

GREGORY BREWER, MD PLLC
REGISTRATION FORM----**please print**

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

Date of birth: _____ Social Security Number: _____

Home Phone: _____ Cell Phone: _____

Your email: _____ Marital Status (circle one) Married/Single/Divorced

Mailing Address: _____

City: _____ State: _____ Zip: _____

Your emergency contact name: _____ Phone: _____

Your Primary Care Physician: _____ Phone: _____

Who referred you here: physician/friend/insurance: _____

Name of your employer: _____ Phone: _____

Name of your Pharmacy: _____ Phone: _____

Provide receptionist copies of your current health insurance AND your drug coverage card if we provide medication(s) to you. You will still need to fill in the below insurance company name and subscriber information.

Your **primary** insurance company name: _____

ID Number: _____ Group Number: _____

Subscriber name (If other than yourself): _____ DOB: _____

Your relationship to the subscriber ---circle one: Self/Spouse/Other: _____

Name of **secondary** insurance company: _____

ID Number: _____ Group Number: _____

Subscriber name (If other than yourself): _____ DOB: _____

Your relationship to the subscriber ---circle one: Self/Spouse/Other: _____

All professional services rendered are the financial responsibility of the patient. We will file claims to your insurance carrier as a courtesy to you. Your signature below authorizes Gregory Brewer, MD to furnish information to insurance carriers concerning your treatment and you assign to the provider(s) all payments rendered for services received.

Signature: _____

Date: _____

GREGORY BREWER, MD PLLC PRACTICE POLICIES

CONSENT FOR MEDICAL TREATMENT: I, the undersigned, am the patient or the patients duly authorized representative, and do hereby voluntarily consent to and authorize medical care and treatment by Gregory Brewer, MD PLLC through its individual physicians, employees, and/or agents. This care and treatment encompasses all diagnostic and therapeutic treatments considered medically necessary or advisable in the judgment of the physician/providers. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations performed by the providers or their office.

PRIVACY PRACTICES: I acknowledge that I have been offered a copy of Gregory Brewer MD, PLLC's Notice of Privacy Practices to review. I understand this information is also posted in the office and on the practice website.

OFFICE FORMS/APPOINTMENTS: Each year the office requires all patients to update their forms. This is a necessity and it ensures that we have current information in order to help serve our patients. Dr. Brewer has a Nurse Practitioner/Physician's Assistant to help meet the scheduling needs of office patients. Due to the amount of time he spends at the hospital, ***patients will often see the Nurse Practitioner during follow up appointments.*** Dr. Brewer collaborates with the NP as well as personally reviewing every note. He is always involved in your care, however he cannot physically see all office visits. We strive to personally make reminder calls for your appointments. Failure to keep a scheduled appointment may result in a "No Show" Fee which would be required to be paid prior to your next appointment.

MEDICATIONS: We need your help to ensure that we avoid possible side effects or complications. To provide the best possible care, we ask that you bring all medications, vitamins, and supplements in the original bottles to every visit. If you are unable to bring these with you, please bring an accurate, up-to-date list including drug name, dosage, and how often you take it. If you do not have your medications or an accurate list with you, your visit may need to be rescheduled. Be sure to let us know if you take your medications differently than it is listed on the bottles. Proper medical care is very complicated. Many patients have multiple physicians and multiple medications. Some use different pharmacies to get the best pricing on their medications. It is impossible for us to know what has been prescribed to you, and by who. There are drug interactions and side effects that can be caused by medications, it is **EXTREMELY IMPORTANT** that you bring medication bottles or an accurate list to every visit.

SAMPLES: If we start you on a new Cardiology related medication, we MAY have some samples to give you for the first couple of weeks (to ensure that there are no side effects, etc.,). **However, we cannot function as your pharmacy; if you have financial difficulty in paying for your prescriptions, there may be patient assistance plans that you could be approved for.**

NON-COMPLIANCE: We try very hard to maintain one of the few solo physician practices in the area. Unfortunately, all the changes in health care reform and insurance plan changes have put a great deal of stress on small medical practices. We want to maintain a professional setting here and to keep our patients informed of any new policies that we implement. Failure to comply with any of these policies (including failure to remit payment for patient balances) could result in termination of the doctor/patient relationship.

PAYMENT POLICIES:

Copayments: We require copays prior to service (and reserve the right to refuse non-urgent treatment). We accept most credit cards, as well as personal check, debit cards, and cash.

No Insurance: If you have no insurance each visit with a provider will be \$70.00 and is due prior to the visit.

Claims: We file claims to your insurance as a courtesy. Please keep in mind that payment remains your responsibility. We do not enter disputes over insurance benefits. We will insurance in accordance with all federal,

state, and other contractual requirements in cases where we have an agreement or if we are a participating provider. We expect payment in full from you if your insurance company delays processing of your claim over 60 days. You agree to pay any portion of the charges not covered by insurance. If your insurance sends payments directly to you, send the payment to our office or bring it in and we will apply it to your account.

Payments: All balances and copayments/coinsurance/deductibles are due prior to each visit. We send patients 3 statements and then accounts are sent to an outside collection agency. If your account is sent to an outside agency, we add a 40% fee to the bill to cover the additional collection agency fees. We require acceptable payment arrangements be set up with our office for balances (or with collection agency for balances that have been turned over) in order to continue treatment for non-urgent issues. Failure to set up an accepted payment plan or failure to keep your agreed payment plan will result in terminating your relationship with our office. We would send this notification by letter to the address on file and it advised you that we would only see you for urgent needs for 30 days from the date of the letter. After that 30 days, our office would not be able to schedule appointments, call in prescriptions, or address any issues. We would provide you with a medical release form to have your records sent to your new Cardiology office. 30 days allows you ample time to make the transition if needed. Knoxville Indigent Care, Cherokee Health Services, and your local health department can provide treatment for financial hardship cases.

Appointments: We request a 1 business day notice (24 hours) cancellation of all office visits in order to avoid being charged a \$40 late cancellation fee. Failure to give appropriate notice for cancelling or rescheduling a Nuclear Stress Test will result in a \$250 fee.

Medicaid: We file Medicaid claims for the state of Tennessee. If you have assistance from another state, you will be responsible for payment of services you receive.

Referrals: If your insurance requires a referral, you are responsible for obtaining it from your primary care physician. Failure to obtain a referral can result in a lower payment or no payment from the insurance company and you will be responsible for payment.

Forms/Letters/Medical Records: We may bill \$25 prepayment for forms or letters that a provider completes on your behalf. We are not disability providers and cannot fill out disability forms. We provide 1 copy of your medical records to you at no charge; any additional copies require prepayment and are billed at the amount determined by the State of Tennessee.

Your signature indicates that you understand the above information and any questions you have were answered.

Patient Printed Name: _____ Date: _____

Patient/Guardian Signature: _____

GREGORY BREWER, MD PLLC

COMMUNICATION OF PRIVATE HEALTH INFORMATION FORM

YOU CAN REVOKE THIS AUTHORIZATION AT ANY TIME BY NOTIFYING US IN WRITING. THE REVOCATION WILL ONLY BE EFFECTIVE FROM THE DATE IS IT RECEIVED IN THIS OFFICE AND WILL NOT APPLY RETROACTIVELY. THIS FORM MUST BE UPDATED ANNUALLY. IF YOU DO NOT LIST ANYONE, THEN WE CAN NOT DISCUSS YOUR HEALTHCARE WITH ANYONE (EVEN YOUR SPOUSE).

I give Gregory Brewer, MD PLLC permission to disclose my health information and account information to:

Please list all parties we may discuss this information with (spouse, other family members, etc.,)

PLEASE PRINT THEIR NAMES TO AVOID ANY CONFUSION.

Name(s) of people you authorize us to share your health information with:

Relationship:

_____	_____
_____	_____
_____	_____
_____	_____

WHERE AND HOW MAY WE CONTACT YOU:

Home Yes No If yes, give phone number: _____

Work Yes No If yes, give phone number: _____

Cell Yes No If yes, give phone number: _____

Email Yes No If yes, give email address: _____

Can we leave a message on your answering machine/voice mail?

At home: Yes No At work: Yes No Cell phone: Yes No

Can we leave a message with the person answering the phone if you do not have answering machine/voicemail?

At home: Yes No At work: Yes No Cell phone: Yes No

PRINTED PATIENT NAME: _____ DOB: _____

PATIENT/GUARANTOR SIGNATURE: _____ DATE: _____

EMPLOYEE WITNESS SIGNATURE: _____ DATE: _____

This authorization expires 1 year from the date it is signed. This authorization will override any previous authorizations on file with this office.