COLLECTION POLICY

I PROMISE TO PAY Arthritis Associates of Kingsport:

Collection Policy:

*Co-pays are due at the time of service.

*Account balances are to be paid in full or require a monthly payment each month and this is to be determined by the billing department.

Collection Agency:

*If you fail to make payment to your account, the account will be placed in a pre-collections status and no appointments will be scheduled for you until the balance is paid in full. If you fail to make payments on your account after being placed in a pre-collection's status, your account will then be placed with an outside collection agency and all upcoming appointments will be cancelled.

By initialing, you acknowledge that you have read and understand the collection policy as described above: _____

_____ _____

(Printed) Patient First and Last Name Signature of patient or person authorized by law

Date of Birth: _____

_____ _____

Witness Signature Date signed

Patient Privacy Notice

Arthritis Associates of Kingsport

PHI- Protected Health Information

We are required by law to protect the privacy of your medical information and to provide you with written Notice describing:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

Please initial you have read and understand the information below:

_____ We may use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

_____We may be required or permitted by certain laws, regulations, or circumstances to use and disclose your medical information for certain purposes without your authorization. Under other circumstances we may need your written authorization (that you may later revoke) to use or disclose your medical information.

_____As our patient, you have important rights relating to inspecting and copying your medical information that we maintain. This includes amending or correcting that information, obtaining any disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

_____You have the right to receive a copy of our most current NOTICE in effect. If you have not yet received a copy of our current NOTICE, please ask at the front desk and we will provide you with a copy.

_____Upon a written request copies of your medical records will be made available in a timely manner. There will be a fee associated with this service.

_____Under this law, we have the right to refuse to treat you should you refuse all or part of your PHI.

The misuse of PHI has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know our employees, managers, and providers undergo training so that they may understand and comply with government rules and regulations regarding PHI and HIPPA compliance regarding privacy of our patients. We will listen to our employees and patients without any thought of penalization if they feel an event in any way compromises our policy of integrity. If you have any questions, concerns or complaints about the NOTICE or your medical information, please contact the HIPPA Compliance Officer.

Patient Signature: _____ Date: _____

Patient Date of Birth: _____

Our office utilizes an electronic prescription service. Your signature allows Arthritis Associates of Kingsport to verify your prescription history electronically:

Patient Signature: _____ **Date:** _____

Arthritis Assoc Of Kingsport PLLC

Three Sheridan Square
Kingsport, TN 37660-7390
(423) 392-6640

PATIENT INFORMATION

NAME (Last, First Middle)	MRN	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	SECONDARY/BILLING ADDRESS (If Applicable)	ETHNICITY

CITY, STATE ZIP	HOME PHONE	CITY, STATE ZIP	HOME PHONE	RACE

PRIMARY CARE PHYSICIAN	REFERRING PHYSICIAN	CONTACT NAME	CONTACT HOME PHONE

PRIMARY EMPLOYER	SECONDARY EMPLOYER (If Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (If Different than above)

NAME (Last, First Middle)	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	SECONDARY/BILLING ADDRESS (If Applicable)
CITY, STATE ZIP	CITY, STATE ZIP
HOME PHONE	HOME PHONE
RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY	POLICY#	
NAME OF INSURED	GROUP#	
ADDRESS OF INSURANCE COMPANY	COPAY AMT $	
CITY, STATE ZIP	DEDUCTIBLE $	
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (If Applicable)

NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED	SSN#	BIRTHDATE	GROUP#
ADDRESS OF INSURANCE COMPANY		COPAY AMT $	
CITY, STATE ZIP		DEDUCTIBLE $	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

Insurance authorization: I authorize AAK to file insurance for services performed in their office and that payment be made to the providers of service. I authorize the above to contact and/or release my health information to Social Security or other insurance carriers regarding payment for services received at AAK. I am responsible for all financial obligations of health services. If for any reason the account should become delinquent, I agree to pay charges, interest or collection costs and reasonable fees.

SIGNATURE OF PATIENT/GUARDIAN _____ DATE _____

Name: _____ Date of birth: _____

Local pharmacy: _____ Phone number: _____

Mail order pharmacy: _____ Phone number: _____

MEDICATION LIST

Please list any medications you are currently taking, prescribed or over the counter.
Please include vitamins and herbal supplements.

Medication	Dosage	Route	Frequency

MEDICATION ALLERGIES

_____ _____

_____ _____

Name:_____ DOB:_____

PAST MEDICAL HISTORY

Please check all that apply

- ☐ Abnormal Bleeding
- ☐ Acid Reflux
- ☐ Alzheimer's Disease
- ☐ Anemia
- ☐ Aneurysm
- ☐ Anxiety
- ☐ Arthritis (Rheumatoid/Osteoarthritis)
- ☐ Asthma
- ☐ Barrett's Esophagus
- ☐ Bleeding Ulcers
- ☐ Blood Clots
- ☐ Cancer _____
- ☐ Cirrhosis of the Liver
- ☐ Colitis
- ☐ Congestive Heart Failure
- ☐ COPD/Lung Disease
- ☐ Crohn's Disease
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulosis
- ☐ Elevated Cholesterol
- ☐ Fatty Liver
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Gout
- ☐ History of Head Injury
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ Hiatal Hernia
- ☐ Hypertension
- ☐ History of Suicide Attempts
- ☐ HIV/AIDS
- ☐ Irregular Heartbeat
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Disease
- ☐ Kidney Failure
- ☐ Kidney Stones
- ☐ Lupus
- ☐ Migraines
- ☐ Mini Stroke/Stroke
- ☐ Neuropathy
- ☐ Osteopenia/Osteoporosis
- ☐ Pancreatitis
- ☐ Parkinson's Disease
- ☐ Peripheral Vascular Disease
- ☐ Pneumonia
- ☐ Prostate Problems
- ☐ Restless Leg Syndrome
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sjogren's Syndrome
- ☐ Sleep Apnea
- ☐ Positive TB SkinTest/ History of TB
- ☐ Thyroid Disease (Under/Over Active)
- ☐ Urinary Tract Infections
- ☐ Vitamin B12 Deficiency
- ☐ Vitamin D Deficiency

SURGICAL HISTORY

(Please include biopsies, eye surgeries, stent placements, etc.)

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE

ARTHRITIS ASSOCIATES OF KINGSPORT, PLLC
THREE SHERIDAN SQUARE
KINGSPORT, TN 37660
P: (423) 392-6840
F: (423) 392-6845

Christopher R. Morris| Annette M. Abril |Emma Greear
Philip Weatherford PA-C| Rachel Rice PA-C| Courtney Carroll FNP

PATIENT AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____

Date of Birth: _____

Last four of SS#: _____

By signing this authorization, I authorize Arthritis Associates of Kingsport to use, disclose, or receive certain protected health information (PHI) about me to or for the party or parties listed below, including all medical records, labs, scans, diagnostic testing, EMG, MRI, CT, etc. This authorization permits Arthritis Associates of Kingsport to use, disclose, or receive health information from/to:

_____

_____

_____

When my information is used or disclosed, it may be subject to redisclosure by the recipient and may no longer be protected by the HIPPA privacy rule. I have the right to revoke this authorization in writing. My written revocation must be in writing to:

ARTHRITIS ASSOCIATES OF KINGSPORT, PLLC
THREE SHERIDAN SQUARE
KINGSPORT, TN 37660

Patient signature/Representative: _____

Date: _____ **Expiration Date:** _____

Witness: _____

Directions to Arthritis Associates of Kingsport
3 Sheridan Square
Kingsport, TN 37660
43-392-6840

From Gate City
Via Interstate: Drive in to Weber City towards I-26 on route 36. Merge right onto I-26 towards Kingsport. Take Meadowview Parkway exit and turn left at the bottom of the ramp. Go approximately 0.5miles towards Wilcox Drive. Proceed through the intersection up the hill towards the rear of Sheridan Square complex. Arthritis Associates of Kingsport is building #3.

Directions from Bristol
Via Interstate: Take I-81 South into Tennessee to exit 57B (Kingsport exit), onto I-26 towards Kingsport. Take exit 4 (Wilcox Drive) and proceed through the first traffic light on Wilcox Drive. Turn right at the next traffic light (Meadowview Parkway) into Sheridan Square. Drive up the hill towards the rear of the complex. Arthritis Associates of Kingsport is building #3.

Directions from Church Hill/Rogersville
Via Interstate: Take 11W east through Kingsport. Proceed on I-26 towards Johnson City for approximately 4 miles. Take exit 3 (Meadowview Parkway) and turn left at the bottom of the ramp. Go approximately 0.5miles towards Wilcox Drive. Proceed through the intersection up the hill towards the rear of Sheridan Square complex. Arthritis Associates of Kingsport is building #3.

Directions from Johnson City/Gray
Via Interstate: Take I-26 West towards Kingsport. Take exit number 4 (Wilcox Drive) and proceed through the first traffic light on Wilcox Drive. Turn right at the next traffic light (Meadowview Parkway) into Sheridan Square. Drive up the hill towards the rear of the complex. Arthritis Associates of Kingsport is building #3.

PLEASE ARRIVE 15 MINUTES PRIOR TO YOUR APPOINTMENT TIME.

IF YOU ARE 15 MINUTES LATE FOR YOUR APPOINTMENT, YOU WILL BE RESCHEDULED.

PLEASE BRING A MEDICATION LIST AND/OR MEDICATION BOTTLES TO EACH APPOINTMENT.