COLLEGE of NURSING
EAST TENNESSEE STATE UNIVERSITY

# Office of Practice & Community Health Center


East Tennessee State University
College of Nursing
P.O. Box 70403
Johnson City, TN 37614
(423) 439-4515

Hancock County School-Based Clinics
P.O. Box 723
Sneedville, TN 37869
(423) 733-2819

Johnson City Community Health Center
2151 Century Lane
Johnson City, TN 37604
(423) 926-2500


| SECTION I | | PATIENT INFORMATION |
|---|---|---|
| **Last Name** | **First Name** | **Middle Name** |
| **SSN** | **Date of Birth** | **Gender**<br>[ ] Male [ ] Female |
| **Address** | **City** **State** | **Zip Code** |
| **Home Phone**<br>( ) | **Cell Phone**<br>( ) | **Work Phone**<br>( ) |
| **E-Mail** | **Contact Preference**<br>[ ] Ok to leave confidential messages<br>[ ] Don't leave confidential messages | |
| **Emergency Contact Name** | **Emergency Contact Number**<br>( ) | **Relationship to Patient** |
| **Mother's Maiden Name**<br>**(used for identification purposes only)** | | |
| **Language Spoken (mark all that apply)**<br>[ ] English<br>[ ] Spanish<br>[ ] Other________________________ | **Marital Status**<br>[ ] Single<br>[ ] Married<br>[ ] Widowed<br>[ ] Divorced | **Student Status**<br>[ ] Full Time<br>[ ] Part Time<br>[ ] Not a Student |
| **Homeless Status**<br>[ ] Not Homeless [ ] Doubling up [ ] Shelter [ ] Street [ ] Transitional [ ] Other____________________ | | |
| **Migrant\Seasonal Status**<br>[ ] **Migrant** *(A person\dependent whose principle employment has been in agriculture within the last 24 months and has had to establish a temporary home for the purpose of such employment)*<br>[ ] **Seasonal** *(A person\dependent whose principle employment has been in agriculture on a seasonal basis and has not had to establish a temporary home for the purpose of such employment)*<br>[ ] **Not a Farm Worker** | | |
| **Interpreter Status**<br>[ ] YES<br>[ ] NO | **Housing Status**<br>[ ] Public Housing<br>[ ] Not in public housing | |
| **Race**<br>[ ] Asian [ ] American Indian<br>[ ] Black\African-American [ ] Native-Hawaiian<br>[ ] More than one race [ ] White<br>[ ] Other Pacific Islander [ ] Other _____________ | **Ethnicity**<br>[ ] Hispanic or Latino<br>[ ] Not Hispanic or Latino | |
| **Veteran Status**<br>[ ] YES<br>[ ] NO<br>[ ] N\A | **Referred By**<br>[ ] Relative\Friend [ ] Church<br>[ ] Health Fair [ ] Hospital<br>[ ] Newspaper [ ] Other __________________ | |
| **Do you have an Advance Directive?**<br>[ ] YES [ ] NO | | |

## SECTION II — RESPONSIBLE PARTY INFORMATION

**Skip if different from Section I**

**RELATIONSHIP TO PATIENT [ ] Self (skip to next section [ ] Spouse [ ] Parent [ ] Other ________________**

| Last Name | First Name | Middle Name |
|---|---|---|
| SSN | Date of Birth | Gender<br>[ ] Male [ ] Female |
| Address (if different from above) | City State | Zip Code |
| Home Phone<br>( ) | Cell Phone<br>( ) | Work Phone<br>( ) |
| Employer | Employer Name | Employer Phone<br>( ) |

## SECTION III — INCOME INFORMATION

| Total household income last month:<br>$ | Total persons living in household last month |
|---|---|

**[ ] Decline to provide household income**

**OFFICE USE ONLY**
**Qualify for sliding fee discounts? [ ] YES [ ] NO**
**[ ] 100% & below [ ] 101-133% [ ] 134-175% [ ] 176-200%**

## SECTION IV — INSURANCE INFORMATION

**Please present all insurance information**

### PRIMARY INSURANCE

[ ] No Insurance [ ]Medicaid\TennCare [ ] Medicare [ ] Other (Employer\Private\Commercial)

**PATIENTS RELATIONSHIP TO INSURED PARTY**

[ ] Self [ ] Spouse [ ] Child [ ] Other __________________

| Plan Name | Policy Number | Group Number |
|---|---|---|
| Insured Name | Insured SSN | Insured Date of Birth |
| Effective Date (if known) | Co-Pay<br>$ | |
| Employer | Employer Address | Employer Phone<br>( ) |

### SECONDARY OR DENTAL INSURANCE

[ ]Medicaid\TennCare [ ] Medicare [ ] Other (Employer\Private\Commercial)

**PATIENTS RELATIONSHIP TO INSURED PARTY**

[ ] Self [ ] Spouse [ ] Child [ ] Other __________________

| Plan Name | Policy Number | Group Number |
|---|---|---|
| INSURED NAME | Insured SSN | Insured Date of Birth |
| Effective Date (if known) | Co-Pay<br>$ | |
| Employer | Employer Address | Employer Phone<br>( ) |

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## PATIENT FINANCIAL & INSURANCE AGREEMENT

**PLEASE READ THOROUGHLY AND SIGN BELOW**

**In consideration of receiving services from the ETSU College of Nursing, Community Health Centers, you agree:**

1. All services are provided to you with the understanding that you are responsible for the charges regardless of your insurance coverage. If you would like to know the charge of a service, please inquire prior to treatment. Please be aware that not all services are a covered benefit with different insurance companies. You are responsible for knowing what services are or are not covered. **KNOW YOUR BENEFITS.**

2. At check-in, we will collect your co-pay, deductible, and payment for uncovered services as well as the patient's portion as determined by insurance or sliding fee scale. We accept cash, check, and credit card of Master Card, Visa, and Discover.

3. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. **It is the patient's responsibility to inform our office immediately of insurance coverage or insurance company changes**.

4. You are responsible for knowing if a referral is required. Make sure you know what providers are in your plan, what facilities are covered and what ancillary services you must use. (Such as laboratory, hospitals, etc.) If we can be of assistance, please let us know.

5. We will bill your insurance company as a courtesy, but you are still ultimately responsible for payment of all services you receive. If your insurance company does not respond within 30 days we will follow up with an inquiry on your behalf. If, however, your insurance does not respond within 60 days of claim submission, a statement will be sent to you. You should call your insurance company to question why the claim is not paid. Our office will assist you only after you have contacted your insurance company.

6. If your medical claim has not been paid and your insurance company has not resolved your dispute, you may register a complaint with the Tennessee Department of Commerce and Insurance. Our office will do everything we can to assist you; however, you must understand you cannot delay payment while you are awaiting the outcome of your complaint.

7. Any unpaid charges over 90 days old will be sent to an outside collection agency with an additional agency fee. **You are responsible for any collection fees, legal fees, or court costs incurred in the collection process**. This agency will report your failure to pay to the THREE (3) national credit reporting agencies.

8. Returned checks are subject to a $40.00 return check fee.

We do understand that temporary financial problems may affect timely payment. We encourage you to communicate any such problems so that we can assist you in the management of your account.

I authorize the East Tennessee State University (ETSU) College of Nursing (CON) Community Health Center (CHC) to examine, evaluate, and treat me, and/or my child, or ward. I authorize the CHC to release any\all clinical information necessary in order to submit my insurance claims to my insurance companies. I also request that my insurance companies pay benefits directly to the CHC for services rendered. I understand that the CHC will refund any overpayments on my account, in a timely manner.

Your signature below forms a binding agreement between the CHC (the provider of service) and the Patient who is receiving services or the Responsible Party for minor patients (those patients under 18 years old). Responsible Party is the individual who is financially responsible for payment of any charges

| ______________________ | ______________________ | ______________________ |
|---|---|---|
| **Patient Printed Name** | **Patient/Guardian Signature** | **Date** |
| ______________________ | ______________________ | |
| **CHC Staff Signature** | **Date** | |

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## HIPAA AUTHORIZATION

I authorize East Tennessee State University (ETSU) College of Nursing (CON) Community Health Centers (CHC) to discuss and \or release my medical information including labs and test results, diagnosis, and treatment discussed to the following persons:

| Name | Relationship to patient | Phone Number |
|---|---|---|
| ______________________ | ______________________ | ______________________ |
| ______________________ | ______________________ | ______________________ |
| ______________________ | ______________________ | ______________________ |

## ACKNOWLEDGEMENT OF PATIENT RIGHTS AND RESPONSIBILITIES
## &
## NOTICE OF PRIVACY PRACTICES

I acknowledge that the East Tennessee State University (ETSU) College of Nursing (CON) Community Health Center (CHC) has provided me with a written copy of Patient Rights and Responsibilities. This information clearly defines my rights and responsibilities as a patient receiving services by a CHC associated provider.

I have also been given the opportunity to review the East Tennessee State University (ETSU) Notice of Privacy Practices and understand that the Notice indicates how my protected health information may be used and disclosed and how I gain access to this information. I have also been given the opportunity to receive a copy of the ETSU Notice of Privacy Practices for further review

### AUTHORIZATION AND RELEASE

I understand that the ETSU CON CHC serves as a training center for students majoring in, but not limited to, Nursing, Audiology, Dental Hygiene, Nutrition, Radiology, and Speech-Language Pathology at ETSU. For this reason, I authorize the use of student observation, video recording, audio recording, pictures, client data, and discussion for professional research or educational purposes. I understand that no names or identifying information will be used in any of these procedures.

I understand that the evaluation and treatment procedures used by the Speech Language Pathologists\Audiologists are non-medical in nature. These procedures meet professional and ethical standards of the American Speech-Language-Hearing Association, and they offer no physical or psychological risk. Although the treatment procedures are expected to be beneficial, I understand that no guarantee of success can be expressed or implied.

**By signing below, I agree to the above-mentioned statements.**

| Patient Printed Name | Patient/Guardian Signature | Date |
|---|---|---|
| ______________________ | ______________________ | ______________________ |

| CHC Staff Signature | Date |
|---|---|
| ______________________ | ______________________ |