Madison Delk PA-C
710 Memorial Blvd. 110
Murfreesboro, TN 37129
Ph: 615-895-6900
Fax: 615-895-6912

Patient Information

Name: ____

DOB: ___________________ Sex:___________ Marital Status: ___________________________________

Street Address: ____

City: ______________________ State: ______ Zip Code: _______________________________________

Home Phone: (____) _____-_______ Cell Phone: (____) _____- ______________________________

Social Security Number: _____ - ____ - ______ Email: ____

Work Phone: (____) _____-_______ Work Address: ______________________________________

Emergency Contact

Name: __________________________ Relationship: _______________________________________

Phone: (____) _____-__________

Insurance Information (We will need to make a copy of your insurance card and photo ID)

Insurance Company Name: ____

Policy Holders Name: ________________________ DOB: ___________________________________

I authorize release if any medical information needed to process this claim. I also authorize any insurance payment of medical benefits to Millennial Medical Clinic for services provided to myself of minor child. I understand that I am financially and totally responsible to Millennial Medical Clinic for charges not covered by my insurance. In the event of default, I agree to pay all costs of collection, including reasonable attorney fees.

I also agree to give medical insurance filing services authorization to complete any credit investigation necessary for the processing of this claim.

Patient Signature: _________________________________ Date: ____________________________

If patient is a minor:
Parent/Guardian Signature: ___________________________________

Millennial Medical Clinic

Statement of Patient Financial Responsibility

Patient Name: ____ DOB: ________________

Millennial Medical Clinic appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payment at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for you balance in full.

I have read the above policy regarding my financial responsibility to Millennial Medical Clinic, for providing medical services to me or above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Millennial Medical Clinic, the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient Signature _________________________________ Date ___________________________

Guarantor Signature ______________________________ Date ___________________________
(If guarantor is not the patient)

Co - Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at each visit. Thank you for your cooperation in this matter.

Patient Signature _________________________________ Date ___________________________

Consent for Treatment and Authorization to Release Information

I hereby authorize Millennial Medical Clinic, through its appropriate personnel, to perform or have performed upon me, or the above-named patient, appropriate assessment and treatment procedures. I further authorize Millennial Medical Clinic, to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

Patient Signature _________________________________ Date ___________________________

Cancellation/No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to canceling your appointment. I understand if I no show for two consecutive appointment I may be dismissed from the practice and a $35.00 fee will be imposed for each no-show appointment. Millennial Medical Clinic will notify you in writing, via certified mail, if you are discharged from care. I have read and understand the above information, and I agree to the terms described.

Patient Signature _________________________________ Date ___________________________

Self-Pay

I do not have health insurance and will be responsible for services rendered here at Millennial Medical Clinic. I agree to pay Millennial Medical Clinic, the full and entire amount of treatment given to me or to above-named patient at each visit.

Patient Signature _________________________________ Date ___________________________

Millennial Medical Clinic

No Show/Missed Appointment Policy

We, at Millennial Medical Clinic understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least a 24-hour notice). You can cancel appointment by calling the following number: (615) 895 - 6900

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a contest, an appointment reminder call to you is made/attempted one (1) business day prior to your scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time.

Please review the following policy:

1. Please cancel your appointment with at least a 24 hours notice: There is waiting list to see the clinician's at Millennial Medical Clinic and whenever possible, we like to fill canceled spaces to shorten the waiting period for our patients.

2. If less than a 24-hour cancellation is given this will be a documented as a "No-Show" appointment.

3. If you do not present to the office for you appointment, this will be documented as a "No-Show" appointment.

4. After the first "No-Show/Missed" appointment, you will receive a phone call or letter warning that you have broken our "No-Show" policy. Millennial Medical Clinic will assist you to reschedule this appointment if needed.

5. There will be a charge of $35.00 for every missed appointment charge to your account that will be due at your next visit.

I have read and understand Millennial Medical Clinic No Show/Missed Appointment Policy and understand my responsibility to plan appointments accordingly and notify Millennial Medical Clinic appropriately if I have difficulty keeping my scheduled appointments.

Patient Name ______________________________ DOB ______ /_______ /__________

Patient Signature or Parent/Guardian if Minor ______________________________

Relationship to Patient (if Minor) ______________________________

Staff Signature ______________________________ Date ____________________

Millennial Medical Clinic

Acknowledgment of Receipt of Notice of Privacy Practices

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practice, which states how we many use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgment, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Patient Name (Print) ___________________________________

Patient Signature _______________________________________ Date___________________________

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list below names(s) of individual(s) you authorize our office to discuss care with. Your PHI may be disclosed to the individual(s) listed below until you notify us otherwise in writing.

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____

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For Office Use Only

We have made every effort to obtain written acknowledgment of receipt of our notice of Privacy from this patient but it could not be obtained because:

_____The patient refused to sign.

_____Due to an emergency situation it was not possible to obtain an acknowledgment.

_____We were not able to communicate with the patient.

_____Other (Please provide specific details)

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Employee Signature ____________________________________ Date ______________________