**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______________________________

**MRN:** _________________________
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**DATE RECEIVED:** _______________

# 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 24-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 who 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

___________________________________ ____________________________
Patient Signature / Authorized Representative Relationship to Patient

___________________________________ ____________________________
Witness Date

Holston Medical Group complies with applicable Federal civil laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Holston Medical Group does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Attention: If you need language or translation services, please ask to speak with the Office Manager.
La atención: Si usted necesita servicios de idiomas o traducción, pida hablar con el Gerente de la oficina.
ان ت باه : إذا ك نت ب حاجة إل ى خدمات ال ل غة أو ال ترجمة، ي رجى أن ت ط لب ال تحدث مع مدي ر م ك تب .

Revised:

Patient's Name______________________________________ MRN____________________

## FINANCIAL POLICY

1. **Proof of Insurance:** Please bring your insurance card(s) with you to every appointment. It is your responsibility to inform the receptionist when the cause of treatment should be billed to a med pay (auto insurance) company instead of your regular primary insurance. It is your responsibility to inform this office of any change in insurance coverage.

2. **Payment is due at Time of Service** : We accept cash, personal checks, debit and credit cards (Visa/MasterCard). All deductibles, co-pays, percentages, and non-covered services are due at the time of service unless payment arrangements have been made in advance. If you have Medicare they may deem the treatment as "medically unnecessary." According to HCFA payment guidelines, you will be asked to sign a waiver (Advanced Beneficiary Notice) prior to treatment and payment is due at the time of service. All Medicare patients will be required to pay the 20 percent co-pay based upon the current Medicare Fee Schedule at checkout unless proof of a secondary insurance policy is presented. Predetermined co-pays are due when you check in for your appointment. If your co-pay is based on a percentage and you do not have a secondary policy, please be prepared to pay a minimum amount on the date of service.

3. **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.

4. **Assignment of Insurance Benefits/Promise to Pay:** For and in consideration of services rendered (and to be rendered) by Seasons Comprehensive Women's Health, I hereby guarantee payment for all charges incurred for the account of the named patient. I understand and agree that payment for such services shall be due at the time of service. I authorize and direct any person, firm, or corporation including but not limited to insurance companies or attorneys representing the patient or any other party for such services to assign proceeds of any payment for services rendered to said patient directly to Seasons Comprehensive Women's Health. I understand that by Seasons Comprehensive Women's Health accepting assignment of said benefits that the provider does not relinquish its right to collect any balance not paid by any third party. I further agree that if such indebtedness is placed in the hands of a collector or attorney for collection that I will pay reasonable collection fees and attorney fees, interest, court costs, and other collection expenses.

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

______________________________________ ____________________
Signature of Patient/Authorized Party Relationship

______________________________________ ____________________
Signature of Witness Date

**Patient:** ______________________________

**MRN:** ______________________________

# Communicating with Seasons
## Obstetrics & Gynecology

### Access to Your Physician and Staff

Your Seasons health care team can be reached either by telephone or electronically through our patient portal, Follow my Health. If you wish to communicate electronically, you may sign up at any office location on our website at your convenience. Please remember, electronic communication is for routine matters and never should be used for emergencies.

It **<u>is not</u>** appropriate to communicate with your health care team through social media, such as **Facebook**, or **texting**. Your privacy is important to us and these are not secure methods of communication. Any questions or concerns should be directed to the patient portal or office during normal business hours.

### After Hours Care

Seasons is dedicated to serving our patients 24 hours a day, 7 days a week. The most effective way to serve you is during regular clinic hours, but we understand acute illnesses can occur at any time. For further instructions on how to contact the Seasons Physician on Call, please contact your Seasons office directly @423-990-2450.

### Prescription Refills

To avoid delays and busy phone lines, the best time to obtain your medication refills is at your office visit. While we realize there may be a need to request a refill via telephone or patient portal, please allow at least 48 hours for all refill request before checking with your pharmacy.

Sample medication will only be distributed during normal business hours.

**Signature:** ______________________________ **Date:** ________________

**Witness:** ______________________________ **Date:** ________________

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