



**FACULTY
PHYSICIANS
KNOXVILLE**

How did you hear about us?

- Healthcare provider Referral
- Family/Friend
- Other Source: _____
- Previous Patient
- FPK Website
- Newspaper

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For Office Use Only

Identification

Name _____
First Middle Last

Previous Name _____ Legal Sex Male Female

Birthdate _____ Social Security # _____ Usual Provider _____

Contact Information

Address _____

City _____ State _____ Zip _____ Country _____

Driver's License # _____ Email _____

Home phone (____)____-____ Mobile phone (____)____-____ Work phone (____)____-____

Employer and address _____

Emergency Contact

Name _____ Relationship _____

Home phone (____)____-____ Mobile phone (____)____-____

Demographics

Language English Spanish Other _____ Race _____ Ethnicity _____

Marital Status S M W D Gender Identity _____

Preferred Pharmacy _____ Phone number (____)____-____

Insurance Information

Primary Insurance _____ Subscriber Name _____

Group # _____ Policy # _____ Birthdate _____

Social Security # _____ Sex Male Female

Subscriber Employer and Address _____

Secondary Insurance _____ Subscriber Name _____

Group # _____ Policy # _____ Birthdate _____

Social Security # _____ Sex Male Female



Authorizations

Please initial acknowledgement of the following authorizations:

_____ I authorize Faculty Physicians Knoxville, PLLC. to submit a blood sample of HIV and HBV testing as deemed necessary by myprovider.

_____ I authorize Faculty Physicians Knoxville, PLLC. or any agents thereof, to notify me by telephone, answering machine, mail,voicemail, etc. regarding appointments, lab/diagnostics, billing, and collection information.

_____ I authorize Faculty Physicians Knoxville, PLLC. to download my prescription history from Surescripts/RxHub and CSMD. I understand the prescription history will solely be used for medical purposes.

_____ I authorize Faculty Physicians Knoxville, PLLC. to download my immunization history from TennIIS, the TennesseeImmunization Information System. I understand the immunization history will solely be used for medical purposes.

_____ I consent to receive calls, emails and/or text from Faculty Physicians Knoxville, PLLC. for my protected healthcare and other services at the phone numbers provided, including my wireless number. I understand I may be charged for any such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

No Show Policy

Welcome to Faculty Physicians Knoxville, PLLC. Please take time to review the following information pertaining to our policy for no-show appointments.

We understand that scheduling conflicts occur from time to time. However, we request 24-hours advance notice if you are unable tokeep your scheduled appointment(s). Two or more missed appointments may result in you being dismissed from Faculty Physicians Knoxville, PLLC. **A \$25 fee may be incurred after the second missed appointment for not providing the office with prior notice of cancellation.**

Faculty Physicians Knoxville, PLLC. has developed this "No-Show" policy to better serve patients by providing same day appointments to those who are sick and need to be seen. If someone schedules an appointment and does not show for the visit, we have lost an available time that could have been used for a sick patient.

We look forward to providing for your health care needs. Your understanding and cooperation helps us provide available appointments for patients who urgently need them.

Please sign below as confirmation that you have read, acknowledge, and understand our "No-show" policy.

Print Name _____ Birthdate _____

Signature of Patient or Authorized Representative _____ Relationship _____

Witness _____ Date _____



Financial Policy

Faculty Physicians Knoxville, PLLC. believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best care for you, and we want you to have an understanding of our financial policy.

1. **PAYMENT is expected at the time of your visit.** Just as we make every effort to accommodate you when you are in need of medical care, we expect you to make every effort to pay your bill promptly. Payment is due at the time services are provided or upon receipt of a statement from our billing office. **We accept cash, check, debit, credit, or health savings accounts.** You may also make a payment online through our patient portal.

Payment will include any unmet deductible, co-insurance, co-payment amount or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of your visit. We do ask for a copy of your current insurance card at the time of your visit to ensure we properly file your claim.

2. **SURGERY PATIENTS:** You may be responsible or required to pay a percentage of surgery charges prior to any surgeries or procedures. This will be determined by information given to us by your insurance company regarding patient percent responsibility.
3. **INSURANCE:** We participate with several insurance plans and will file your claims on your behalf. It is your responsibility to ensure coverage for services prior to your visit. You will be responsible for the complete charges for any non-covered services provided. In addition, all co -payments, deductibles or non-covered charges will be due at the time of service. You must provide proof of insurance at each visit so we can ensure proper billing to your benefit plan. We do not bill third party payors but will be happy to provide a copy of the original claim if requested.
4. **HIGH-DEDUCTIBLE PLANS:** Under these plans, your insurance company will provide you a discount off our billed charges, but you are responsible for the discounted amount due until you meet your deductible. **We accept cash, check, debit, credit, or you may use your health savings account.**
5. **SELF-PAY/OUT-OF-NETWORK:** Patients will be provided with a Good Faith Estimate within 3 business days of making an appointment that will list the maximum charge per specified visit compliant. If appointment occurs within those 3 business days, then the Good Faith Estimate will be provided no later than 3 business days after the appointment.
6. **MOTOR VEHICLE ACCIDENTS:** Faculty Physicians Knoxville does not see MVA related complaints.
7. **RETURNED CHECKS:** Returned checks will incur a service charge currently set at \$30, which may vary from time to time as determined by our financial institution.
8. **ACCOUNTING PRINCIPLES:** If there is an overpayment on your account, we will refund any overpayment to you after overpayment credit is applied to any outstanding account balance (s). Payment and credits other than copays are applied to the oldest charges first, except for insurance payments, which are applied to the corresponding date of service.
9. **FORMS FEES:** Fees are to be paid when form is completed/picked up. Rates are as follows:
 - a. *DURING an office visit:* No Charge for a simple form; Complex forms will not be completed during visit
 - b. *AFTER an office visit:* \$5 / Simple form (completed within 3 business days)
 - i. Examples of Simple Forms: Handicap tag/sticker, concussion clearance, WIC, Home Bound Status



Short form, Bank Loan College & Camp Form.

c. *Complex Forms*: \$25 (completed within 10 business days)

i. Examples of Complex Forms: Short Term Disability form, Long Term Disability form, FMLA

Financial Policy (Continued)

10. **MISSED APPOINTMENTS:** If you fail to cancel a previously scheduled appointment at least 24 hours in advance, you may be charged a fee as outlined below:

a. **\$25 after the second missed appointment.**

This charge cannot be billed to the insurance company. Failure to pay a no-show fee will be treated according to our policy on unpaid balances. This charge is not applicable to patients with Medicaid/TennCare insurance coverage.

After 3 no-show appointments in a calendar year, you may be discharged from the practice, at the discretion of the responsible provider and management. Medical care will not be withheld for a medical emergency for thirty days from date of dismissal.

11. **UNPAID BALANCES:** All outstanding balances shall be due within 30 days of the date of service. At that time, all past due balances in their entirety must be paid prior to the time of your next visit. Balances that remain outstanding for a period of 120 days or more may be referred to a collection agency and could affect your credit. Any Collection agency fees will be a patient responsibility and will be added to your total balance due.

12. **FINANCIAL DISMISSAL:** Patients who do not make payment arrangements risk being dismissed from the practice. Faculty Physicians Knoxville, PLLC. reserves the right to dismiss patients for delinquent financial accounts on personal balances. If dismissed by one Faculty Physicians Knoxville, PLLC. provider due to a delinquent financial account, patient may not be able to establish with or continue seeing any other Faculty Physicians Knoxville, PLLC. provider. If dismissed, medical care will not be withheld for a medical emergency for thirty days from date of dismissal.

13. **BILLING QUESTIONS:** We will be happy to help you resolve your balance and can be reached at (844) 526-2727, Monday - Friday 8:00AM - 5:00PM

I have read, understand, and agree to the Financial Policy as provided to me. I understand that charges not covered by my insurance company, as well as applicable co-payments, deductibles, and any charges older than 30 days from the date of service are my responsibility.

I authorize Faculty Physicians Knoxville, PLLC. to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim. I authorize my insurance benefits be paid directly to Faculty Physicians Knoxville, PLLC. I understand and acknowledge that I am financially responsible for services rendered by Faculty Physicians Knoxville, PLLC. I agree to pay all reasonable attorney fees and court cost in the event of default on my account.

Print Name _____ Birthdate _____

Signature of Patient or Authorized Representative _____ Relationship _____

Witness _____ Date _____



Acknowledgement of Receipt of Notice of Privacy Practices & Patient Rights

By signing this document, I acknowledge that I have reviewed and/or received a copy of the Notice of Privacy Practices and Patient Rights, which provides a more complete description of how my protected health information (PHI) may be used or disclosed. I understand that Faculty Physicians Knoxville, PLLC. reserves the right to change their notice and information practices and that I may view a copy of the current Notice on Faculty Physicians Knoxville website, www.facultyphysiciansknoxville.com, in any of their offices, or by a request in writing.

Print Name _____ Birthdate _____

Signature of Patient or Authorized Representative _____ Relationship _____

Witness _____ Date _____

Communicating with Your Faculty Physicians Knoxville Provider

Access to Your Provider and Staff

Your Faculty Physicians Knoxville, PLLC health care team can be reached either by telephone or electronically through our patient portal. If you wish to communicate electronically, you may sign up for Athena portal at any office location or on our website. Please remember, electronic communication is for routine matters and never should be used for emergencies.

It is not appropriate to communicate with your health care team through social media, such as Facebook, or texting any provider or staff members' personal number. Your privacy is important to us, and these are not secure methods of communication. Any questions or concerns should be directed to the patient portal or office during normal business hours.

After Hours Care

Faculty Physicians Knoxville, PLLC. is dedicated to serving our patients 24 hours a day, 7 days a week. The most effective way to serve you is during regular clinic hours, but we understand acute illnesses can occur at any time. After office hours and on weekends, our telephone is answered by our answering service, which relays the message promptly to the physician on call for emergencies. This may not be your usual physician, so be prepared to answer some health history questions for the on-call physician if needed.

Please use the emergency room only in a true emergency (i.e. chest pain, shortness of breath, stroke-like symptoms).

Prescription Refills

To avoid delays and busy phone lines, the best time to obtain your medication refills is at your office visit. While we realize there may be a need to request a refill via telephone or patient portal, please allow at least 72 hours for all refill request before checking with your pharmacy.

Sample medication will only be distributed during normal business hours.

Monthly refills of any controlled medications (pain medication, anxiety, etc.) will only be given during an office visit within regular business hours.

Print Name _____ Birthdate _____



Signature of Patient or Authorized Representative _____ Relationship _____

Witness _____ Date _____