Lenoir Medical Clinic
308 East Broadway Street
Lenoir City, TN. 37772
Phone: 865- 988-5774
Fax: 865- 374-2148

Date:_____

PATIENT INFORMATION					
Name (Last, First, Middle):		SSN#	Birthdate	Age	Sex
Mailing Address		City, State, Zip			
Home Phone	Cell Phone	Email Address			
Marital Status / Student Status ☐Full-Time ☐Part-Time	Smoker? Yes or No / Veteran (Y/N)?	Ethnicity: Hispanic or Non-Hispanic	Primary Care Physician		
Referring Physician	Referring Physician Contact #	Other Medical Providers			
Race (**Circle Answer**): African American, Alaskan Native, Asian, French, German, Greek, Hawaiian, Hispanic, Indian, Multi-Racial, Native American Indian, Pacific Islander, White			Language		
Emergency Contact Name	Emergency Contact Phone #s Hm:	Cell:			
Employer Name and Address		Work Phone #			

If patient is a minor, please fill out this portion			
Parent or Guardian's Name:	Parent or Guardian's Phone #s Hm:	Wk:	Cell:

RESPONSIBLE PARTY INFORMATION (if different from above)			
Name (Last, First Middle	SSN#	Birthdate	Sex
Address	City, State, Zip		
Home Phone / Cell Phone / Work Phone	Relationship to patient		

PRIMARY INSURANCE			
Name of Insurance Company	Name of Insured	Address of Insured (If different than address above)	
Insured's Birthdate	Insured's SSN #	Insured's Insurance ID #	Relationship to patient

SECONDARY INSURANCE (if applicable)			
Name of Insurance Company	Name of Insured	Address of Insured (If different than address above)	
Insured's Birthdate	Insured's SSN#	Insured's Insurance ID #	Relationship to patient

Workers Compensation	
Are you here for workers compensation YES____ NO____	Date:

Accident	
Auto ☐ Work ☐ Other ☐	Date of Accident:
Do you have any Advanced Directives? (e.g., Living will or Advanced Care Plan)	Yes_____ No_____
Do you have a Power of Attorney?	Yes_____ No_____
If yes to the above questions please make sure we have a copy for your medical record.	

Covenant Medical Group

IN CONSIDERATION OF THIS PHYSICIAN PRACTICE (THE "PRACTICE") FURNISHING SERVICES TO THE PATIENT, PATIENT (OR PATIENT'S LEGALLY AUTHORIZED REPRESENTATIVE, ON PATIENT'S BEHALF) AGREES AS FOLLOWS:

I. CONSENT TO MEDICAL TREATMENT AND SERVICES: The below-signed individual hereby authorizes the Practice and its associated professionals to furnish medical treatment and services to the patient, including medical treatment and services furnished through telehealth visits, and consents to diagnostic and therapeutic medical care, items, services, and procedures furnished by the Practice, its professionals, and their assistants and designees. Such consent includes consent to photographic/video documentation of the patient's medical treatment as the patient's treating professional finds medically necessary. There are potential risks and hazards to any medical treatment or service, and there is no guarantee any particular treatment or service furnished by the Practice or its professionals will be successful. It is the Practice physician's responsibility to provide adequate information concerning a proposed treatment or service and to obtain any additional necessary consent before proceeding except as limited by emergency or other time-sensitive circumstances. The Practice's staff may obtain signature for such consent. The patient has the right to question and refuse treatment; however, if a proposed treatment is refused, the undersigned agrees CMG, the Practice, and their associated professionals and staff shall be released from any and all liability for failure to provide treatment to the patient.

TELEMEDICINE: The Practice and its associated professionals deliver certain health care services by virtual means, including without limitation, through telehealth (interactive audio, video, and other electronic communications), patient portal communications, and by telephone (collectively, "Virtual Services"). RISKS AND BENEFITS: Benefits of Virtual Services include enhanced access to care, patient convenience, reduced risk of exposure to communicable disease, and access to ongoing care and follow-up communication with a health care provider. Medical information is protected to the same extent as in a face-to-face visit, although confidentiality and privacy at the patient's location is not controlled by the Practice. There are risks and limitations to Virtual Services. Virtual Services and care may not be as complete as face-to-face services as a result of a practitioner's potential lack of access to all diagnostic modalities/medical equipment necessary to obtain vital signs, labs, and other pertinent health information to treat the patient, lack of access to complete medical records, and problems with information transmission, including missed information or inaccurate information being transmitted, that could affect a practitioner's medical decision-making. Further, although the Practice uses available encryption and privacy modes for Virtual Services, it is also possible security protocols could fail, causing a breach of privacy of medical information. The alternative is a face-to-face visit, which the patient may request at any time, but an equivalent in-person service may not be available at the same location or time as a Virtual Service. During a Virtual Service, a practitioner may perform a physical exam through the use of technology or a facilitator in the room with the patient. Not all medical conditions can be treated as effectively through a Virtual Service, including emergency conditions. If a practitioner determines a face-to-face evaluation is needed, the patient will be referred to an appropriate location for such evaluation. A practitioner can withdraw from a Virtual Service for any reason, including when, in the practitioner's medical judgment, treatment is not safe, private, or effective. In such event, the practitioner can instruct the patient to seek in-person care and the patient agrees to follow such instruction, including for emergency care. Virtual Services are subject to charges, copayments, and deductibles consistent with this Agreement. While a patient may expect the anticipated benefits from the use of telehealth, no results can be guaranteed. It is the patient's duty to inform his or her physician of electronic interactions that the patient may have with other health care providers. CONSENT TO TREATMENT VIA VIRTUAL SERVICES: By electing to proceed with a Virtual Service, the undersigned has been informed of the risk and benefits of Virtual Services, understands and agrees to the above, and consents to medical treatment or consultation by means of a Virtual Service.

II. CONSENT TO COMMUNICABLE DISEASE TESTING: The below-signed individual consents for the patient to be tested for hepatitis, human immunodeficiency virus infection, or any other blood-borne infectious disease, as well as for any other communicable disease or condition, if and when another patient, a health care practitioner, or other individual furnishing services to patient at the Practice, a Practice employee, or an emergency aid worker has a potential exposure from the patient. If such testing becomes necessary, it will be performed at no charge to the patient.

III. CALCULATION AND PAYMENT OF CHARGES: The patient is liable and individually obligated for payment of the Practice's charges on the patient's account and the undersigned individual understands and agrees to the following: (1) The Practice's charges are set out in a chargemaster, the relevant portions of which may be examined for purposes of verifying the patient's account during regular business hours in our billing office. The Practice reserves the right to change the rates in the chargemaster. Charges on the patient's account are calculated based on chargemaster rates in effect as of the date charges for items or services are accrued. (2) The patient is liable for the uninsured portion of the Practice bill, which is due in full when services are rendered. Any amount not paid in full by insurance, for any reason, is the responsibility of the patient. (3) The Practice has both an uninsured patient discount policy and an indigent care policy. If the patient is uninsured, the patient is automatically entitled to a discount on chargemaster rates in accordance with the Practice's uninsured patient discount policy. In addition, if the patient is uninsured and meets certain criteria set forth in the Practice's indigent care policy (including, without limitation, income criteria), the patient may be entitled to further discounts to chargemaster rates. Please contact the Practice's financial counselors in our office or the CMG billing office at 865-374-5200 for more information. (4) The amount of the patient's Practice charges may differ from amounts other patients are obligated to pay based upon each patient's insurance coverage, Medicare/Medicaid coverage, or lack of insurance coverage. The amount of any discount from charges varies based on the circumstances applicable to each individual under the Practice's policies. (5) After reasonable notice, delinquent accounts may be turned over to a collection agency and/or attorney for collection. The patient agrees to pay the costs of collection, including court costs, reasonable attorney fees, collections charges, and reasonable interest charges, associated with Practice's efforts to collect amounts due.

IV. MEDICARE/MEDICAID PATIENT CERTIFICATION AND ASSIGNMENT OF BENEFITS: The undersigned individual certifies that the information provided in applying for payment or reimbursement under Titles XVIII and XIX of the Social Security Act is true and correct. Further, the undersigned certifies that correct and complete information has been provided regarding the patient's insurance, HMO, health plan, workers' compensation, or other coverage for services and items furnished to the patient by the Practice, and the undersigned consents to the Practice's billing such payers for items and services furnished by the Practice to patient. The undersigned hereby irrevocably assigns to CMG (or, if

Practice professionals are not CMG employees, to Practice) all rights, title, and interest in compensation or payments otherwise payable to the patient, or received by or on behalf of the patient, for Practice items or services from any source or payer on file for the patient's account, including Medicare/Medicaid/TennCare, insurance companies, HMOs, and any other third-party payer or financially responsible person, not to exceed charges for services or items rendered. Any person, corporation, or government entity having notice of this assignment is authorized and directed to pay directly to CMG (or, if Practice professionals are not CMG employees, to Practice) all amounts due for health care items and services provided to the patient by the Practice. Except as provided in Section III or by law, the patient is financially responsible to the Practice for the charges not covered by these authorizations. The undersigned understands there are certain items and services for which payers, including Medicare and TRICARE/CHAMPUS/CHAMPVA, do not pay. Any sums not paid by a third-party payer are the patient's obligation. **The patient is responsible for all health insurance or health plan deductibles and co-insurance, as well as noncovered or excluded items or services.** If it is later determined the patient has an HMO or other health plan primary to Medicare and failed to inform the Practice prior to service of such election, the patient shall be responsible for paying the account. In the case of series services furnished to the patient by Practice, this Agreement shall remain in full force and effect for all such series services until specifically revoked in writing. The undersigned agrees to sign such further documents as may be reasonably requested to confirm and substantiate the Practice's or CMG's rights hereunder. The undersigned further agrees that a copy of this assignment may be used in place of the original copy.

V. RECEIPT OF NOTICE OF PRIVACY PRACTICES; CONSENT TO USE AND DISCLOSE HEALTH INFORMATION: The undersigned acknowledges receipt of the Practice's Notice of Privacy Practices, which is provided at https://www.covenanthealth.com/privacy-notice/ and incorporated into this Agreement by reference, and consents to use and disclosure of the patient's protected health information and other patient records (a) consistent with such Notice, including without limitation, for purposes of the treatment, payment, and health care operations functions described in such Notice, whether through electronic health information exchange or otherwise; and (b) as authorized or permitted by federal or state law. Consistent with the above, the undersigned agrees to the Practice's disclosure of all or part of the patient's medical record for treatment purposes and to any person, corporation, or agency that is or may be liable for charges incurred at the Practice or for determining the necessity, appropriateness, amount, or other matter related to such services or charges, including, without limitation, insurance companies, HMOs, PPOs, workers compensation carriers, welfare funds, governmental health plans, the Social Security Administration, the Centers for Medicare & Medicaid Services, or any contractors of the same. The undersigned also consents to release by the patient's health plan or other insurance carrier to the Practice and CMG of any eligibility, utilization, or plan data concerning the patient's coverage that may be required.

VI. PATIENT IDENTIFICATION; PERSONAL VALUABLES: The undersigned consents to photographic documentation of the patient for purposes of identification and registration. Further, the undersigned agrees that Practice is not responsible for loss of or damage to any money, jewelry, eyeglasses, clothing, hearing aids, or other personal property.

VII. HEALTH PLAN NOTIFICATION/AUTHORIZATION; APPOINTMENT: If the patient's health plan, insurer, or other coverage requires notification/authorization as a condition of payment for services, the patient must provide such notification and obtain such authorization. The patient hereby assumes full financial responsibility for charges incurred as a result of failure to comply with prior notification/authorization requirements. Notwithstanding the foregoing, the undersigned hereby appoints Practice as patient's agent for purposes of requesting prior authorization for services Practice professionals order at a Covenant Health hospital (e.g., lab services) and agrees Practice may delegate such appointment to such hospital. The undersigned acknowledges there is no guarantee or assurance authorization will be obtained.

VIII. AMENDMENTS: Revisions to this Agreement are not effective or enforceable unless accepted in writing by a CMG corporate officer.

IX. CONTACTING PATIENT. Patient may be contacted at the following number: _____. In addition, ***please check one of the following***:

☐ Practice may contact or leave messages regarding appointments and lab/test results with the following:

Name:_____Relation to patient:_____Phone:_____

Name:_____Relation to patient:_____Phone:_____

☐ Practice may not leave messages regarding appointments and lab/test results with anyone other than patient.

I HAVE READ AND UNDERSTAND THIS REGISTRATION AGREEMENT AND BY SIGNING BELOW, AGREE TO ITS TERMS. IF THE UNDERSIGNED IS NOT THE PATIENT, SUCH INDIVIDUAL HEREBY CERTIFIES THAT HE/SHE IS THE PATIENT'S AUTHORIZED REPRESENTATIVE AND HAS ALL NECESSARY LEGAL AUTHORITY TO ENTER INTO THIS AGREEMENT ON THE PATIENT'S BEHALF.

SIGNATURE: PATIENT (OR PATIENT'S LEGALLY AUTHORIZED REPRESENTATIVE)

SIGNED _____ PRINTED NAME _____

PATIENT NAME _____ RELATIONSHIP TO PATIENT _____

DATE and Time _____

A copy of this agreement will be provided on request.

Patient's Name: _____ Today's Date: _____

Social Security Number: _____ Date of Birth: _____

Past Medical History

Previous Physician's name: _____ Date of last exam: _____

Have you ever been hospitalized? ☐ Yes ☐ No If yes, what for? _____

Have you ever been tested for hepatitis A,B or C? ☐ Yes ☐ No Which hepatitis virus? _____

Have you ever been vaccinated for hepatitis B? ☐ Yes ☐ No If yes, date vaccine series completed _____

Have you ever been vaccinated for hepatitis A? ☐ Yes ☐ No If yes, date vaccine series completed _____

Last Tuberculosis (TB) Screening? _____ Result of TB screening: ☐ Positive ☐ Negative

If Positive TB screen, date of last chest x-ray: _____ Result of Chest x-ray: ☐ Positive ☐ Negative

Have you had a sexually transmitted disease? ☐ Yes ☐ No Diagnosis: _____

Which of the following conditions are you currently beeing treated or have been treated for in the past (please √)

☐ Heart Disease / Murmur / Angina	☐ Shortness of breathe	☐ Eye disorder / Glaucoma	☐ Diabetes
☐ High cholesterol	☐ Asthma	☐ Seizures	☐ Kidney / Bladder problems
☐ High blood pressure	☐ Lung problems /cough	☐ Stroke	☐ Liver problems / Hepatitis
☐ Low blood pressure	☐ Sinus problems	☐ Headaches / Migraines	☐ Arthritis
☐ Heartburn (reflux)	☐ Seasonal allergies	☐ Neurological problems	☐ Cancer
☐ Anemia or blood problems	☐ Tonsillitis	☐ Depression / Anxiety	☐ Ulcers / colitis
☐ Swollen ankles	☐ Ear problems	☐ Psychiatric care	☐ Thyroid problems

Please describe any current or past medical treatment not listed above:

_____

_____

Please list Your past surgeries :

_____

_____

Please list any medications you are taking :

_____

_____

Allergies:

Are you allergic to penicillin or any other drugs? ☐ Yes ☐ No

Please list : _____

Social and Preventive History :

Do you currently smoke or chew tobacco? ☐ Yes ☐ No If no, have you in the past? ☐ Yes ☐ No
How many packs per day? _____

Do you drink alcohol, beer, or wine? ☐ Yes ☐ No If no, have you in the past? ☐ Yes ☐ No
How many drinks per week? _____

Do you currently drink coffee and/or tea? ☐ Yes ☐ No If yes, how many cups per day? _____

Do you exercise daily / weekly? ☐ Yes ☐ No

Do you use seatbelts while driving? ☐ Yes ☐ No Do you wear a helmet while riding a bike ☐ Yes ☐ No

Family History:

	Living		Age (or age of death)	List serious illness		
Mother	Yes	No				
Father	Yes	No				
Sisters	Yes	No				
	Yes	No				
	Yes	No				
Brothers	Yes	No				
	Yes	No				
	Yes	No				

Has any member of your family (including children and parents) had any of the following illnesses:

ILLNESS: Family member w/ Illness ILLNESS: Family member w/Illness

Anemia or Blood disease _____ Cancer _____
Diabetes _____ Glaucoma _____
Heart Disease _____ High blood pressure _____
HIV/AIDS _____ Mental Illness/ Depression _____
Stroke _____ Other serious illness _____

Females: Gynecological History:

How may times have you been pregnant? _____ Date of last Pap Smear: _____
Have you had an abnormal Pap Smear? _____ Diagnosis:_____ Follow Up:___
Have you had a sexually transmitted disease? ☐ Yes ☐ No Diagnosis:
Date of last mammogram:_____ Mammogram results:_____Have you ever had a breast biopsy?
☐ Yes ☐ No Biopsy results: _____

Have you ever had a breast biopsy? ☐ Yes ☐ No Biopsy results: _____

By signing below, I hereby, certifiy that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate

Patient /Legal Guardian Signature _____ Date: _____

COPY

LENOIR MEDICAL CLINIC
308 E. Broadway St.
Lenoir City, TN 37771
(865) 988-5774

Authorization to Release Health Information

I, _____, hereby authorize :

Provider from whom records are being requested to disclose health information regarding the following patient:

Provider/Facility Name:
(from whom records to be received)
_____
_____

Patient Name:_____

Patient Phone No_____
Patient Date of Birth: _____

Address:_____
_____

Patient Address:_____
_____

Phone_____

Patient SSN:_____

Fax No: _____

The information is to be disclosed to the following persons or organizations:
Name: LENOIR MEDICAL CLINIC – DR . MOEZ PREMJI
Address: 308 EAST BROADWAY STREET
LENOIR CITY TN 37771 TEL: 865-988-5774

2. Purpose. The purpose of the use or disclosure is:

☐ At the request of the patient
☐ Other: _____
_____

If the purpose is for marketing, will the Provider receive direct or indirect compensation or payment in return for using or disclosing the patient's health information? ☐ YES ☐ NO

Will the Provider receive direct or indirect compensation or payment in return for using or disclosing the patient's health information? ☐ YES ☐ NO

3. Information to be Disclosed. The information to be disclosed includes only those items checked below, with respect to services provided on or around _____ *(insert dates)*: **I understand that this information may include, but not limited to, information related to psychiatric or psychological treatment, treatment for drug and/or alcohol use, or information relating to Acquired Immune Deficiency/HIV.**

- Entire medical record, other than psychotherapy notes*; OR
- The following of the medical record

▪ Discharge summary	▪ Progress notes
▪ Lab results	▪ Photographs, videotapes, or other images
▪ History and physical exam	▪ Mental or behavioral health records
▪ Consultation reports	▪ Psychotherapy notes *
▪ X-ray reports	▪ Genetic test results
▪ HIV/AIDS test results and treatment	▪ Admission notes
▪ Treatment plan	▪ Summary of treatment
▪ Alcohol and drug treatment records	
▪ Other (specify): _____	

* *If the authorization is for psychotherapy notes, it may not request any other part of the medical record.*

- The following billing and payment information: _____
_____
_____

- Other information: _____
_____
_____

4. Revocation. I understand that I may revoke this authorization at any time by sending a written notice to the Provider. However, the revocation will not have any effect on any uses or disclosures the Provider may have made before the revocation was received.

5. Expiration. I understand that unless I revoke the authorization earlier, this authorization will automatically expire on the later of the following: (A) one year after the date this authorization is signed or (B) on the occurrence of the following event: _____ (e.g., end of research study; final resolution of specified litigation).

6. Redisclosure. I understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be redisclosed by the receiving party.

7. Refusal to Sign. I understand that I may refuse to sign this Authorization and that the Provider will not condition treatment on whether I sign this Authorization.

8. Certification. I certify that I am *(check whichever applies)*:

☐ the patient, and the identification that I have provided is true and correct.

☐ the patient's authorized representative, and that the identification and proof of authority that I have provided are true and correct. My relationship to the patient is that of: _____.

Signed this _____ day of _____, 20___.

Signature: _____
Print name:
Address: _____
_____
Phone No: _____

(ONE COPY TO BE RETAINED BY THE PATIENT)

For Provider Use Only:

Date received: _____ Expiration date: _____

How was identity verified? _____ Copy made? ☐ Yes ☐ No
How was authority verified?: _____ Copy made? ☐ Yes ☐ No

By: _____ Title: _____ Date: _____

CONSENT TO EMAIL AND/OR TEXT MESSAGE COMMUNICATIONS

This physician practice (the "Practice") has the ability to send email and/or text messages to patients reminding them of upcoming appointments. The Practice also may send an email or text message after appointments with link to a brief survey in order to allow the Practice to improve quality and service.

Consent to Email and/or Text Communications. By signing below, I authorize the Practice to contact me by email and/or text message for appointment reminders, survey requests, and other health-related communications using the cellular telephone number and/or email address I have provided on my patient intake forms.

Security Advisement. I understand that text messaging and email are secure forms of communication and information contained in texts and emails sent to the telephone number or email address I have provided could be accessed or used by unauthorized third parties. I further understand that my wireless carrier may charge for text messages and that these messages may come from an automated dialing system. By signing below, I understand and agree not to include my sensitive or private information in any responses to surveys I receive, because such survey responses are not transmitted by secure means and could be intercepted by unauthorized third parties.

Opt Out. I understand that I may opt out of receiving text message and/or email communications at any time by contacting the Practice.

Signature:_____

Name: _____

Date: _____

Email: _____

Lenoir Medical Clinic
Electronic Prescription System Information

The form listed below is necessary pharmacy information needed for our "Electronic Prescription System". The system allows the physician to send your prescription(s) and/or refills to your pharmacy in a timelier manner.

Your Full Name: _____

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone Number: _____

Pharmacy Fax Number: _____