Welcome to Liberty Healthcare Partners!

LIBERTY
HEALTHCARE
PARTNERS

To ensure quality care, our practice has limited capacity, and an application is required to join.

Important Information for New Patients:

- All required paperwork must be completed and submitted before your first appointment is scheduled.
- Your initial visit is intended to establish care with your provider and discuss any current health concerns. Please note that annual wellness exams and physicals will not be conducted during this visit due to insurance billing regulations.
- All medical decisions regarding treatment, preventive care, or evaluations will be discussed with you and your provider, emphasizing a shared decision-making approach.

Ongoing Care & Urgent Medical Needs:

- Once you are an established patient, you are welcome to call with medical concerns outside of your scheduled appointments. We strive to accommodate urgent care needs on the same or next business day.
- Calls will be screened and triaged by our nursing team. If you require a medical consultation, evaluation of an acute issue, or a potential new prescription, you will be scheduled for a visit during office hours on the same or the next business day.
- A provider is available for urgent consultations Monday through Friday.

By signing below, I confirm that I have read and understand the policies outlined above. If I have any questions, I will reach out to a staff member for clarification.

Name (Printed): _____

Signature: _____

Date: _____

phone: 423-498-5839 fax: 423-498-5840 w: libertyhealthcarepartners.com

Liberty Healthcare Partners

Doctor: _____

PATIENT INFORMATION

First Name: _____ Last Name: _____

Birth Date: _____ Social Security: _____ Gender: ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zipcode: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Marital Status: Married Single Divorced Partner Separated Widowed

Race: African American Asian/Pacific Islander Caucasian Hispanic/Latino Other: Specify _____

Language: English Spanish Other: Specify _____

Emergency Contact Person: _____ Emergency Contact Number: _____

Relationship: Spouse Parent Child Sibling Cousin Friend Guardian Other: _____

INSURANCE INFORMATION

Primary Insurance Carrier: _____ Member/Subscriber ID #: _____

Secondary Insurance Carrier: _____ Member/Subscriber ID #: _____

Person responsible for payment: _____ Relationship to patient: _____

Address (if different from patient: _____

City: _____ State: _____ Zipcode: _____

How did you hear about our office: Patient of practice ***(name of pt):*** _____ Google

Hospital Specialist office Insurance Company Marketing event Other: Specify _____

Previous PCP: _____ Previous PCP Phone: _____

PRESCRIPTION REFILL POLICY

- *Request for prescription medications need to be called into our office between 8:30 AM and 4 PM Monday - Friday.*
- *All approved prescriptions will be sent to the pharmacy electronically by the end of business day.*
- *Prescription should be taken as directed.*
- *Early refills may be denied. No medications will be refilled after hours or on weekends unless you're subscribed to UrgentCall.*
- *Non-controlled medications have a 24-hour turnaround time for it to get to the pharmacy and controlled medications have a 48 -72 hour turnaround time to get to the pharmacy.*

Preferred Pharmacy: _____

Preferred Pharmacy Address: _____

Mail Order Pharmacy: _____

DISCLOSURE OF PROTECTED HEALTH INFORMATION

According to office policy, test results and release of medical information, including, but not limited to, appointment time lab or test results, etc. Will be provided to the patient only. Please specify below whom information may be released to other than yourself.

I grant permission for liberty healthcare partners, LLC to release any and all of my medical information to the person (S) listed below.

Name: _____ Name: _____

Relationship: _____ Relationship: _____

PATIENT SIGNATURE: _____ **DATE:** _____

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Patient Name:_____ Birth Date:_____ Age: _____

Medical History

*List any problems/medical conditions you currently take medications for. If none, please write **"NONE"***

Surgical/Hospitalization History

If none, please write ***"NONE"***

Type of Surgery or Hospitalization	Date:	Type of Surgery or Hospitalization	Date:

Allergies

List medications and/or materials/foods you are allergic to and reaction type If none, please write ***"NONE"***

Name of medication/material/food	Reaction	Name of medication/material/food	Reaction

Current Medications

List all prescribed and/or non prescription. If none, please write ***"NONE"***

Name of medication	Dosage and frequency	Name of medication	Dosage and frequency

Family History

*List **ANY** family history of medical problems* If none, please write ***"NONE"***

Social History

Alcohol use: Never Rarely Moderate (2 drinks/day Heavy (More than 2 drinks /day)

Tobacco use: Never Smoker ___ (packs /day) Previous (quit date:____) Vape Snuff Chew

Are you routinely exposed to second-hand smoke? Yes No

Preventative Health

If none, please write ***"NONE"***

Testing	**Date Performed**	**Normal Results (CIRCLE)**			
Mammogram		Yes	No	Unsure	N/A
Pap Smear		Yes	No	Unsure	N/A
Bone Density/Dexa Scan		Yes	No	Unsure	N/A
Colonoscopy		Yes	No	Unsure	N/A
Prostate Exam		Yes	No	Unsure	N/A
Eye exam		Yes	No	Unsure	N/A

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Liberty Healthcare Partners

PATIENT CONSENT AND ASSIGNMENT FORM

1. Consent to Treat

I authorize Liberty Healthcare Partners, its healthcare practitioners, clinical staff, office staff, and other individuals involved in my care to examine me and perform any tests, procedures, and/or treatments that may be helpful to care for my injury or illness**.**

2. Payment and Financial Obligations

I request that payment of authorized Medicare/Medicaid and/or other insurance company benefits be made to Liberty Healthcare Partners for any services furnished by my physician/provider. I authorized any holder of medical information about me to release to Medicare/Medicaid and/or other insurance companies and its agents any information needed to determine the benefits of the benefits payable for related services. I understand my signature request that payment be made and authorized release of medical information necessary to pay the claim. In Medicare/Medicaid and/or other insurance company-assigned cases, the physician or supplier agrees to accept the charge determined by the Medicare/Medicaid and/or other insurance company as the full charge and the patient is responsible only for the deductible, co-insurance, and non-covered insurance services. Co-insurance and the deductible are based upon the charge determination of the Medicare/Medicaid and/or other insurance company.

I understand that I am responsible for paying all charges associated with this treatment. If I have health insurance, I understand that I am financially responsible in the event that all or some payment is denied by my insurance carrier or other third party who is responsible for payment. I am also responsible for those charges not covered by my insurance such as deductibles, co-pays, or evaluation or treatment that are not included as an insurance benefit. I understand that if my insurance plan requires a referral or pre-cert for imaging or testing and this has not been obtained, I am responsible for payment of services rendered with that facility.

I authorize my health insurance carriers) or other third parties who are responsible for paying for my healthcare to pay costs associated with my evaluation and care directly to Liberty I authorize the release of any medical information necessary to process this claim. I realize that in the event these claims are denied, I am responsible for payment. I authorize my private health

3. Consent to Use and Disclosure of Protected Health Information

I consent to Liberty Healthcare Partners, its healthcare practitioners, staff, and other individuals, use and disclosure of my protected health information (PHI) in support of my diagnosis and treatment, payment for the medical services I receive, and the legitimate healthcare operations of the medical practice. I consent to Liberty Healthcare Partners disclosure of PHI to other healthcare practitioners and facilities that are involved in providing medical services to me.

Also, I consent to Liberty Healthcare Partners disclosure of my PHI to my health insurance carrier, utilization review organization, or third-party administrator to support payment for my medical services.

I understand that Liberty Healthcare Partners agreement to provide medical services to me is conditioned upon my signing of this consent and that Liberty Healthcare Partners requests my consent to ensure that Liberty Healthcare Partners can properly carry out the professional responsibility of caring for me.

My PHI, which is the subject of this consent, includes demographic information about my physical or mental health or condition, and information about the medical services provided to me (including payment information) if any of that information may be used to identify me. (Depending upon the medical services, I request or require this information may include information about treatment for HIV/AIDS, sexually transmitted diseases, mental health or psychiatric conditions, or substance abuse.)
1 understand that I have a right to restrict Liberty Healthcare Partners' use and disclosure of my PHI and that Liberty Healthcare Partners is not obligated to agree to the requested restriction, but that an agreement to restriction binds Liberty Healthcare Partners. I may revoke this consent at any time by providing Liberty Healthcare Partners with a written, signed, and dated request except to the extent any restriction on the use and disclosure of PHI or revocation of this consent may result in improper diagnosis or treatment, denial or coverage of a claim for insurance benefits, or other adverse consequences.

I acknowledge that this consent will remain in effect for all subsequent uses and disclosures for the limited purposes outlined above for 30 months (2½ years) from the date of this consent unless I revoke it earlier as described above.

I have received a copy of Liberty Healthcare Partners Notice of Privacy Practices that provides a more complete description of the uses and disclosures addressed above and I have had an opportunity to review the Notice by contacting the office staff at any time.

Patient Communication Policy

There will be no tolerance for abusive, inappropriate, disruptive, insulting, threatening, or disrespectful language by phone or in any interaction with staff from patients or patient representatives. This will be the reason for the patient's discharge from the practice. Repeated or excessive phone calls, requests, and demands of any medication or service will be considered harassment and will not be tolerated. This will be a reason for patient discharge from the practice.

Leaving without being Seen

Upon arrival at the clinic, before your appointment, during triage, or your appointment with the doctor, you will not be rescheduled if you decide to leave abruptly or against medical advice. You will need to find another healthcare provider. If you have an emergency or scheduling conflict, please let the clinical staff know so you can reschedule or cancel your appointment.

Controlled Substance Policy

We may not be able to see you if:

- You are taking chronic scheduled pain medication. If you are currently taking chronic scheduled pain medication and are under the care of a pain specialist, our office may make an exception in your case. If an exception is made for you, please understand we will NOT refill your chronic scheduled pain medication or assume responsibility for the pain medication you are already taking.

- •You are taking chronic scheduled benzodiazepines. If you are currently taking scheduled benzodiazepines (Xanax, Klonopin, Valium, etc.) and are under the care of a psychiatrist, our office may make an exception in your case. If an exception is made for you, please understand we will NOT refill scheduled benzodiazepines or assume responsibility for the medication you are already taking.

Late/No-Show Policy

We work hard to accommodate getting patients seen as close as possible to their appointment time. If you are more than 15 minutes late for your appointment you may need to reschedule your appointment or you may have to wait until an appointment time later that day becomes available. If you No- Show to 3 scheduled appointments during a 12 month period of time, it could results in being discharged from the practice. .

I **have read and understand the policies listed above. I understand that should I have any questions, I will be directed to a staff member who can address my concerns**

Signature of Patient/Legal Guardian: _____

Printed Name: _____

Date: _____

Liberty Healthcare Partners
6740 Lee Hwy. Chattanooga, TN 37421
Phone: 423-498-5839 | Fax: 423-498-5840

MEDICAL RECORDS RELEASE AUTHORIZATION

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ City, State & Zip Code: _____

Phone: _____ Social Security Number: _____

AUTHORIZED DISCLOSURE I hereby authorize the following medical facility/physician practice to release my medical records:

Facility/Physician Name: _____

Address: _____ City, State & Zip Code: _____

Phone: _____ Fax: _____

INFORMATION TO BE DISCLOSED

□ All of my medical-related information
□ Office Notes, Labs, and Imaging Reports
□ Other: _____

PURPOSE OF DISCLOSURE

□ Transition of Care
□ Continuation of Care
□ General Purpose / At My Request

AUTHORIZED RECIPIENT

I authorize the disclosure of my medical records to:

Liberty Healthcare Partners Primary Care, LLC
6740 Lee Hwy, Chattanooga, TN 37421
Phone: (423) 498-5839 | Fax: (423) 498-5840

This authorization will expire one year from the date it is signed.

ACKNOWLEDGMENT OF RIGHTS

I understand the following:

- I may revoke this authorization in writing at any time, except where disclosure has already occurred based on my initial authorization.
- Medical records released under this authorization may be subject to redisclosure and may no longer be protected by HIPAA Privacy Standards.
- My treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization unless the purpose is solely for creating records for a third party or participating in a research study.
- I will receive a copy of this authorization after signing, and a copy shall be as valid as the original.

PATIENT OR LEGAL REPRESENTATIVE SIGNATURE

Patient Name (Print): _____
Signature: _____
Date: _____

If signed by the Legal Representative, indicate the patient relationship:
□ Parent/Guardian
□ Power of Attorney
□ Other: _____