CIRCLE OF LIFE FAMILY MEDICINE
MATTHEW C. TINNEY, DO, MARCHEL TINNEY, FNP

4841 Hixson Pike Suite A
Phone: 423-305-7980 Fax: 423-305-7981
circleoflifefamilymedicine@yahoo.com

REGISTRATION FORM

(Please send these in as soon as possible to set up an appointment)

Date: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Primary Phone Number: _____/_____ Cell Number: _____/_____

Email address for appointment reminders:_____

Date of Birth: _____ Sex: Male / Female Marital Status: S M D W

SSN#: _____

Race:_____Ethnicity:_____

Employment Status:_____

INSURANCE INFORMATION:

Insurance Carrier:_____

Policy Number:_____Group #:_____

Primary policy holder:_____

Relationship to Patient:_____

Date of Birth:_____SSN:_____

CANCELLATION, NO SHOW, AND LATE APPOINTMENT POLICY

You must notify us (not on voice mail) within 24 hours should you choose to cancel or change your appointment.

If you do not show for a confirmed scheduled appointment (which may be left on voice mail or with a family member) without prior notification, you will be charged a **$30.00** fee which will need to be paid before another appointment will be made.

If you are more than 20 minutes late for a scheduled appointment, it will be necessary to reschedule.

We hope you understand this policy is meant to reduce your waiting time and to be fair to the staff and your fellow patients.

Signature: _____ Date: _____

MEDICATION REFILL POLICY

All patients are required to bring in ALL MEDICATION AND VITAMIN BOTTLES to every appointment. Failure to do so may result in delay of medication refills.

Please do not wait until the day before your prescription runs out to call for a refill. Prescriptions are being electronically sent so this will give us 24-48 hours to get approval and send to pharmacy.

GENERAL CONSENT FOR TREATMENT

We look forward to treating you as a patient; however, we need your permission for our physician to examine you, provide treatment, and perform diagnostic studies as necessary. If more invasive procedures are deemed necessary, the risks and benefits of those invasive treatments will be explained to you. When you agree to proceed with an invasive treatment, you will be asked to sign a more detailed consent.

I GIVE GENERAL CONSENT TO BE TREATED:

Name: _____ Date: _____

FINANCIAL POLICY/ASSIGNMENT OF BENEFITS

PATIENT/PATIENTS REPRESENTATIVE: As a courtesy to our patients, the practice accepts assignment from most commercial insurance programs. ***I understand that it is my responsibility as the insurance carrier to be aware of your in and out of network benefits and lab companies, co-pays, and deductibles.*** We will file your primary insurance claim for you. Once the primary insurance has paid, we will also file your secondary insurance, if you have provided us with that information. However, insurance is a contract between YOU and YOUR INSURANCE COMPANY. Therefore, we ask that you acknowledge your responsibility for notifying staff of insurance changes and payment of our services. Also, your insurance company may ask us to provide information concerning your treatment before they will pay for the services.

If the insurance denies coverage, disallows a service, or otherwise does not pay the claim, you are still responsible for the fees at your next appointment. Balances not paid within 30 days after your first treatment will be subject to a 1 ½% service charge per month. In addition, if the fees for our services are not paid, we may turn the account over to a collection agency. Attorney fees and court costs will be added to the outstanding balance if it becomes necessary to take legal action to collect past due amounts. You will then be dismissed from practice.

I ACKNOWLEDGE IT IS MY RESPONSIBILITY TO ENSURE PAYMENT OF FEES FOR SERVICES PROVIDED BY THE PRACTICE AND AUTHORIZE THE PRACTICE TO RELEASE ANY MEDICAL INFORMATION, IF NECESSARY, TO MY INSURANCE COMPANY. THE UNDERSIGNED, GIVE AUTHORIZATON TO TREAT AND ASSIGN DIRECTLY TO CIRCLE OF LIFE FAMILY MEDICINE, ALL MEDICIAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. *I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT PAID BY MY INSURANCE.* I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS AND AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

Signature: _____ Date: _____

PATIENT CONSENT & CLINICAL TESTING NOTIFICATION

We are thankful to be a partner with you in your healthcare. To keep you informed about your health, we will notify you about the results of clinical testing. Please tell us how you would like to be contacted by initializing the appropriate response:

_____ Please call me at this number _____ or _____
If I am not available at one of the numbers listed above, I authorize you to leave a message on my answering machine (and /or voice mail).

_____YES _____ NO

_____ I authorize you to leave a message with my spouse or family member.

_____YES _____ NO

I understand that it is my responsibility to notify CIRCLE OF LIFE FAMIY MEDICINE in writing if this information changes.
Signature: _____ Date: _____

PRIVACY RESTRICTION

New federal regulations require physician practices to keep your medical information private. Our practice has always guarded the privacy of our patients. We only share medical information with our healthcare providers that are participating in your care, your insurance company to provide your benefits, or for medical management issues. We will keep your record as long as you are a patient of the practice and seven years after your last visit.

I acknowledge that I am informed about the privacy of my medical records, and the practice's Privacy Policy has been made available to me.

Name: _____ Date: _____

As your healthcare provider, I want you to understand that everything you tell me is confidential. Our practice has always guarded the privacy of our patients. We only share your medical information with other healthcare providers that are participating in your care, your insurance company to provide your benefits, or for medical management issues. We will not discuss your condition with anyone else (i.e. parents/guardian, spouses, children) without approval in writing.

I understand the above statement and (check on below):

_____ I do not mind that my medical information is shared with my parent/guardian/spouse/adult child.

_____ I want my medical information to remain confidential. My protected health information should not be shared with any other individual. I realize that unless I pay cash for all services provided, there is a chance that an insurance company may request information and must be approved by Circle of Life Family Medicine, Privacy Officer.

Signature: _____ Date: _____

Emergency Treatment EXCEPTION: If the Privacy Officer agrees to a restriction. HIPAA privacy regulations provide an exception in emergency treatment for a hospital or physician to use and disclose necessary information to treat the patient

Circle of Life Family Medicine is a wellness practice. We strive for whole body fitness. Many of our services are CASH pay. THEY ARE NOT COVERED BY INSURANCE.

These include:

Aesthetics including Botox and Fillers

Diet Supplements

IV vitamin infusions

Microdermabrasion

Some injections

Some lab work

Vitamins and supplements

Weight loss program

Please be aware these services are **not covered by insurance** and payment is expected at time of services rendered. Payment will be collected before treatments. You will be notified in advance before these services are provided.

I have read the above statement. I am aware that I am responsible for any cash pay services and will pay before treatments are rendered.

Signature: _____ Date: _____

PATIENT RIGHTS AND RESPONSIBILITIES

Circle of life Family Medicine wants to make sure its patients are educated on their rights and responsibilities. To comply with regulatory and accrediting requirements, here is a reminder of those rights and responsibilities. These reminders are intended to make it easier for patients to access quality medical care and to attain services.

MEMBER RIGHTS

Members have the right to:

- Be treated with respect, dignity, and need for privacy.
- Receive information about policies and services of this office, including structure, operation, quality improvement activities, Practitioners and Providers, and Patient rights and responsibilities.
- Participate with Practitioners in the decision-making regarding their health care.
- Voice complaints or appeals about the organization or the care it provides.
- A candid discussion of appropriate Medically Necessary treatment options for their condition regardless of cost or benefit coverage.
- Make recommendations regarding the office's Patient rights and responsibilities.

MEMBER RESPONSIBILITIES

Members are expected to:

- Provide, to the extent possible, all information that the office and its Practitioners and Providers need in order to provide care.
- Follow plans and instructions for care that they have agreed to with their Practitioners.
- Understand their health problems and participate in developing mutually agreed upon treatment goals, to the degree possible.

ALLERGIES/ADVERSE REACTIONS

____ No known allergies
____ Yes

MEDICATION	REACTION	MEDICATION	REACTION

MEDICATIONS

List any medications you are currently taking.

NAME	DOSE	FREQUENCY	30 OR 90 DAYS

SUPPLEMENTS

NAME	DOSE	FREQUENCY

PAST MEDICAL HISTORY

Have you had the following?	Yes	No	When?
Alzheimer's Disease			
Anxiety			
Asthma			
Anemia			
Arthritis			
Atrial Fibrillation			
Back Pain			
Blood Clots			
Cancer-Breast			
Cancer-Colon			
Cancer-Lung			
Cancer-Elsewhere			
COPD			
Colon Problems			
Depression			
Diabetes			
Endometriosis			
GERD			
Glaucoma			
Gout			
HIV			
Headache			
Hepatitis			
Hernia			
Hypertension			
Heart Attack			
Kidney Stone			
Kidney Problems			
Liver Disease			
Migraine			
Osteoporosis			
Peptic Ulcer			
Postpartum Depression			
Prostate Problem			
Stroke			
Seizures			
Thyroid Disease			
Tuberculosis			

PAST SURGICAL HISTORY

Please list all surgeries	Date performed

SCREENING

Chest X-ray	
Cholesterol Screen	
Colonoscopy	
EKG	
Heart Disease	
High Cholesterol	
High Blood Pressure	
Mammogram	
PAP	

FAMILY HISTORY

Have any of your relatives had the following?	Yes	No	If yes, which relative?	If deceased, cause and age at death?
Diabetes				
Congenital Heart Defect				
Epilepsy				
Glaucoma				
Heart Disease				
High Cholesterol				
Hypertension				
Immunodeficiency				
Osteoporosis				
Pulmonary Embolism/DVT				
Stroke				
Thyroid Disorder				

Please give a brief description of the reason(s) you would like to be seen at Circle of Life:

SOCIAL HISTORY

Tobacco: Do you now, or have you in the past used tobacco products? (check one)

____Never
____ In Past
- When did you quit? _____
- How much did you smoke? _____
- How long did you smoke? _____

____Current
- How much do you smoke? _____
- How long have you smoked? _____
- Have you ever tried to quit? _____
- What method(s) have you used? _____

Other Tobacco use:

Dip_____ Chew_____ Other _____

Recreational Drugs: Do you now, or have you in the past used recreational drugs? ___yes ___ no, what kinds? _____
- How long did you use it (them)? _____
- How often? _____

Alcohol: How many alcoholic drinks do you drink weekly? _____
What type of alcohol do you drink? _____

Caffeine: How many servings of caffeine do you have daily?
Coffee _____ Tea _____ Soft drinks _____

Diet Plan: Do you follow any certain diet plan? ___Yes ___ No
If yes, what type? _____

Depressed: Do you feel depressed? Yes ____ No_____, If yes, how _____
_____

Stress: On a scale of 1 to 10, with 10 being the worse stress, what is your normal everyday stress level? 0 1-2 3-4 5-6 7-8 9-10

Sleep: How many hours per night are you sleeping? _____
Do you have difficulty falling asleep? ____yes ____ no
Do you have problems waking up in morning? ____yes ____ no
Do you snore or hold your breath while sleeping? ____yes ____ no
Do you have difficulty staying awake while sitting quietly? ____yes ____ no

IMPORTANT INFORMATION

- In order to provide the best possible care, it is important to have regular labs and follow up care. If you receive medication for hypertension, cholesterol, diabetes, thyroid disease, or hormone replacement, we cannot provide refills without lab results and a follow up visit at least every 3-6 months. This is to assure you are on the proper dosage of your medication and there aren't any other concerns. In some cases, labs may be required every 3 months in order to get the levels stabilized.
- During your visit, discuss if you would like additional labs checked on your next lab order so it can be prepared and coded properly.
- If you receive controlled substance medication you must have a follow up visit every month for assessment and refills.
- If you think you need an antibiotic or a change in medication, you must be seen to be assessed.

MEDICATION REFILLS

- We prefer you get refills during your regular visit and get refills for the next 3-6 months.
- The next best way is calling in and requesting your refills, providing your labs are up to date. Please be sure to leave a complete message with the name of the medication and pharmacy, particularly if you use more than one pharmacy. Please check back with your pharmacy within 24-48 hours. We cannot possibly return every refill call. Plan several days ahead. Please do not wait until you have taken your last pill.
- We can receive calls or faxes from your pharmacy for refills, but we are unable to process E-prescribe requests. Many times a pharmacy will tell you they sent us a request for a refill, but they actually send an E-prescribe request which we did not receive.

Please understand the importance of keeping your labs and visits current so that there will bot be an issue refilling your medication. You can always call the receptionist and find out when you are due to come back in.

PLEASE SILENCE YOUR CELLPHONES DURING YOUR VISIT

Accordance with Federal government privacy rules implemented through the Healthcare Portability of 1996 (HIPAA), in order for your healthcare provider or staff of Circle of Life Family Medicine to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so.

I give permission to the physician, and/or their staff, to discuss my health condition with the following individuals:

Individual's Name	Relationship to Patient
Individual's Name	Relationship to Patient
Individual's Name	Relationship to Patient
Individual's Name	Relationship to Patient

Patient's Name (printed):_____

Date of Birth:_____

Patient's Signature:_____

Date:_____

This consent will remain in effect until revoked in writing by patient.