Name _____ Date of Birth _____

Patient Intake Form

Please fill out this form to the best of your knowledge. Your answers help us plan and provide your care.

Personal Information

Address: _____

Zip Code: _____ City: _____ State: _____ Age: _____ Sex:M☐ F☐

Email: _____

Primary Language: _____**Race**: _____**Occupation**_____

Home Number:_____ **Mobile Number:**_____

Marital Status _____ **Referring Physician**: _____

PCP: _____ Last Seen Date: _____

Pharmacy Information

Pharmacy Name: _____ Address: _____

Zip Code: _____ City: _____ Phone: _____

Reason we are seeing you today:

_____

Medical Insurance Info: _____ ID: _____
Secondary Ins: _____ ID: _____
If Workers Comp Insurance please provide us with your Adjustors Information, Claims #, and Date of Accident:

_____
_____
_____.

Current Prescriptions *(list all medications you are taking at present)*

Medication name Dosage/ Route	How often
Example: Lasix 20 mg, PO	*Daily*

Any medication allergies? _____

Name _____ Date of Birth _____

Mental Health

Over the last 2 weeks, how many bad days have you had:	
Had little interest or pleasure in doing things?	
Felt down, depressed or hopeless?	

Past Medical History (*check all that apply)*

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood clot *(DVT/PE)*
- ☐ Coronary artery disease (*Heart attack)*
- ☐ COPD/emphysema
- ☐ Cancer/History of cancer
- ☐ Chronic kidney disease
- ☐ Chronic liver disease/cirrhosis
- ☐ Congestive heart failure
- ☐ Depression
- ☐ Diabetes Type I/II
- ☐ GERD
- ☐ Hepatitis (type ____)
- ☐ Hypertension *(High blood pressure)*
- ☐ Hyperlipidemia (*High cholesterol)*
- ☐ Migraine
- ☐ Seizure
- ☐ Stroke
- ☐ Thyroid (hypo/hyper)

Please list any other conditions not mentioned above:

_____

_____

Past Surgical History *(check all procedures that apply)*

- Appendectomy
- Coronary artery bypass (*open heart)*
- Cholecystectomy (*removal of gallbadder)*
- Gastric bypass
- Hysterectomy (*removal of uterus)*
- Joint repair/replacement (*i.e hip, knee,shoulder)*
- Nephrectomy (*removal of kidney)*
- Spinal surgery
- Splenectomy (*removal of spleen)*

Please list any other procedures not mentioned above: _____

_____

Social History Yes/ How much or often	No
Do you smoke tobacco?	
Do you drink alcohol?	
Have you ever struggled with addiction? If yes, have you been sober?	

Name _____ Date of Birth _____

Family History (*please indicate first degree relatives only)*

- ☐ Anemia
- ☐ Asthma
- ☐ Blood clot *(DVT/PE)*
- ☐ Coronary artery disease (*Heart attack)*
- ☐ COPD/emphysema
- ☐ Cancer
- ☐ Chronic kidney disease
- ☐ Chronic liver disease/cirrhosis
- ☐ Congestive heart failure
- ☐ Depression
- ☐ Dementia
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Hypertension *(High blood pressure)*
- ☐ Hyperlipidemia (*High cholesterol)*
- ☐ Osteoporosis
- ☐ Seizure
- ☐ Skin condition
- ☐ Stroke
- ☐ Thyroid (hypo/hyper)

Would you be interested in learning more about *(check all that apply)***:**

- ☐ Botox Injections
- ☐ Foot and ankle care/ peripheral
- ☐ Neuropathy
- ☐ IV therapy (fluid hydration, vitamins)
- ☐ Skin care products

Anything else you would like to share with the provider? _____

_____

How did you hear about us? _____

Extended Auth

I hereby authorize Music City Primary Care, PLLC to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to Music City Primary Care, PLLC all payments for medical services rendered to myself or my dependents. I am aware that it is my obligation to know my insurance company's policies and that I am responsible for any payment if I have not fulfilled their requirements. I also acknowledge the receipt of HIPAA privacy policy.

Signature: _____**Date**: _____

Consent for Treatment

I hereby request and voluntarily consent to such office care, including routine diagnostic procedures and medical treatment as may be deemed necessary by Music City Primary Care, PLLC and/or his designees.

Signature: _____ **Date:** _____

FINANCIAL POLICY

Thank you for choosing Music City Primary Care for your primary care needs. Our physicians and staff are committed to delivering quality care and service to you. Understanding our financial policy is an important part of our professional relationship. Below is an explanation of our payment, cancellation, and no-show policies. Please make yourself aware of these policies as you sign off on them.

IN-NETWORK INSURANCE

Music City Primary Care (MCPC) participates in most major insurance plans. To ensure that MCPC is in network with your insurance, please contact your insurance carrier. It is your responsibility to provide MCPC with accurate, up-to-date insurance information.

- MCPC is currently in network with United Healthcare, Medicare, Cigna (with the exception Connect/EPO Network), Cigna Healthspring, Aetna, Amerigroup, TennCare, Medicaid, Blue Cross and Blue Shield, UHC Community Plan, Humana Medicare plans, and Bright Health.
- At this time, MCPC cannot see Oscar, or PHCS/Multiplan patients including but not limited to: Blue Care (Medicaid), Blue Care Plus dual eligibility Medicare/Medicaid Plan, Cigna Connect/EPO, WellCare, Humana, Ascension Complete, BCBS Medicare Advantage PPO.

COPAYMENTS, DEDUCTIBLES, AND COINSURANCE

Your insurance co-payment is due at the time of your visit. Nail biopsies and in-house pathology services will be charged along with the office visit. If further testing is required to obtain an accurate diagnosis, your specimen will be sent to an outside laboratory, where additional charges may apply. If you are unable to pay your co-payment at the time of your visit, we will reschedule your office visit. If we determine that you have a deductible or a co - insurance amount due, you will be asked to pay $75 at your visit. We do our best to have accurate collections, but please note that your co-pay/deductible are subject to determination by your insurance company. As a courtesy, our office will file your claim with your insurance company and initiate correspondence with the purpose of getting you the maximum coverage your insurance allows.

SELF-PAY FEE SCHEDULE

MCPC is out of network with certain insurance providers. It remains the responsibility of the patient/policyholder to know your insurance coverage, including out-of-network benefits. MCPC does not file out-of-network benefits. MCPC has a flat fee schedule for out-of-network patients. These fees are subject to change without notice. MCPC will provide information regarding the fees upon request. If you have not provided medical insurance, you hereby confirm that you do not have insurance to be billed and understand that payment is due at the time of service.

HEALOW PAY (Online Payment)

MCPC encourages patients to pay through Healow Pay (an online payment system) when insurance claims are filed. Healow Pay helps reduce the amount of paper statements sent. After a claim for services rendered has been submitted and fully processed by your insurance company, any balances listed as “Patient Responsibility'' can be paid through Healow Pay. Patients will receive an email and text message with a link to pay. The transaction will try and process for 4 consecutive business days. If the payment fails or declines, the claim will remain declined, and the patient will receive a statement in the mail.

INSURANCE BALANCES

MCPC will submit claims to in-network insurance on behalf of the patient as a courtesy. The balance becomes your responsibility if we do not receive payment or resolution from your insurance company within 60 days of filing the claim. The patient is responsible for non-covered medical services.

APPOINTMENT CANCELLATIONS AND NO-SHOWS

We understand that situations arise in which you must cancel your appointment. It is required that if you must cancel your appointment, you provide **24 hours notice**. Providing advanced notice is a courtesy to your provider and allows another patient to be seen. Without notification, you are subject to a late cancellation fee or a no-show fee. We understand that special unavoidable circumstances may cause you to cancel within 24 hours prior to your appointment. Fees in this instance may be waived, but only with management approval.

_____ (initial) I understand that office appointments which are canceled with less than 24 hours notice are subject to a **$35.00** cancellation fee.

_____ (initial) I understand that if I no-show an appointment, I will be charged **$35.00** to reschedule an office appointment and to reschedule a procedure appointment.

CHARGEBACKS AND RETURNED CHECK FEES

There will be a **$25.00** fee in addition to the original amount owed if your check is returned from the bank or your credit card charge is charged back to MCPC.

_____ (initial) I understand that a **$25.00** fee will be incurred for returned checks and credit card chargebacks.

PAST DUE BALANCES

Past account balances must be settled prior to being seen for a subsequent appointment.

_____ (initial) I understand that past due balances must be paid prior to being seen for a subsequent appointment.

GUARANTOR INFORMATION AND PAYMENT FOR PATIENTS UNDER THE AGE OF 18

Guarantor information is responsible party information. A guarantor (or responsible party) is the person held accountable for the patient's bill and services rendered. A patient presenting for care that is 18 years of age or older is always the guarantor for bills relating to their care, except in an incapacitated adult. College students 18 years or older are always the guarantor for services they receive. MCPC does not bill absent parents for payments due at the time of service. The adult presents the minor for care to the responsible party and guarantor.

NOTE: If the parent presenting the minor brings a divorce decree stating that the other parent is financially responsible for the child's medical bills, the guarantor is changed to the parent designated in the divorce decree. The financially responsible parent's information is required before the patient can be treated, including full name, billing address, phone number, email address, and phone number.

Guarantor name: _____

Relationship to patient: _____ **DOB:** _____/_____/_____

Mailing Address, if different than patient:

Street Name: _____ **City:** _____

State: _____ **Zip:** _____

Email Address:_____ **Phone Number:** _____/_____/_____

I certify that I have read the financial policies of Music City Primary Care and I agree to abide by these policies.

Signature _____ Today'sDate: _____/_____/_____
(Patient or Parent/Guardian)

MEANINGFUL USE QUESTIONNAIRE

We collect this information from all of our patients and use it to track quality of care. This information goes into your medical record and is confidential.

Today's Date:_____

Patient Name:_____DOB:_____

Gender: ___ Male ___Female ___I decline to answer

Race: ___White/Caucasian ___American Indian ___ Asian
___ Black/African American ___ Native Hawaiian/Pacific Islander
___ Other_____
_____I decline to answer the question above

Ethnicity: ____Hispanic or Latino _____Non-Hispanic or Latino
_____ Other_____
_____ I decline to answer the question above

Language: ____ English ___Spanish ___French ___ Russian
___Italian ___Dutch ___Portuguese
___Other_____
_____ I decline to answer the question above

What is meaningful use?

The Federal government requires us to capture this information to improve health outcomes in the following areas: Improve the quality of care, efficiencies, and safety in treating patients Reduce health disparities Engage patients and families Improve care coordination Improve population and public health Guarantee adequate privacy and security protection of PHI

Consent Form

Giving permission for a relative/friend/carer to discuss a patient's confidential information

Music City Primary Care
2201 Murphy Ave suite #215
Nashville, TN 37203

I……

(Enter the full name and date of birth of the patient)

Hereby give my permission for:.....

Relationship to the patient…….

Address:.....

To discuss my confidential medical information (listed below) held at the Practice with the practice staff, on my behalf (please tick applicable boxes below)

- ☐ Prescriptions
- ☐ Test results
- ☐ Medical conditions
- ☐ Other issues (please add).....

Name of Patient……

Address:.....

Signature:.....Date:.....

Review of Systems

General
- ☐ Chills
- ☐ Fatigue
- ☐ Fever

Skin
- ☐ Rashes
- ☐ Itching
- ☐ Change in Hair or Nails

HEENT
- ☐ Headaches
- ☐ Glasses or contacts
- ☐ Change in Vision
- ☐ Change in hearing
- ☐ Ear Pain
- ☐ Ear Discharge
- ☐ Ringing
- ☐ Dizziness
- ☐ Nasal Stuffiness
- ☐ Sore Throat
- ☐ Hoarseness

Respiratory/Cardiac
- ☐ Shortness of Breath
- ☐ Cough
- ☐ Wheezing
- ☐ Coughing up blood
- ☐ Chest Pain
- ☐ Night Sweats
- ☐ Heart Palpitations

Gastrointestinal
- ☐ Change of appetite
- ☐ Nausea
- ☐ Heartburn
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Abdominal Pain

Urinary
- ☐ Difficulty in urination
- ☐ Pain or burning on urination
- ☐ Frequent urination at night
- ☐ Urgent need to urinate
- ☐ Incontinence/ Dribbling
- ☐ Blood in urine

Musculoskeletal
- ☐ Pain
- ☐ Swelling
- ☐ Stiffness

Neurologic
- ☐ Headaches
- ☐ Weakness
- ☐ Muscle spasm

Endocrine
- ☐ Increased Appetite
- ☐ Increased Thirst
- ☐ Heat/Cold intolerance
- ☐ Excessive Sweating

Psychiatric
- ☐ Anxiety
- ☐ Sleep problems