

Patient Registration Form - Please Print

First Name _____ M.I. _____ Last Name _____

Birth Date ____/____/____ Gender _____ SS# _____

Marital Status: Single / Married / Other Doctor who referred you to our office _____

Patient Address _____ Apt# _____ City _____ ST _____ Zip _____

Home Phone _____ - _____ - _____ Cell Phone _____ - _____ - _____

Email Address _____

Employment Status: Employed FT Student PT Student Self Employed Retired

Employer Name: _____ Employer Phone: _____ - _____ - _____

Emergency Contact Name: _____ Emergency Contact Phone: _____ - _____ - _____

Guarantor (Complete if patient is under age of 18 years)

Name: _____ SS#: _____ DOB: _____

Relationship to Patient: _____

Address (if different from patient): _____

Home Phone _____ - _____ - _____ Cell Phone _____ - _____ - _____

Guarantor Employment Status: Employed FT Student PT Student Self Employed Retired

Employer Name: _____ Employer Phone: _____ - _____ - _____

The information below is being collected pursuant to the requirements of the TN Department of Health in compliance with Tennessee state law.

Race: White/Black/American Indian Eskimo or Aleut Asian or Pacific Islander
 Other Race Unknown Race

Ethnicity: Hispanic Origin Not Hispanic Origin Unknown Hispanic Origin

Please check the appropriate box in answer to the following question. Have you executed an Advance Health Care Directive, a Living Will or a Power of Attorney? Yes No

On the Job Injury: Yes No Motor Vehicle Accident: Yes No Accident/Injury Date: _____ State: _____

Workers' Compensation Insurance - If work related injury, please provide us the following information:

WComp Insurance Name: _____ WComp Phone: _____ - _____ - _____

Claim Number: _____ Case Manager: _____

Adjuster: _____ Authorized by: _____

If this is a Motor Vehicle Accident see our Financial Policy regarding handling of claims.



AdvancedHEALTH

HEALTH INSURANCE INFORMATION

Check here to indicate you do **NOT** have Health Insurance Coverage as of this date.

Primary Insurance _____ Policy/Member Number _____

Plan Name _____ Group Number _____

Relationship: Self/Spouse/Child/Other _____ Subscriber Name _____

Subscriber Date of Birth ____/____/____ Subscriber SS# _____

Secondary Insurance _____ Policy/Member Number _____

Plan Name _____ Group Number _____

Relationship: Self/Spouse/Child/Other _____ Subscriber Name _____

Subscriber Date of Birth ____/____/____ Subscriber SS# _____

If you are enrolled with Medicare, please check your Medicare Enrollment Type:

- | | |
|---|--|
| <input type="checkbox"/> 12 - Working Age beneficiary/spouse with an employer group health plan | <input type="checkbox"/> 16 - Public Health Service or other federal agency |
| <input type="checkbox"/> 13 - End-Stage Renal Disease (ESRD) beneficiary in Medicare coordination period with an employer health plan | <input type="checkbox"/> 41 - Black Lung |
| <input type="checkbox"/> 14 - No-Fault, including auto/other | <input type="checkbox"/> 42 - Veteran's Administration |
| <input type="checkbox"/> 15 - Workers' Compensation | <input type="checkbox"/> 43 - Disabled beneficiary under age 65 with large group health plan |
| | <input type="checkbox"/> 47 - Other Liability Insurance |

Request or Consent for Release of Medical Information or Records

I hereby authorize the following person(s) to have access to my medical and billing information as indicated on the HIPAA consent form which I signed.

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

In addition to sending my medical report to the ordering doctor, I also authorize the following physicians/practitioners/hospital to have access to my medical records for continuum of healthcare.

Physician or Hospital Name: Premier Radiology

Address: 28 White Bridge Pike, Nashville, TN 37205 Phone: 615.356.3999

DELINQUENT ACCOUNTS: We review past due accounts frequently and at every statement cycle. Your communication and involvement to ensure your balance is paid timely is important to us. It is imperative that you maintain communications and fulfill your financial agreement and arrangements to keep your account active and in good standing.

If your account becomes sixty (60) days past due, further steps to collect this debt may be taken. If you fail to pay on time and we refer your account(s) to a third party for collection, a collection fee will be assessed and will be due at the time of the referral to the third party. The fee will be calculated at the maximum percentage permitted by applicable law, not to exceed 18 percent. In addition, we reserve the right to deny future non-emergency treatment for any and all debtor-related unpaid account balances.

CONSENT TO CONTACT: I grant permission and consent to AdvancedHEALTH and its agents, assignees, and contractors (which may include third party debt collectors for past due obligations): (1) to contact me by phone at any number associated with me, if provided by me or another person on my behalf; (2) to leave messages for me and include in any such messages amounts owed by me; (3) to send me text message or emails using any email address I provided or any phone number associated with me, if provided by me or another person on my behalf; and (4) to use prerecorded/artificial voice messages and/or an automated telephone dialing system (an auto dialer) as defined by the Telephone Consumer Protection Act in connection with any communications made to me as provided herein or any related scheduled services and my account. I understand that my refusal to provide the consent described in this paragraph will not affect, directly or indirectly, my right to receive healthcare services.

MY SIGNATURE INDICATES THAT ALL INFORMATION REFLECTED ON THIS FORM IS TRUE AND ACCURATE

Signature of patient, responsible party or patient's representative

____/____/____
Date

Front Desk Initials _____



AdvancedHEALTH

Revised 8.28.2020

Notice Of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

Patient Name or Legal Guardian: _____

Signature: _____

Date: _____

PRACTICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date: _____ Initials: _____

Reason: _____



General Consent For Treatment

As the patient, you have the right to be informed about your conditions and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify appropriate treatment and/or procedure for any identified condition(s).

I request and authorize medical care as my provider, his assistant or designees (collectively called "the providers") may deem necessary or advisable. This care may include, but is not limited to, routine diagnostics, radiology and laboratory procedures, administration of routine drugs, biological and other therapeutics, and routine medical and nursing care. I authorize my provider(s) to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my (the patient) care is directed by my provider(s) and that other personnel render care and services to me (the patient) according to the provider(s) instructions.

I understand that I have the right and the opportunity to discuss alternative plans of treatment with my provider and to ask and have answered to my satisfaction any questions or concerns.

In the event that a healthcare worker is exposed to my blood or bodily fluid in a way which may transmit HIV (human immunodeficiency virus), hepatitis B virus or hepatitis C, I consent to the testing of my blood and/or bodily fluids for these infections and the reporting of my test results to the healthcare worker who has been exposed. _____ (initial)

I HAVE READ OR HAD READ TO ME AND FULLY UNDERSTAND THIS CONSENT; I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS AND HAD THESE QUESTIONS ADDRESSED.

Name of Patient: _____

Signature of Patient: _____ Date: _____

Consent of Legal Guardian, Patient Advocate or Nearest Relative **if patient is unable to sign**

Consent Caregiver **if patient is unable to sign**

Name of Legal Guardian, Patient Advocate, Nearest Relative or Other: _____

Relationship: _____ Telephone: _____

Address: _____

Signature of the above: _____ Date: _____ Time: _____

Signature of Witness: _____ Date: _____



AdvancedHEALTH

Patient Financial Policy

This is an agreement between AdvancedHEALTH, as creditor, and the Patient/Debtor named on this form and indicated by patient/debtor signature below.

In this agreement the words "you", "your" and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us" and "our" refer to AdvancedHEALTH. By executing this agreement, you are agreeing to pay for all services that are rendered.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect. A copy of your signed financial agreement will be provided to you.

HEALTH INSURANCE - It is YOUR responsibility to:

- Ensure we have been provided with the most current insurance information relative to filing your claim including insurance card, ID number, employer, birth date and patient address. This information will be located on our patient registration form.
- Ensure we are contracted with your insurance carrier to receive maximum benefits.
- Pay your co-payment or patient portion at the time of service.
- Inform us of any insurance changes made after this signed agreement/date of service. Insurance carriers have specific timely filing guidelines and pre-authorization requirements for certain services. If revised insurance information is not provided to us within your insurances' timely filing limits, you will be required to pay for services in full. If prior authorization was required for services already received and your claim is denied for lack of authorization, you will be required to pay for services in full.
- Contact your insurance company if no correspondence is received by you within 45 days of the date of service.

It is OUR responsibility to:

- Submit a claim to your health insurance carrier based on the information provided by the patient/debtor at the time of service or as updated information is provided.
- Provide your health insurance carrier with information necessary to determine benefits. This may include medical records and/or a copy of your insurance card.
- Provide MVA patients a courtesy health insurance claim form for their records upon request.

PAYMENT OPTIONS: Per our contracted agreement with your insurance carrier, we are required to collect your co-payment on the day of service. If you do not have insurance, you are required to pay for treatment at the time of service unless other arrangements have been formally made. A separate self-pay financial agreement will be provided to you. Our office collects all copays plus estimated coinsurance and deductibles at the time of service

We accept the following: Cash Check Credit Card (Visa, MasterCard, Discover, American Express)

A twenty-five dollar (\$25.00) returned check fee will be assessed to the patient account per incident.

For convenience, payments may be made online at www.ePayItOnline.com. To utilize this service you will need your account number, access code, and Code ID. This information can be found on the patient statement you will receive reflecting your balance. **Patients who no-show may be subject to a no-show fee.**

PENDING APPROVALS FOR SERVICES: In the event we are unable to obtain approval for services and you wish to proceed, we will not bill your insurance. Services will be reduced to the in-network insurance allowable amount and will apply to the patient's responsibility.

_____ Initials

Patient and/or Debtor Signature: _____ Date ____/____/____

Additional financial explanations are continued on the back side of this page



AdvancedHEALTH

WORKERS' COMPENSATION INJURIES: Written approval/authorization by your employer and/or workers' compensation carrier prior to your initial visit is needed. We will contact your case manager and/or supervisor to confirm your workers' compensation injury. If this claim is denied, for any reason by your employer or your employer's workers' compensation carrier, you will be responsible for payment in full. If denial is made by workers' compensation, health insurance can be filed for these denied services and you will be held responsible for the account.

MOTOR VEHICLE ACCIDENTS (MVA's) – Yes, I was involved in a MVA on ____/____/____. Unless prior agreement has been reached or I am a Medicare recipient, my **health insurance** will be filed for services related to this accident. In the event I do not provide insurance information upon initial visit, I understand insurance denials may occur depending on type of service(s) received or carrier specific filing requirements. I agree, as the patient or patient's guardian, I am ultimately responsible for all balance(s) due to this facility and/or its physician(s) for services rendered regardless of insurance denial(s) or unfavorable case outcomes. If I have chosen an attorney to oversee my case, this financial agreement will serve as a Letter of Protection to my attorney. I further understand my account may be handled by an outside entity that specializes in attorney lien accounts at the facilities discretion.

____ Yes, I have chosen to retain an attorney. Signed: _____ Date: ____/____/____

Attorney Name: _____ Phone: _____

BILLING INFORMATION

STATEMENTS: A statement of account will be provided to you if insurance has paid leaving a patient portion, denied or no response is received. Due to the type of service we provide, you may receive billing from more than one practice, otherwise known as split billing. The balance on your statement is due and payable within 30 days of receipt unless other arrangements are made with our billing department. The statement will be sent to the address provided at the time of service. In the event your mailing address changes after your service date and your account has not been paid in full, you are required to notify our billing office of this change by email at billing@phydata.com or call 615-851-6033. In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child at time of service will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, court documentation is required for any guarantor address changes, otherwise, it is the authorizing/custodial parent's responsibility to collect from the other parent. Any account with a credit balance of less than <\$5.00> will not be refunded without specific request from the patient/debtor.

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WAIVER OF CONFIDENTIALITY:

You understand if your account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

MEDICAL RECORDS:

You will be required to request in writing or sign a medical authorization form for the release of your medical records to any organization or physician. We charge a **\$20 flat rate** for 1-5 pages plus .50 per additional page and postage.



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