105 W. Stone Drive, Suite 2B • Kingsport, TN 37660 • Telephone 423.247.7500 • Facsimile 423.247.7556

Christopher Mitchell, MD, FACOG
Danielle Spurling, FNP

WELCOME

Thank you for choosing Seasons Comprehensive Women's Health for your gynecological care. Enclosed is a packet of information you will need to complete and bring with you to your initial visit. Also, please bring your health insurance card and a list of your current medications. We have enclosed a Seasons brochure that provides information about our providers. We welcome you to visit our website at www.seasonsforyou.com.

OFFICE HOURS

We see patients Monday through Friday, 8:00 a.m. – 5:00 p.m., except holidays. Our office staff will be available to answer your phone calls from 8:00 a.m. to 5:00 p.m., Monday through Friday.

APPOINTMENTS

Please call 423-247-7500 to schedule your appointments. We make every effort to stay on schedule; however, due to our commitment to providing the most effective patient care, we cannot always predict the length of each office visit. We ask for your understanding if your appointment is delayed. We will keep you as informed as possible regarding delays with our schedule. If you are unable to keep a scheduled appointment, please contact our office as soon as possible. This will enable us to reschedule your appointment to a more convenient time and allow our staff to offer your appointment to someone else.

EMERGENCY CARE

We do our best to respond to emergencies promptly – day or night. If you have a problem that is severe and requires immediate care, please go to the nearest emergency room and the emergency department will contact our provider on call. If the situation is not severe, but you wish to make our office aware of your problem, please call our office at 423-247-7500 during normal business hours. When our office is closed, all calls are forwarded to our answering service. Our physicians share emergency call coverage at night and on weekends. Our answering service will page our provider on call in the event of an emergency.

PRESCRIPTIONS AND REFILLS

Requests for prescriptions and refills are handled only during normal office hours. No prescription requests for narcotic medication are processed after office hours or on weekends. Please call our office at least one week before you anticipate needing a prescription refill. Please understand that we are unable to refill prescriptions for you if you have not been evaluated in our office within the last twelve months.

PAYMENT

Payment for office visits is expected at the time of service. Our practice does participate with numerous insurance plans, and we will be happy to file your insurance claim for you. Please understand we are required by our participation agreements to collect your co-payments and/or deductibles, and these are collected at time of service. You may pay by cash, check, or credit card (Visa, Mastercard or Discover).

Please do not hesitate to contact us with any concerns or questions. We look forward to meeting you!

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Welcome to our office

Where did you hear about us?
❒ Yellow Pages (YP) ❒ Newspaper (NP) ❒ Website (WS)
❒ Friend or Family (FF) ❒ Physician Referral (PR)
❒ Other (OT) _____

OFFICE USE ONLY
Physician: _____
Approved by: _____
Date: _____

NEW PATIENT INFORMATION (Complete if different from billing party)

Name _____
First Middle Last

Address _____

City _____ State _____ Country _____ Zip _____ Phone # (____) _____

Birthdate _____ Sex M or F Race _____ Marital Status S M W D

Social Security # _____ Employer _____

Address of Employer _____ Work Phone # _____

May we contact you at work? Y N By E-Mail Y N E-Mail Address _____

Emergency Contact Name _____ Emerg. Phone # (____) _____

Relationship to billing party _____

Guarantor/Responsible Party

Name _____
First Middle Last

Address _____

City _____ State _____ Zip _____ Phone # _____

Birthdate _____ Sex M or F Marital Status S M W D

Social Security # _____ Driver's License # _____

Place of employment _____ Work Phone # _____

OTHER INFORMATION

Name and address of nearest relative not living with you _____

Address _____ City _____ State _____ Zip _____ Phone # _____

If you are currently under another physician's care, please list:

Name _____

Address _____ City _____ State _____ Zip _____

Whom may we thank for referring you to us? _____

INSURANCE

1. Primary Insurance Company Name _____

Group # _____ Policy Member # _____

Subscriber Name _____ Subscriber Birthdate _____ Sex M or F Social Security # _____

Subscriber Employer and Address _____

2. Secondary/Supplemental Insurance Name _____

Group # _____ Policy/Member # _____

Subscriber Name _____ Subscriber Birthdate _____ Sex M or F Social Security # _____

Subscriber Employer and Address _____

Please note whomever brings a child in to be seen is responsible for payment at time of service unless prior arrangements have been made. It is the custodial parent's responsibility to arrange reimbursement from a non-custodial parent.
By signing below I hereby give my consent for Holston Medical Group to treat my minor child, under 18 years of age

INSURANCE AUTHORIZATION AND ASSIGNMENT:
I understand that I am financially responsible for any medical service at time of service. I authorize my insurance carrier to pay to Holston Medical Group any assigned claims filed by them and authorization for release of medical information requested by my insurance company. For Medicare beneficiaries: I request payment of authorized Medigap benefits be made to me or on my behalf to Holston Medical Group and medical information about me to be released to my Medigap insurer.

Date _____ Signature _____

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MRN: _____

Date Received: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have received a copy of the *Notice of Privacy Practices*, which provides a more complete description of how my protected health information (PHI) may be used or disclosed. I understand that Holston Medical Group reserves the right to change their notice and information practices and that I may view a copy of the current *Notice* on Holston Medical Group's website, www.holstonmedicalgroup.com/hipaa, in any of their offices, or by a request in writing.

_____ _____
Print Patient Name Patient Date of Birth

_____ _____
Patient Signature (if applicable) Date

_____ _____
Authorized Representative Signature Relationship to Patient

I understand that my protected health information will only be given to those individuals listed below. Those individuals will be required to communicate the last four (4) digits of my Social Security Number, along with my date-of-birth, before any information will be given to them.

List the individuals that you want protected health information given to:

_____ _____

_____ _____

FOR INTERNAL USE ONLY:

Date Acknowledgement Received: _____ Med Rec #_____

-OR-

Reason Acknowledgement Could Not Be Obtained:

_____

_____

_____

_____ _____
Employee Signature Date

Seasons
Comprehensive women's health solutions for every season of life.

Abingdon / Bristol / Kingsport

Patient's Name _____ **MRN** _____

CONSENT FOR TREATMENT

1. **General Consent for Treatment and Tests:** I consent to treatment by Seasons Comprehensive Women's Health's physicians and staff for my illness and/or health evaluations including but not limited to x-rays, blood tests, laboratory procedures, medications, and minor procedures. I acknowledge and agree that NO GUARANTEES have been made to me as to the results or outcome of my medical care. I understand that State Law requires physicians to report certain communicable diseases to the Health Department.

2. **Independently Practicing Doctors:** I understand and agree that most of the radiologists, pathologists, anesthesiologists, and some allied health professionals are engaged in the practice of their professions on behalf of themselves or other corporations. I hereby authorize payment directly to these physicians the insurance benefits otherwise payable to me, but not to exceed the total charges due to the physicians. I also authorize the release of any medical information necessary to process these insurance claims.

3. **Release from Liability for Leaving Against Medical Advice:** I agree that if I leave a physician's office against the advice of my physician or Seasons Comprehensive Women's Health medical staff, that Seasons Comprehensive Women's Health, its personnel, and my physician(s) are released from responsibility or liability for any injuries or damages which may result from my leaving against medical advice.

4. **Authorization to Release Medical Information:** I authorize Seasons Comprehensive Women's Health and all physicians involved in my care to disclose and release my medical information (which may include alcohol and drug abuse, psychiatric, sickle cell anemia, AIDS and HIV test results) to each other and to any person or organization which is or may be liable or responsible for payment of my bill, including Medicare intermediaries and fiscal agents.

I have read and understand this document and agree to the terms.

_____ _____

Signature of Patient/Authorized Party Relationship

_____ _____

Signature of Witness Date

FINANCIAL POLICY

Holston Medical Group believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to have an understanding of our financial policy.

1. **PAYMENT** is expected at the time of your visit. Just as we make every effort to accommodate you when you are in need of medical care, we expect that you will make every effort to pay your bill promptly. Payment is due at the time services are provided or upon receipt of a statement from our billing office. ***We will accept cash, check, debit, credit or health savings accounts***. You may also make a payment online through our patient portal, ***myHMG***.

   Payment will include any unmet deductible, co-insurance, co-payment amount or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause payment in full is expected at the time of your visit. For visits under a "global" or a follow up trauma visit (from a procedure performed by an HMG physician) or for ongoing rehabilitation treatment plans, you will only be responsible for your co-payment if applicable based on your insurance. We do ask for a ***copy of your current insurance card*** at the time of your visit to ensure we properly file your claim.

2. **SURGERY PATIENTS:** You may be responsible or required to pay a percentage of surgery charges prior to any surgeries or procedures. This will be determined by information given to us by your insurance company in regard to patient percent responsibility.

3. **INSURANCE:** We participate with several insurance plans and will file your claims on your behalf. It is your responsibility to ensure coverage for services prior to your visit. You will be responsible for the complete charges for any non-covered services provided. In addition, all co-payments, deductibles or non-covered charges will be due at the time of service.You must provide proof of insurance at each visit so we can ensure proper billing to your benefit plan. If there is an overpayment on your account, we will refund any overpayment to you after overpayment credit is applied to any outstanding account balance(s). We do not bill third party payors, but will be happy to provide a copy of the original claim if requested.

4. **HIGH-DEDUCTIBLE PLANS:** Under these plans, your insurance company will provide you a discount off our billed charges, but you are responsible for the entire amount due until you meet your deductible. ***We will accept cash, check, debit, credit or you may use your health savings account***.

5. **RETURNED CHECKS** will incur a $30.00 service charge.

6. **ACCOUNTING PRINCIPLES:** If there is an overpayment on your account, we will refund any overpayment to you after overpayment credit is applied to any outstanding account balance (s). Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding date of service

7. **FORMS FEES:** Medical records, except those involving worker's compensation cases, will be billed at the rates listed below:

   Simple Forms (completed within 2 business days)
   DURING an office visit: No Charge
   AFTER an office visit: $5 / form
   Examples of Simple Forms: Handicap tag/sticker, work re-entry forms, immunization, medication, sports, concussion clearance, WIC, Home Bound Status Short form, Disability Short Form, Bank Loan Form, Foster Parent Health Form, College & Camp Forms

   Complex Forms: $25 (completed within 10 business days)
   Examples of Complex Forms: FMLA (per illness per year), Disability Long Form, Home Bound Status Long Form.

FINANCIAL POLICY

8. **MISSED APPOINTMENTS:** If you fail to cancel a previously scheduled appointment at least 24 hours in advance, you may be charged a fee as outlined below:

- Established office visit: $20
- Allergy Testing: $75
- New patient visit or consultation: $100
- GI Procedure: $250

This charge cannot be billed to the insurance company. Failure to pay a no show fee will be treated according to our policy on unpaid balances, with the exception of collection accounts. This charge is not applicable to patients with Medicaid/TennCare insurance coverage.

After 2 no-show appointments in a rolling calendar year, you may be discharged from the practice, at the discretion of the responsible provider and management. Medical care will not be withheld for a medical emergency for thirty days from date of dismissal.

9. **UNPAID BALANCES:** All outstanding balances shall be due within 30 days of the date of service. At that time, all past due balances in their entirety must be paid prior to the time of your next visit. Balances that remain outstanding for a period of 90 days or more may be referred to a collection agency and could affect your credit.

10. **FINANCIAL DISMISSAL**: Patients who do not make payment arrangements risk being dismissed from the practice. Holston Medical Group reserves the right to dismiss patients for delinquent financial accounts on personal balances. If dismissed, medical care will not be withheld for a medical emergency for thirty days from date of dismissal.

11. **BILLING QUESTIONS:** We will be happy to help you resolve your balance and can be reached at **(423) 578-1802, Monday – Friday 8:00AM – 5:00PM.**

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FINANCIAL POLICY

MRN#: _____

Date Received: _____

Holston Medical Group believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to have an understanding of our financial policy.

I have read, understand and agree to the Financial Policy as provided to me. I understand that charges not covered by my insurance company, as well as applicable co-payments, deductibles and any charges older than 30 days from the date of service are my responsibility.

I authorize Holston Medical Group to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim. I authorize my insurance benefits be paid directly to Holston Medical Group.

By signing below, I indicate my agreement with the policy as provided to me.

_____	_____	_____
Date	**Signature**	**Printed Name**

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NO SHOW POLICY

Welcome to Holston Medical Group. Please take time to review the following information pertaining to our policy for no show appointments.

We understand that scheduling conflicts occur from time to time. However, we request at least two hours advance notice if you are unable to keep your scheduled appointment(s). Two or more missed appointments may result in your family being dismissed from Holston Medical Group. Patients that fail to show up for a scheduled appointment may be charged a fee for not providing the office with prior notice of cancellation.

Holston Medical Group physicians have developed our No Show policy in an effort to better serve our patients by providing same day appointments to those who are sick and need to be seen. If someone schedules an appointment and does not show for the visit, we have lost an available time that could have been used for a sick patient.

We look forward to providing your health care needs. Your understanding and cooperation helps us to provide available appointments for patients who urgently need them.

Please sign below as confirmation that you have read, acknowledge and understand our policy regarding no show appointments.

Please Print Patient Name	Date of Birth	Account Number

Please Sign Authorized Representative	Relationship to Patient

Witness	Date

ADVANCE DIRECTIVES

What happens if you become too sick to make your own decisions regarding your medical care? Your family and doctor must decide what treatment to use, when not to treat, and/or when to stop treatment. Your family may not know what you would desire or may not agree on what would be best for you. It is best if they are aware of what you would desire and who you want to make these decisions on your behalf.

With the enactment of a federal law, The Patient Self-Determination Act, you have the right to make decisions about your future health care. This includes the right to accept or refuse medical or surgical treatment and to place and direct the types of health care you may receive if you become unable to express your wishes. You can exercise this right by making an Advance Medical Directive.

Different providers have, in accordance with the state law, varying practices regarding the implementation of an advance directive. Information regarding such practices must be made available to you, upon request, when selecting or receiving care from the provider.

If your physician, as a matter of conscience, is unable to comply with your directives, he/she must take all reasonable steps to arrange to transfer you to another physician.

WHAT IS AN ADVANCE DIRECTIVE?

An advance directive explains, in writing, your choices about the treatment you want or do not want, or about how health care decisions will be made for you if you are too ill to express your wishes.

An advance directive expresses your personal wishes and is based upon your beliefs and values. When you make an advance directive, you will consider issues like dying, living as long as possible, being kept alive on machines, being independent, and the quality of your life.

Use of an Advance Medical Directive makes it possible for your wishes to be carried out during a serious illness.

If you are an adult and of “sound mind”, you can make an advance directive.

There are two types of formal advance directives. You can complete either a Living Will, a Power of Attorney for Health Care, or both.

LIVING WILL

A Living will informs your physician that you want to die naturally if you develop an illness or injury that cannot be cured. It tells your physician that, when you are near death or in a vegetative state, he or she should not use life-prolonging measures which postpone, but do not prevent, death.

A Living Will allows you to refuse treatments or machines which keep your heart, lungs, or kidneys functioning when they are unable to function on their own.

POWER OF ATTORNEY FOR HEALTH CARE

The Power of Attorney for Health Care is a form that you may complete to appoint another person (a “health care agent’) to make health decisions for you if you are not capable of making them yourself.

MAINTAINING YOUR ADVANCE DIRECTIVE

You should review and update your advance directive periodically. You have the right to change or discontinue your directive at any time. You should keep your advance directive in a safe place where you and others can easily find it. (Do not keep it in a safety deposit box.) You should make sure your family members and your lawyer, if you have one, know you have made an advance directive and know where it is located. Be sure your physician has a copy of your directive in your medical file.

WILL ALL STATES RECOGNIZE MY DIRECTIVES?

If you plan to spend time in a state other than your state or residence, from which you obtained your Advance Medical Directives, you may wish to execute advance directives in compliance with that state’s laws as well.

Specific question should be directed to your physician and/or attorney for guidance.

Follow the instructions provided by your state when completing the Advance Directives forms.

To obtain additional information, brochures, or forms, you may write to the address below:

Tennessee Commission on Aging
Nashville, Tennessee 37243-0860

I have read and understand the above:

Name: _____

Signature: _____ Date: _____

Date of Birth: _____ MRN: _____