Tennessee Health and Wellness

Welcome to Tennessee Health and Wellness. Please take the time to complete all the information below so that we can better serve you.

Intake Form

Date: _____

Patient's Full Name: _____

Address: _____

City_____ State_____ Zip_____

Phone: Cell _____ Home _____ Work _____

Email Address: _____

Date of Birth: _____ Age: _____ Martial Status: S - M - D - W

Occupation: _____

Pharmacy: _____

Emergency Contact and Phone Number: _____

Advance Directive Y/N If yes, please provide copy to our office at your earliest convenience.

Legally authorized representative Y/N If yes, please provide name and number

_____

How did you hear about our office: _____

Primary Care

Provider:_____

INTAKE FORM

Past Health History

1: List current Allergies: _____

2: Prior Surgeries: _____

3: Any history of: Arthritis Cancer Diabetes Strokes/TIA's Heart disease

Other Diseases: _____

Family Health History

1: Any Family history of: Arthritis Cancer Diabetes Strokes/TIA's Heart disease

Other Diseases: _____

2: Deaths in immediate Family: Father Mother Brother/Sister

Reason for Death: _____

Social History

1: Occupational activities: _____

2: Hobbies: _____

3: General Activity Level: Intense moderate mild sedentary

4: Alcohol use: Y / N

Have you ever felt the need to cut down on your drinking? Y / N

Have people Annoyed you by criticizing your drinking? Y / N

Have you ever felt Guilty about drinking? Y / N

Have you ever felt you needed a drink first thing in the morning (eye opener) to steady your nerves or to get rid of a hangover? Y / N

5: Tobacco use: Y / N Caffeine use: Y / N Drug use: Y / N

Medications

_____

_____

_____

_____

Consent

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and **INITIAL YOUR AGREEMENT.**

_____I instruct the providers for Tennessee Health and Wellness to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health.

_____I may request a copy of the **HIPAA Notice of Privacy Practices** and understand it describes how my health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

_____I realize that an x-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant at this time.

_____I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails, or health information to me as an extension of my care in this office.

_____I authorize payment of insurance benefits directly to Tennessee Health and Wellness and its providers. I authorize the provider to release all information necessary to communicate with personal physicians and other providers and payers to secure the payment of benefits.

_____ I achknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive any non-payment of services may be turned over to collections.

_____To the best of my abillity, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

_____I realize that it is CRITICAL that I am here for EVERY appointment in my treatment plan. This is a treatment regimen tailored to my needs. If needing to cancel and/or reschedule, please do so at least 24 hours prior to appointment and understand a $50 fee may be applied for not showing without notification for every 15 minutes that was blocked of the schedule for your appointment. If I am more than 20 minutes late, I may have to forfeit my appointment.

Please call 931-651-1918 to reschedule a make-up day if you anticipate a change in your schedule. If you do not show for two appointments without calling to cancel or reschedule you may receive a letter of dismissal from the program.

_____Your insuranced will be billed for only services rendered and they will notify you by sending you and Explanation of Benefits (EOB) statement. This document states their exact coverage and payment for each date of service. **We will insure accurate billing of all services**. If there are any discrepancies or additional balances that you are responsible for, we will notify you as soon as we are made aware of them from your insurance company. Your exact coverage is based on the specific plan you have chosen through your insurance carrier and is a contract between you and them alone. We have no control over their payment decisions.

_____Copays, Coinsurance, and Deductibles for services rendered are expected to be paid at each visit. If for any reason the request cannot be met, arrangements should be made in advance before seeing the provider.

How will payment be made today? (Please circle one) Cash - Check - Credit Card - Other _____

Signature: _____ Date: _____