performance of medical treatments and of any other minor surgical procedures which may be considered medically necessary if advisable by Dr. Susan Reyes and/or any Nurse Practitioners. By signing below, I acknowledge that I have read and understand the information on this form, and that I have had the opportunity to ask questions and understand the benefit/risk of my treatments now and on-going.

Insurance Consent

I certify that the information given by me in applying for payment under Title XVIII and/or Title XIX, of the Social Security Act, is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits for physician(s) services. I understand that I am responsible for my health insurance deductibles and coinsurance.

Patient Agreement

SR Medical Services is a smoke free, litter free facility. Smoking is not permitted on any grounds at any location. Violation of policy is grounds for dismissal per Office Management.

Federal Anti-Kickback Laws

Due to policy provisions in your insurance contract with your insurance carrier and under the terms of the Federal Anti-Kickback Laws, we are legally prohibited from writing off deductibles, patient responsibility coinsurance, and co-pays as directed by your insurance carrier. Also, if your policy is an out of network policy with our office and the provisions of your insurance mandates the allowable benefits are less, you will be responsible for your co-payments & coinsurance. It is the patient's responsibility to verify that their insurance is in network with our providers.

Financial Agreement

If you have medical insurance we will file claims to your medical insurance company for the services rendered. Please make sure we have all correct insurance information, including any secondary and/or tertiary policies. Co-payments are due at the time the service is rendered. We accept cash, check, money order, debit, and credit card(s). I understand I will be charged a $20.00 fee for any returned check. All patients without insurance will be responsible for the entirety of their office visit charge before services are rendered. Please note that additional services may be ordered by your provider, which will be additional charges. Payment plans can be set up at no additional charge. All no-show appointments will be charged $25.00 automatically. Every plan covers services differently, in the event that insurance determines a service "not covered", you will be responsible for the complete charge. You may have additional medical services ordered by your provider, such as laboratory tests, which will be sent out of the clinic. In this case, you will receive separate billing which, if not covered by your insurance, will be your responsibility.

HIPAA Guidelines/Advanced Directive

I have received and/or reviewed HIPAA guidelines.
Advanced Directive & HIPAA available upon request.

SR Medical Services is dedicated to providing the best care for you and we want you to completely understand our policies & procedures. Your signature below indicates that you have read these statements & understand the content.

Signature: _____ Date: _____

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PERSON SUPPORTED INFORMATION

Name: _____ Date of Birth: ___/___/_____
Address: _____
City: _____ State: _____ Zip: _____
Previous Name/Alias: _____
Social Security #: _____-_____-_____ Phone #: (____)_____

RECORDS ARE TO BE RELEASED FROM:

Name/Agency: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone #: (_____)_____ E-mail: _____

AND TO BE RECEIVED BY:

☐ Mail ☐ Fax

INFORMATION REQUESTED

Dates of Treatment to be Released Include:
____/_____/_____ to ___/____/_____ or Specific Date of: ___/____/_____
___/____/_____ to ____/____/_____ or Specific Date of: ___/____/_____
___/____/_____ to ____/____/_____ or Specific Date of: ___/____/_____
Materials to be Released Include:
Please release a copy of all my most recent records, including but not limited to, history & physical, discharge summary, operative notes, laboratory results, mental health records, substance abuse records, & diagnostic testing unless specific documents state otherwise.

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PURPOSE OF RELEASE

_X_ Patient Care ☐ Appointment/Sharing with other Health Care Provider as needed
☐ Personal Use ☐ Disability/Insurance Application Claim
☐ Administrative ☐ Attorney/Legal Case
☐ Research/Other (Specify): _____
_____
_____

Authorization for Release

I understand that my medical record may include information on diagnosis or treatment related to psychiatric or psychological conditions, drug or alcohol abuse, and acquired immune deficiency syndrome (AIDS) or HIV status. I agree that any information about such diagnosis or treatment may be released.

PLEASE READ THE STATEMENT BELOW AS IT APPLIES

I do authorize this information to be released.
I would like to limit the information to (Specify): _____
_____

I understand that:
• I may refuse to sign this authorization.
• Refusing to sign this authorization will not affect my treatment, payment, enrollment, or eligibility for benefits.
• I may take back (revoke) this authorization in writing, except for any actions already taken based upon it.
• I understand that this authorization will expire when the records are released for the request dated below or unless specified otherwise within 1 year of the signing of this authorization. Any future requests will need a separate authorization.
• If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy rules and may be shared with others.
• I get a copy of this form after I sign it. (upon request)

Signature of Person Supported or: _____
Legal Representative
Relationship to Patient: _____ Date: _____

SR Medical Services

Dear Patient,

As a patient with two or more chronic conditions, you may benefit from a new program that SR Medical Services offers all Medicare patients. Our goal is to make sure you get the best care possible from everyone that is involved with your care. We can help coordinate your visits with other doctors, facilities, lab, radiology, or other testing; we can talk to you on the phone about your symptoms; we can help you with the management of your medications; and we will provide you with a comprehensive care plan. Medicare will allow us to bill for these services during any month that we have provided at least 20 minutes of non-face-to-face care of you and your conditions. You must provide your consent to participate once a year.

Your assigned clinician in charge of your care is _____.

Sometimes other staff from our practice will talk to you or handle issues related to your care, but please know that your assigned clinician will supervise all care provided by our staff or clinicians who may be involved in your care.

You agree and consent to the following:

As needed, we will share your health information electronically with others involved in your care. Please rest assured that we continue to comply with all laws related to the privacy and security of your health information.

We will bill Medicare for this chronic care management for you once a month. The fee for this service allowed by Medicare is $42.17 of which your portion will be 20%, or approximately $8.00. Although you may or may not come into the office every month, your account will reflect this charge and you will be responsible for payment. Our office will have a record of our time spent managing your care if you ever have a question about what we did each month.

Only one physician can bill for this service for you. Therefore, if another one of your physicians has offered to provide you with this service, you will have to choose which physician is best able to treat you and all of your conditions. Please let your physician or our staff know if you have entered into a similar agreement with another physician/practice.

You have a right to:

A Comprehensive Care Plan from our practice to help you understand how to care for your conditions so that you can be as healthy as possible.

Discontinue this service at any time for any reason. Because your signature is required to end your chronic care management services, please ask any of our staff members for the CCM termination form.

Our goal is to provide you with the best care possible, to keep you out of the hospital, and to minimize costs and inconvenience to you due to unnecessary visits to doctors, emergency rooms, labs, or hospitals. We know your time and your health is valuable and we hope that you will consider participation in the program with our practice.

I agree to participate in the Chronic Care Management program.

Name: _____ Signature: _____ Date: _____

SR Medical Services

Remote Patient Monitoring (RPM) Program Consent Form

I understand that:

• I, or my responsible caregiver, are the only person(s) who should be using the remote monitoring equipment as instructed. I will not use the device for reasons other than my own personal health monitoring. I understand that I can only participate in this program with one Medical Provider at a time.

• I will not tamper with the equipment. I understand that I am responsible for any fees associated with misuse of the equipment.

• I understand the devices are only designed for the RPM program.

• I acknowledge that I received a tablet, pulse oximeter, and blood pressure monitor

Serial # :_____

• The device is meant to collect pulse and blood pressure Readings and transfer those readings to an online website. It is NOT AN EMERGENCY RESPONSE UNIT AND IS NOT MONITORED 24/7. Call 911 for immediate medical emergencies.

• I am aware my pulse and BP daily readings will be transmitted from the monitor to a website located in a HIPAA compliant, safe, and secure manner.

• I can withdraw my consent to participate in this program, and revoke service at any time by returning all the devices (tablet, pulse oximeter, and blood pressure cuff) back to SR Medical.

• SR Medical will securely and confidentially store my collected data, and record and store my readings into my Electronic Medical Record monthly.

• I will do my best to take my pulse and BP every day. I am aware that a Remote Patient Monitoring Qualified Health Professional will only view my readings every 30 days, and that this program is NOT a 24/7 Monitoring Service. I will be contacted every 30 days, by phone, to review and discuss my results and progress.

I, _____(name), have read and understood the information outlined above and consent to participate in the Remote Patient Monitoring program as stated above. I am aware that this consent is valid as long as I am in possession of the RPM equipment/device.

Printed Name: **Signature of Patient or Authorized Person (Relationship of Authorized Person):**

_____

Phone: **Date:** **Date of Birth:**

_____