SR Medical Services

Patient Information

Last Name:	First Name:		M.I.:
Mailing Address:			Apt#
City/State/Zip:			
Date of Birth:	S.S.#	Sex: Male Female	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 & Location:

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:

Mobile Office: 6908 Hospitality Circle Knoxville, TN 37909 Phone: (865) 599-0300 Fax: (865) 321-8887

Harriman Office: 2497 S. Roane St STE 110 Harriman, TN 37748 Phone: (865) 297-4499 Fax: (865) 234-8924

SR Medical Services

Medical Information

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

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

_____
_____
_____
_____

List all known allergies:

_____
_____

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*

Current living situation *(circle all that apply)*

Single Family household *Multi Family Household* *Homeless* *Shelter* *Skilled Nursing Facility* *Other*: _____

Smoking/Tobacco Use: Current Past Never

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

Alcohol Use: *Current* *Past* *Never* *Drinks per week:*

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*

Any other social or emotional concerns you would like to discuss?

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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	
Allergies		Dementia		Kidney Stones		Peripheral Vascular Disease	
Anemia		Depression		Kidney Disease		Peptic Ulcer	
Anxiety		Diabetes 1 or 2		High Cholesterol		Psoriasis	
Arrhythmia		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		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

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SR Medical Services

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 TO:

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.

SR Medical Services

PURPOSE OF RELEASE

__ 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 INITIAL THE STATEMENT BELOW AS IT APPLIES

(You must initial one): __ I do __ I do not 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.

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