Healthplus

Phone: 423-634-4242

A Physician Treating People, Not Just Symptoms

PATIENT INFORMATION **Today's Date:**_____

Legal First Name:_____ Legal Last Name:_____

Middle Name:_____ Name you prefer to go by:_____

Date of Birth:_____ Sex: (please check one) ◯ Male ◯ Female

Mailing Address:_____

City:_____State:_____Zip Code:_____

Primary Phone: (____)_____(please check) ◯ Home ◯ Cell ◯ Work

Secondary Phone: (____)_____(please check) ◯ Home ◯ Cell ◯ Work

SS#_____ Email address:_____

Marital Status: ◯ S ◯ M ◯ D ◯ W Spouse Full Legal Name:_____

Employer:_____ Employer Phone:_____

Emergency Contact (someone not living in your household)

Contact Name:_____Relationship:_____

Primary Phone:_____ Secondary Phone:_____

Person responsible for bill if patient is a minor:_____

Date of Birth:_____ Phone:_____

Address (if different) _____

INSURANCE INFORMATION

Primary Insurance Company: _____

Name_____SS#_____DOB_____

Relation to primary cardholder_____

Secondary Insurance Company:_____

Name_____SS#_____DOB_____

Relation to primary cardholder_____

Financial Responsibility Agreement:

Patient must provide accurate and up to date insurance information to ensure proper filing; otherwise the bill will become the patient's responsibility. Our office will file insurance for all reimbursable services however our policy requires that you pay fees due today, including copayments, deductibles and fees not covered by your insurance plan. I authorize the release of medical or other information about me to the above listed service provider in order to process my claim. I authorize any collection or attorney fee owed in addition to court costs if charges are not paid in full.

Date:_____Signature:_____

PAST MEDICAL HISTORY. List illnesses and conditions you have had and the year.	
1.	4.
2.	5.
3.	6.

MEDICATIONS: List medications you are currently taking including OTC and Supplements.		ALLERGIES: To medications or substances
1.	9.	
2.	10.	
3.	11.	
4.	12.	
5.	13.	
6.	14.	
7.	15.	
8.	16.	

SURGICAL HISTORY:		
Type of Surgery	Year	Complications if any

SOCIAL HISTORY: Check the substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Alcohol	
	Exercise	

FAMILY HISTORY: List any illnesses that run in your family:	
1.	5.
2.	6.
3	7.
4.	8.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

Signature:_____ Date: _____

Robert A. Crook D.O.

Notifications and Releases

Listed below are several notices. ***Please read them carefully and sign where indicated that you have read each statement.***

****General Consent for Treatment**

We look forward to treating you as a patient, however, we need your consent for Dr. Crook to provide treatment or services. Also, certify that no guarantee or assurance has been made regarding the result that may be obtained.

I hereby grant consent to treatment or services.

_____ Date: _____

Patient/Patient's representative

**** Financial Policy/Assignment of Benefits**

As a courtesy to our patients, Dr. Crook accepts assignment from most major insurance plans. We will file your insurance claim for you. However, insurance is a contract between you and your insurance company. Therefore, we ask that you acknowledge your responsibility for the payment of our services. Payment for self pay, coinsurance % and any deductibles for the office visits, injections, and other charges are to be paid at time of service. We accept payment by Cash, Check, Money Order, Visa, Master card.

We contract with: Blue Cross Blue Shield, United Health Care, Aetna, and several other plans.

We **DO NOT** accept: Medicare, Cigna, TENN CARE, Workers Compensation, or Car Accidents under Litigation!

A 24-hour notification is required for cancelled/rescheduled appointments, or you will be subject to a fee. _____ (Patient Initial)

If the insurance denies coverage, disallows a service, or otherwise does not pay the claim, you are still responsible for the fees. In addition, if the fees for our services are not paid, we may turn the account to a collection agency. Attorney's fees and court costs will also be added to the outstanding balance if it becomes necessary to take legal action to collect past due amounts. Also, your insurance company may ask us to provide information concerning your treatment before they will pay for the services.

I authorize payment of benefits to be made on my behalf to Dr. Crook; Healthplus for medical services provided.

I acknowledge it is my responsibility to ensure payment of fees for services provided by Dr. Crook and authorize Healthplus to release any medical information, if necessary, to my insurance company.

_____ Date: _____

Patient/Patient's representative

****Privacy Policy**

Federal regulations require physician practices to keep your medical information private. Healthplus guards the privacy of our patients. We only share medical information with other healthcare providers that are participating in your care, your insurance company to provide your benefits, or for medical management issues.

I acknowledge that I have been informed about the privacy of my medical records.

_____ Date: _____

Patient/Patient's representative

Robert A. Crook, D.O.

PRIVACY RESTRICTION

As your healthcare provider, I want you to understand that everything you tell me is confidential. 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 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/guardians, spouses) without your approval in writing.

I understand the above statement and (check one box below):

( ) I do not mind that my medical information is shared with my parent/guardian or spouse at anytime.

( ) 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 release information to the person(s) paying for my medical insurance. I also realize that restriction must be approved by Healthplus who may deny my request.

_____

Patient Signature

_____

Date

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

Robert A. Crook, D.O.

Standard Authorization of Use and Disclosure of Protected Health Information

- The information covered in this authorization form includes medical mail outs, lab test results, diagnostic testing results, pertinent medical information and account status.
- You have the right to request restriction of use and disclosure of your health information for any purpose than those listed. Any changes to this information must be submitted in writing to this office.
- Information disclosed under this authorization may be disclosed again by the person or organization to which it is sent. Once we disclose this information to another party, it becomes their responsibility to protect your right of privacy.

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 initialing the appropriate response.

_____Please call me at this number: _____or_____

If I am not available at one of the numbers 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

_____Please mail my results:_____

If No, how may we contact you regarding this information?_____

Please list any restrictions regarding your medical information._____

Please specify any person(s) or organization(s) with whom information may be

disclosed:_____

I understand that it is my responsibility to notify **Healthplus** in writing if this information changes.

Patient Signature:_____

Witness:_____Date:_____