INSURANCE COMPANY NON-PARTICIPATION ACKNOWLEDGEMENT

DATE:_____ **CHART #**_____

PATIENT:_____

INSURANCE COMPANY: _____

I acknowledge that I have been informed that OB/GYN Professionals of East Tennessee, P.C. do not participate in any insurance plan listed below and will not be filing a claim to that insurance company.

PLEASE NOTE THAT WE DO NOT PARTICIPATE IN THE FOLLOWING INSURANCE PLANS

Windsor Medicare
Humana Gold
United Healthcare Medicare Complete
Bluecare-TN Care
Blue Advantage Medicare
Cariten Senior Health
United Health Community Plan
Sterling
Americhoice- TN Care
Security Choice
Unicare-Medicare
BCBS–Network X
BCBS-Cover TN- TN Care

_____

SIGNATURE

OB/GYN PROFESSIONALS OF EAST TENNESSEE

PATIENT CONSENT FOR E-SCRIBING (ELECTRONIC PRESCRIBING)

DATE_____ CHART _____

I _____have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to send this protected health information.

DATE_____

SIGNATURE _____

RELATIONSHIP TO PATIENT _____

WITNESS _____

CHART # _____

Office Policy for Prescription Refills

- Our office requires a 48 hour notice on any prescription refills
- Our office does not accept any refill requests directly from your pharmacy either by fax or phone. If you require a refill, you must contact the office directely.
- Our office reserves the right to deny any prescription refills if you are due or overdue for an appointment with your physician.
- After you have requested your refill with our office, please call your pharmacy first to see if your refill has been processed or is on file before contacting our office a second time.

Patient Signature: _____

Date: _____

OB/GYN PROFESSIONALS OF EAST TENNESSEE, P.C.
PATIENT INFORMATION

DATE: _____ CHART # _____

PLEASE READ & INITIAL EACH ITEM BELOW

RESPONSIBILITY FOR CHANGES. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO NOTIFY THIS OFFICE OF ANY CHANGES IN *MY ADDRESS, PHONE NUMBER OR INSURANCE COVERAGE.*
INITIAL_____

FINANCIAL RESPONSIBILTY. *I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT PAID BY MY INSURANCE CARRIER.* I UNDERSTAND THAT SUCH BALANCES WILL BE DUE UPON RECEIPT OF STATEMENT FROM OB/GYN PROFESSIONALS OF EAST TENNESSEE, P.C. I UNDERSTAND THAT A FINANCE CHARGE OF 21.9% APR WILL BE ASSESSED ON ANY BALANCES STILL DUE AFTER 30 DAYS FROM THE DATE OF BILLING. I UNDERSTAND THAT ANY DISPUTE IN PAYMENT BY MY INSURANCE COMPANY IS MY RESPONSIBILITY. IF IT BECOMES NECESSARY TO REFER MY ACCOUNT BALANCE FOR COLLECTION. I UNDERSTAND THAT A MINIMUM OF 30% (THIRTY PERCENT) COLLECTION FEE WILL BE ADDED TO MY ACCOUNT BALANCE. I ALSO AGREE TO PAY ANY COURT COSTS AND/OR ATTORNEY FEES IF MY ACCOUNT IS REFERRED FOR COLLECTION

INITIAL_____

RELEASE FOR BILLING. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS FOR MEDICAL SERVICES, AS PER HIPAA REGULATIONS. I REQUEST PAYMENT OF MEDICAL BENEFITS DIRECTLY TO OB/GYN PROFESSIONALS OF EAST TENNESSEE, P.C.
INITIAL_____

RESPONSIBILITY FOR CO-PAYMENTS. *I UNDERSTAND THAT CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE.* IF MY INSURANCE CHARGES CO-PAYMENT ON LABS OR OTHER TESTS, I WILL PAY THOSE CHARGES WHEN BILLED.
INITIAL_____

RESPONSIBILITY FOR REFERRALS. I UNDERSTAND THAT IF MY INSURANCE REQUIRES A REFERRAL FROM MY PRIMARY CARE PHYSICIAN, IT IS MY RESPONSIBILITY TO OBTAIN THAT REFERRAL PRIOR TO MY VISIT IN THIS OFFICE. I UNDERSTAND THAT THE FAILURE TO DO SO WILL RESULT IN MY BEING RESPONSIBLE FOR FULL PAYMENT OF THAT DAY'S CHARGES.
INITIAL_____

TENN CARE PROGRAMS. I ACKNOWLEDGE THAT OBGYN PROFESSIONALS OF EAST TN **DOES NOT PARTICIPATE** IN ANY TENN CARE PROGRAM AND CLAIMS WILL NOT BE FILED TO ANY OF THESE PROGRAMS **AS PRIMARY OR SECONDARY INSURANCE.** I ACCEPT FULL FINANCIAL RESPONSIBILITY FOR ALL BILLS DUE RELATING TO THESE CLAIMS.
INITIAL _____

CELLULAR PHONE USE: CELL PHONE USE IS **PROHIBITED IN THE EXAM ROOMS/CLINIC AREA.** VIDEO AND VOICE RECORDING IS PROHIBITED IN THE EXAM ROOMS WITHOUT CONSENT FROM THE PHYSICIAN IN ADVANCE.
INITIAL _____

NO-SHOW: ANY MISSED APPOINTMENTS WITHOUT PRIOR 24-HOUR NOTICE WILL INCURE A $25 FEE.
INITIAL _____

SIGNATURE: _____ DATE: _____
2/7/25

DATE _____ **CHART** _____

OB/GYN PROFESSIONALS OF EAST TENNESSEE, P.C.

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed and/or received a copy of the **Notice of Privacy Practices** for OB/GYN Professionals of East Tennessee and authorize the release of my **Protected Health Information** as outlined in the policy. This authorization will remain in effect until revoked in writing. A photocopy of this release is to be considered as valid as the original.

OB//GYN Professionals of East Tennessee has my permission to leave appointment and medical information **(INCLUDING NORMAL TEST RESULTS)** with:

Please initial each method that you approve.

___Anyone in my home.

___At home answering machine.

___At work answering machine or voice mail.

___ Parent _____

___Spouse/partner only

___Patient only

___Cell phone/voice mail

_____
NAME OF PATIENT (Please print)

_____
SIGNATURE OF PATIENT

_____
DATE

_____
Signature of patient representative (Required if the patient is a minor or an adult who is unable to sign this form)

RELATIONSHIP_____

1/22/2025 tsb

OB/GYN PROFESSIONALS OF EAST TENNESSEE

DATE_____ CHART_____

You are scheduled for an annual appointment today. Problem focused issues you may be having are not part of the annual preventative visit. If you wish to address these issues during your annual preventative visit additional charges will be billed to your insurance company. This could result in your insurance company putting a balance over as your responsibility.

If you would like to schedule a separate appointment to discuss any problem focus issues we will be glad to make that appointment for you.

Date _____

Signature _____

CHART: _____

OB/GYN PROFESSIONALS OF EAST TENNESSEE

REVIEW OF SYSTEMS

PLEASE LIST ANY PROBLEMS UNDER THE FOLLOWING

1) Eyes, Ears, Throat: ___NONE ___YES EXPLAIN:

2) Thyroid: ___NONE ___YES EXPLAIN:

3) Diabetes: ___NONE ___YES EXPLAIN:

4) Heart, Vessels: ___NONE ___YES EXPLAIN:

5) Lungs, Chest: ___NONE ___YES EXPLAIN:

6) Stomach, Abdomen: ___NONE ___YES EXPLAIN:

7) Kidneys, Bladder: ___NONE ___YES EXPLAIN:

8) Breasts: ___NONE ___YES EXPLAIN:

9) Genital Area: ___NONE ___YES EXPLAIN:

10) Legs, Feet: ___NONE ___YES EXPLAIN:

11) Arms, Hands: ___NONE ___YES EXPLAIN:

12) Nerves: ___NONE ___YES EXPLAIN:

13) Brain, Nervous System: ___NONE ___YES EXPLAIN:

14) Sleep Problems: ___NONE ___YES EXPLAIN:

Did you fill out this form by yourself? Yes _____ No_____

Signature: _____Date_____

Did you have any assistance filling this form out? Yes____ No___

Assistant signature: _____

Relationship: _____ Date: _____

Reviewed by: _____Date: _____

OB/GYN PROFESSIONALS OF EAST TENNESSEE

ANNUAL REVIEW SHEET DATE: _____

NAME: _____ **CHART #** _____

DOB: _____ **AGE:** _____ **FAMILY DOCTOR:** _____

MEDICATIONS: (Include Vitamins and other Supplements) **ALLERGIES:**

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

PAST MEDICAL HISTORY: (Circle any that apply to you)

Blood clots in legs	Depression, Anxiety, or Both		Asthma	Cancer
Bone problems	Skin Problems	Thyroid Problems	Bowel Problems	Diabetes
Heart Murmur	Heart Disease	High Blood Pressure	Kidney Problems	

PAST SURGERY: _____

_____

_____

_____

SMOKER: _____YES _____NO **ALCOHOL:** _____YES _____NO

RECREATIONAL DRUGS: (Marijuana, Cocaine, etc.)
How much? _____ How long: _____

GYNECOLOGY HISTORY:
Number of pregnancies _____
Number of living children _____
Date of last menstrual period _____
How many days do you bleed? _____
How many days between periods? _____
How heavy? Light _____ Moderate _____ Heavy _____
Do you have pain before your period? Yes _____ No _____
How many days before? _____
Painful intercourse? Yes _____ No _____
Age at menopause _____
Do you have a history of STD? Yes _____ No _____
If yes, please circle: Chlamydia Gonnorrhea Herpes Warts HIV Hepatitis Syphillis
Date of last Mammogram: _____ Where: _____
Date of last Pap _____ Have you ever had an abnormal Pap? ____Yes ____No
Date of last Colonoscopy: _____
Date of last Bone Mineral Density Test: _____
Date of last Cholesterol Test _____
What do you currently use for birth control? _____

FAMILY HISTORY
Does anyone in your immediate family have a history of cancer? _____YES _____NO
If so, what type? _____Breast _____Bowel _____Ovary _____Other

Any other major medical problems in your immediate family:

_____

CHART: _____

Insurance Information

Primary Insurance
Company Name:
Address:
City, State, Zip:
Phone:
Insured's Name:
Relationship to Patient:
Insured's Birth Date:
ID Number:
Group Number:
SSN:
Secondary Insurance
Company Name:
Address:
City, State, Zip:
Phone:
Insured's Name:
Relationship to Patient:
Insured's Birth Date:
ID Number:
Group Number:
SSN:

- **We must have the SSN and DOB of the primary subscriber for the insurance. It is necessary for billing purposes. Without it, we will be unable to send out specimens to the lab.**

Signature: _____

Date: _____

CHART: _____

Preferred Phone Number: _____ Ok to leave a message? o Yes o No	Alternate Phone Number: _____ Ok to leave a message? o Yes o No
Email Address: _____ Would you like to join our portal? o Yes o No	Emergency Contact Name: _____ Relationship: _____ Phone Number: _____
Employer: _____ Job Title: _____	Who is your Family Doctor? _____ Location: _____ Phone: _____

Preferred Pharmacy: _____

Location: _____

_____

Phone Number: _____