SENIOR CARE PARTNERS
OF EAST TENNESSEE

WELCOME NEW PATIENT!

Welcome to The Senior Care Partners Clinic. We look forward to your upcoming visit and want to share with you what to expect. We work very hard to see patients at their scheduled appointment times to allow you to spend as much time as possible with your provider. To make this possible **we request that you arrive 15-20 minutes prior to your scheduled appointment.**

In order to make the most of your visit, please bring with you the items listed to the right:

Patients with memory problems or dementia should be accompanied by the family member or advocate who is most familiar with your current situation. If this person is unavailable, we encourage you to reschedule your appointment for a time when they can attend.

Bring to Each Visit:

- **Current Insurance Card**
- **Current Medications:** All medications (prescribed and over the counter) that you are currently taking. You may bring a medication list, but it is very important you bring the **actual bottles or pill containers** as well.
- **Face Mask**: A face mask to wear while in the clinic if having respiratory symptoms or running a fever.

We proudly utilize geriatric focused Nurse Practitioners in clinic to expand our ability to see patients promptly. All patients should expect to see their assigned physician and our nurse practitioners. We feel that this team-based approach is the future of medicine, and we are proud to be offering this care to the seniors. We look forward to your visit. Please call if you have any questions.

Sincerely,

Teresa M Salazar-Catron MD

Renée J Hyatt MD

Kevin M James MD

John F Kriese DO

Eric Redmon, MD

Jiyoung Janice Chae AGPCN

Jennifer M Morton FNP-BC

Ovidiu Ghita, DO

Rachel Best FNP-BC

1812 E. LAMAR ALEXANDER PARKWAY · MARYVILLE · TN 37804 | PHONE: 865.980.5200 | FAX: 865.980.5201 | SENIORCAREPARTNERSTN.COM |

SENIOR CARE PARTNERS
OF EAST TENNESSEE

PATIENT INFORMATION FORM

Last Name:_____ **First:**_____ **Middle:**_____

SS#:_____ **DOB:**_____ **Sex:** F M **Marital Status:** S M W D

Race: African American American Indian Asian Hispanic White Other

Ethnicity: Hispanic Non-Hispanic **Primary Language:**_____ **Speaks English:** Y N

Address:_____

Daytime Phone:_____ **Cell Phone:**_____ **Email:**_____

Billing Address:_____

Emergency Contact Name:_____ **Relationship:**_____
Cell:_____ **Other Phone:**_____ **Email:**_____
Power of Attorney:_____ **Relationship:**_____
Preferred Pharmacy/location:_____ **Phone:**_____
Additional Pharmacy/location:_____ **Phone:**_____
Person Completing this Form:_____ **Relationship:**_____

INSURANCE INFORMATION: *WE REQUIRE AN UPDATED INSURANCE CARED FOR EVERY VISIT.*

PRIMARY INSURANCE CO:_____

Where will we be seeing you? ☐ **Maryville Office** ☐ **Vonore Office**

How did you hear about us? ☐ **family/friend recommendation** ☐ **other doctor/agency**_____

☐ **radio** ☐ **newspaper** ☐ **billboard** ☐ **other** _____

Subscriber Name:_____ **Relationship to Subscriber:**_____

Subscriber SS#:_____ **Subscriber DOB:**_____ **Subscriber Phone:**_____

Employer Name:_____

ID#:_____ **Group#:**_____ **Effective Date:**_____

Claims Address:_____

SECONDARY INSURANCE CO:_____

Subscriber Name:_____ **Relationship to Subscriber:**_____

Subscriber SS#:_____ **Subscriber DOB:**_____ **Subscriber Phone:**_____

Employer Name:_____

ID#:_____ **Group#:**_____ **Effective Date:**_____

Claims Address:_____

SENIOR CARE PARTNERS
OF EAST TENNESSEE

PATIENT INFORMATION FORM

TERTIARY INSURANCE CO: _____

Subscriber Name: _____ **Relationship to Subscriber:** _____

Subscriber SS#: _____ **Subscriber DOB:** _____ **Subscriber Phone:** _____

Employer Name: _____

ID#: _____ **Group#:** _____ **Effective Date:** _____

Claims Address: _____

PERMISSION TO CONTACT:

Please check your preferences (all that apply):

- ☐ ONLY leave information with me
- ☐ Leave lab results on my answering machine or voice mail.
- ☐ Leave the general questions/medical information on my answering machine or voice mail
- ☐ Leave lab results with authorized people (listed below)
- ☐ Leave general questions/medical information with authorized people (listed below)
- ☐ It is acceptable to mail results to my home

The following people are authorized to discuss my personal medical records, results, treatment options and billing information:

1) _____ Relationship: _____ Phone: _____

2) _____ Relationship: _____ Phone: _____

3) _____ Relationship: _____ Phone: _____

Current Prescriptions: To improve safety and accuracy, SCP of TN is authorized to access my current medications from the SureScripts database. ☐ **I agree** ☐ **I disagree** (Note: The last option *does not* apply to controlled substance prescriptions.)

Your signature below allows us to:

1. Accept payment of benefits directly from your insurance company under the terms of your insurance.
2. Release medical records to your insurance, hospitals, any physician, and attorneys for the purpose of determining benefits, coordination of care, or legal matters.
3. Obtain necessary information from your other health care providers.

Your signature below also indicates your acknowledgement that you have been provided with a copy of the Notice of Privacy Practices Policy (HIPAA), and that your answers regarding permission to contact and authorized individuals is accurate.

_____ _____

Signature of Patient or Legally Authorized Representative **Date**

_____

Name and Relationship of Legally Authorized Representative to Patient (Printed)

SENIOR CARE PARTNERS
OF EAST TENNESSEE

FINANCIAL POLICY

The doctors and staff of Senior Care Partners of East Tennessee, PLLC would like to welcome you to our practice. We strive to provide you with excellent medical care and our goal is to make your visit as convenient as possible.

By signing below you confirm that you have read this policy and understand that:

- It is your responsibility to inform Senior Care Partners of East Tennessee with any insurance changes.
- Your account will need to be kept current – accordingly, all self-pay or insurance co-payments, co-insurances and deductibles will be billed following the visit. Payable by cash, check or credit card.
- A returned check will result in a $25.00 service charge and all future payments being required in the form of cash or credit card.
- You will only be sent a statement if your balance is over $5.00.
- Refunds will be issued within 4 weeks from the date requested, if there are no pending insurance claims.
- If your account is turned over to a collection agency, you will be responsible for any costs incurred in collections of said balance, which may include collection agency fees up to 35% of your outstanding balance, court costs and attorney fees.

If you have health insurance coverage:

We will submit your claims; however, we must emphasize that as medical providers; our relationship is with you, not your insurance company. Although we attempt to verify your benefits with your insurance policy, please be advised this is only an estimate of your coverage based on the information given to us at the time of inquiry. Your insurance company will need to have a provider with Senior Care Partners of East Tennessee listed as your Primary Care Provider.

By signing below you confirm that you understand:

- It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be re- verified prior to your appointment.
- Not all services are a covered benefit with all insurance plans.
- It is your responsibility to be aware of what service is being provided to you and if it is a covered benefit under your insurance policy.

You are responsible for any non-covered charges not payable by your insurance policy.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, please do not hesitate to ask us. We are here to help you!

I have read and understand the above Financial Policy and agree to meet all financial obligations.

Signature of Patient or Legally Authorized Representative _____ Date _____

Name and Relationship of Legally Authorized Representative to Patient (Printed) _____

SENIOR CARE PARTNERS
OF EAST TENNESSEE

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:

For Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, or others who need to know about you to provide quality patient care. This information may be disclosed through information we record in your medical record or verbally between health care providers. We will also provide other medical facilities with information about you and your diagnoses which they will need in order to treat you.

For Payment: We may use and disclose medical information about you so that the treatment and services you receive may be billed and payment may be collected from you, an insurance company or a third party. For example, we may need to give your insurance company information about a procedure we performed so we can be paid for the office visit.

For Health Care Operations: We may use and disclose medical information about you for operational purposes. For example, your health information may be disclosed to members of our staff, risk or quality improvement personnel, and others to evaluate the performance of our staff, assess the quality of care, learn how to improve our office and services.

Appointments: We may use your information to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

SPECIAL SITUATIONS IN WHICH YOUR INFORMATION MAY BE RELEASED:

(Including in Response to Federal State or Local Law)

- for judicial administrative proceedings pursuant to legal authority
- to report information related to victims of abuse, neglect or domestic violence and to assist law enforcement officials in their law enforcement duties
- if necessary to reduce or prevent a serious threat to your health or safety or the health or safety of another person or the public
- in response to appropriate military authorities if you are a member of the military (including veterans)

Local Public Health Authorities:

- in reporting child or elder abuse and neglect
- in reporting communicable diseases or your potential exposure to such
- in notifying you of recalls of drugs, products or devices you may be using

Deceased Patients:

- to a medical examiner or coroner to assist in identifying the cause of death
- to allow funeral directors to do their jobs.

Organ/Tissue donation:

- Your health information may be used or disclosed for cadaveric organ, eye or tissue donation purposes

Workers' Compensation:

- Your health information may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation

WE WILL ALWAYS GET YOUR WRITTEN AUTHORIZATION BEFORE RELEASING OR USING YOUR INFORMATION:

- for marketing purposes
- in a manner that would constitute the sale of your protected health information
- in a manner not described in this notice and where required by either Federal or State Law

YOUR HEALTH INFORMATION RIGHTS:

You have a right to:

- request a restriction on certain uses and disclosures of your information as provided by 45 CFR §164.522. This may include a limit on medical information we disclose about you to someone who is involved in your care or payment for your care, such as a family member or friend. We are, however, not required to agree to a requested restriction except in cases where you have paid your bill in full and requested a restriction on releasing your information to a group health plan, insurer, or other payer for purposes of payment or health care operations. You may request a restriction by completing a form developed by the office or you can send a written request.

SENIOR CARE PARTNERS
OF EAST TENNESSEE

NOTICE OF PRIVACY PRACTICES

- obtain a paper copy of this notice at any time from the front desk
- inspect and obtain a paper copy of your health record and obtain an electronic copy to the extent the office utilizes an electronic medical record
- amend your health record as provided in 45 CFR §164.526. To request a copy or to amend your information you must make your request in writing and submit the request to the front desk or office address
- request communications of your health information by alternative means or at alternative locations
- revoke special authorizations to use or disclose health information for certain purposes except to the extent that action has already been taken
- request an accounting of all disclosures of your health information when the disclosure has not been pursuant to treatment, payment, operations, or an authorization and, if your information is maintained in an electronic format, request an accounting of any disclosures dating back three years from the date of the request
- request a hard copy of your medical information; or an electronic copy in a format requested by you if such format is readily producible
- receive a written notification of any inappropriate release or use of your protected health information

OBLIGATIONS OF SENIOR CARE PARTNERS OF EAST TENNESSEE, PLLC

We are required to:

- maintain the privacy of protected health information
- provide you with this notice of our legal duties and privacy practices with respect to your health information
- abide by the terms of this notice
- notify you of certain breaches or the inappropriate release or use of your information
- notify you if we are unable to agree to a requested restriction on how your information is to be used or disclosed
- accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations
- release the minimum amount of your information necessary to accomplish information related functions and de-identify your information to the extent practicable
- obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law

CHANGES TO THIS NOTICE:

We reserve the right to change our information practices and to make new provisions effective for all protected health information we maintain. At the end of this notice you will be asked to sign that you have received the notice and have had the opportunity to receive a copy. Your signature is requested to help us determine which version of the notice you have received. A paper copy will be made available to you upon request.

If you have questions or complaints, please contact:

Senior Care Partners of East Tennessee, PLLC
1812 E. Lamar Alexander Pkwy
Maryville, TN 37804
P: 865.980.5200 F: 865.980-5201

If you believe your privacy rights have been violated, you can file a complaint with the Department of Health and Human Services. There will be no retaliation for filing a complaint.

ACKNOWLEDGEMENT:

_____ _____

Signature of Patient or Legally Authorized Representative Date

_____

Name and Relationship of Legally Authorized Representative to Patient (Printed)

SENIOR CARE PARTNERS
OF EAST TENNESSEE

PRACTICE POLICIES

MEDICATION PRACTICES:

- It is very uncommon for our practice to provide chronic narcotic medications or chronic anxiety medications (such as Xanax or Klonopin). We believe this is the safest way to practice modern medicine. If you are on a chronic controlled substance it is very likely that we will recommend tapering off of this medication once you establish in our practice. We cannot promise that our providers will continue any controlled substance that your previous physician may have prescribed.
- Routine prescription refills are handled at the time of your appointment or, in some cases, by phone during business hours. If you need refills between visits we kindly request one week's notice.
- The after hours physician on call will not call in routine medication refills.
- Controlled substances may not be refilled outside of appointments.

APPOINTMENT SCHEDULING PRACTICES:

- Please arrive 5-10 minutes prior to your appointment time.
- Cancellation of your appointment will be accepted until 3 business hours prior to your appointment time. Failure to cancel an appointment, or cancellation within 3 business hours prior to your appointment may result in a "No Show" fee of $50.
- Three or more "no shows" may result in dismissal from our practice.

WEAPONS POLICY:

- For the safety of our patients, guests, and staff, we do not allow firearms in the clinic.

ACKNOWLEDGMENT:

Signature of Patient or Legally Authorized Representative _____ Date _____

Name and Relationship of Legally Authorized Representative to Patient (Printed) _____

SENIOR CARE PARTNERS
OF EAST TENNESSEE

RELEASE FOR MEDICAL RECORDS

PATIENT'S NAME:_____ DOB:_____

Social Security:_____ Phone:_____

CURRENT PHYSICIAN:_____

Practice Name:_____

Address:_____ City State Zip:_____

Phone:_____ Fax:_____

I authorize and request the release of, or request access to the protected information specified below from the medical record(s) of the above named patient.

INFORMATION YOU MAY RELEASE SUBJECT TO THIS SIGNED FORM:

- ☐ Complete Medical Records
- ☐ Most Recent Office Visit
- ☐ Care Plan
- ☐ Pathology Reports
- ☐ History and Physical
- ☐ Medication Record
- ☐ Progress Notes
- ☐ Radiology Reports
- ☐ Health maintenance including screenings and vaccinations

☐ Other_____

RELEASE TO: Senior Care Partners of East Tennessee, PLLC
1812 E. Lamar Alexander Pkwy.
Maryville, TN 37804
Phone: 865.980.5200 Fax: 865.980.5201

REASON:

- ☐ To establish new patient
- ☐ For continued medical care
- ☐ Requested by Provider:
  - ☐ RENEE J HYATT MD
  - ☐ KEVIN M JAMES MD
  - ☐ JOHN F KRIESE, DO
  - ☐ JIYOUNG JANICE CHAE AGPCNP
  - ☐ JENNIFER M MORTON FNP-BC
  - ☐ OVIDIU GHITA, DO
  - ☐ RACHEL BEST, FNP-BC
  - ☐ OTHER:_____

I understand that medical records are confidential and cannot be disclosed without written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

ACKNOWLEDGEMENT:

_____

Signature of Patient or Legally Authorized Representative Date

_____

Name and Relationship of Legally Authorized Representative to Patient (Printed)

SENIOR CARE SPECIALTY

FOOT/WOUND CARE CONSENT FORM

Patient's Name:_____ DOB:_____

Senior Care Specialty nurse practitioners are trained to assess wounds, feet, and lower extremities. Based upon our assessment, we will determine the care needed and will provide appropriate treatment. We will suggest further testing or assessment regarding laboratory testing, advanced radiographic imaging, or specialist consultation if necessary.

Foot care consent includes permission to assess and treat toenail and feet/lower legs, including but not limited to toenail debridement, wedge excision of ingrown toenails, and callus paring as necessary.

Wound care consent includes permission to assess and treat wounds which include but are not limited to dressing changes, debridement, and other procedures that will be defined /explained as indicated.

We often have students working with our medical staff. If you feel uncomfortable with a student participating in your care, please let us know.

ACKNOWLEDGEMENT:

I have read and understand the proposed wound, foot, and nail care treatment consent. I agree with the provisions and consent for treatment of the following: (Check all that apply)

☐ Feet/Nails ☐ Yes ☐No ☐ N/A

☐ Wounds ☐ Yes ☐No ☐ N/A

If wound, please describe: _____

_____

I consent to permitting staff of Senior Care Specialty to discuss information about my care with other members of the healthcare team who are involved with my care. I consent to treatment as noted above.

_____ _____

Signature of Patient or Legally Authorized Representative Date

_____

Name and Relationship of Legally Authorized Representative to Patient (Printed)

SENIOR CARE PARTNERS
OF EAST TENNESSEE

MEDICAL PRESCRIPTION RECORDS

Senior Care Partners of East Tennessee (SCP) utilize SureScripts to improve the accuracy and safety of all of our patients. As a part of that, we are required to have your authorization to look up and verify your current prescriptions.

PLEASE CHOICE ONE OF THE FOLLOWING OPTIONS:

_____I authorize SCP to access my current medical prescriptions through SureScripts or other electronic database.

OR

_____I do not authorize SCP to access my current medical prescriptions through SureScripts or other electronic database. I understand this option may prevent sharing of critical information in my treatment including possible drug interaction, reaction, overtreatment and/or potentially harmful effects. (NOTE: This option does not apply to controlled substances which remain accessible per Federal Law.)

ACKNOWLEDGEMENT:

_____ _____

Signature of Patient or Legally Authorized Representative Date

_____

Name and Relationship of Legally Authorized Representative to Patient (Printed)