Stephanie S. Becker, MD

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Holly M. Webb, FNP-BC

Dear Patient,

Welcome to Internal Medicine West. We are pleased that you have chosen us to provide your healthcare. Enclosed is information to help familiarize you with our practice as well as information to help us know more about you. We want you to know about our office procedures and methods of practice.

Please complete the New Patient Information Packet. All of this information must be completed and where appropriate signed prior to scheduling an appointment. For your convenience the packet can either be mailed or faxed back to our office.

Please bring your current insurance information and your insurance card with you to each of your appointments. We must have this information in order to file your claims. If you do not provide us with up to date insurance information, you will be responsible for any balance denied by your insurer.

Co-payments are due and must be paid at the time of each office visit. We are contractually obligated to collect your co-payment at the time of service. Co-payments cannot be billed. For your convenience, your co-payment can be paid with cash, check, or credit card. We accept American Express, Discover, MasterCard, and Visa. Failure to bring your insurance card or co-payment may result in the need to reschedule your appointment.

Also, you will find enclosed a Patient Information Sheet and Notice of Privacy Practices Acknowledgement. Please complete both and return with your other paperwork. If you would like a copy of our Privacy Notice, it is available at the front desk.

Please note, we require new patients to arrive 30 minutes early. If you do not keep your new patient appointment and fail to cancel it (no-show), you will not be able to reschedule with this office.

Thank you for choosing us to be your healthcare provider. We look forward to serving you. If you have any questions, please ask we are here to help you.

Internal Medicine West

9330 Park West Boulevard, Suite 402 • Knoxville, TN 37923
Phone: (865) 690-3003 • Fax: (865) 374-2143
www.imwknox.com

Internal Medicine West
A Member of Covenant Health
9330 Park West Blvd. Suite 402
Knoxville, TN 37923
Phone: 865-690-3003/ Fax: 865-374-2143

Date: ______________

PATIENT INFORMATION

Name (Last, First, Middle):	SSN#	Birthdate	Age	Sex

Mailing Address	City, State, Zip

Home Phone	Cell Phone	Email Address

Marital Status	Student Status ☐Full-Time ☐Part-Time	Smoker? Yes or No	Veteran (Y/N)?	Ethnicity: Hispanic or Non-Hispanic	Primary Care Physician

Referring Physician	Referring Physician Contact #	Other Medical Providers

Race (**Circle Answer**): African American, Alaskan Native, Asian, French, German, Greek, Hawaiian, Hispanic, Indian, Multi-Racial, Native American Indian, Pacific Islander, White	Language

Emergency Contact Name	Emergency Contact Phone #s Hm: Cell:

Employer Name and Address	Work Phone #

How did you learn about our office? Please circle one. Billboard Ad . Direct Mail Hospital Referral
Insurance Newspaper Ad Patient Referral Physician Referral Previous Patient
Internet Self-Referral Yellow Pages Other:

If patient is a minor, please fill out this portion

Parent or Guardian's Name:	Parent or Guardian's Phone #s Hm: Wk: Cell:

RESPONSIBLE PARTY INFORMATION (if different from above)

Name (Last, First Middle)	SSN#	Birthdate	Sex

Address	City, State, Zip

Home Phone	Cell Phone	Work Phone	Relationship to patient

PRIMARY INSURANCE

Name of Insurance Company	Name of Insured	Address of Insured (if different than address above)	
Insured's Birthdate	**Insured's SSN #**	**Insured's Insurance ID #**	**Relationship to patient**

SECONDARY INSURANCE (if applicable)

Name of Insurance Company	Name of Insured	Address of Insured (if different than address above)	
Insured's Birthdate	**Insured's SSN#**	**Insured's Insurance ID #**	**Relationship to patient**

Workers Compensation

Are you here for workers compensation YES_____NO_____ Date:

Accident

Auto ☐ Work ☐ Other ☐ Date of Accident:

Do you have any Advanced Directives? (e.g., Living will or Advanced Care Plan) Yes_____ No_____
Do you have a Power of Attorney? Yes_____ No_____
If yes to the above questions please make sure we have a copy for your medical record.

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IN CONSIDERATION OF THIS PHYSICIAN PRACTICE (THE "PRACTICE") FURNISHING SERVICES TO THE PATIENT, PATIENT (OR PATIENT'S LEGALLY AUTHORIZED REPRESENTATIVE, ON PATIENT'S BEHALF) AGREES AS FOLLOWS:

I. CONSENT TO MEDICAL TREATMENT AND SERVICES: The below-signed individual hereby authorizes the Practice and its associated professionals to furnish medical treatment and services to the patient, including medical treatment and services furnished through telehealth visits, and consents to diagnostic and therapeutic medical care, items, services, and procedures furnished by the Practice, its professionals, and their assistants and designees. Such consent includes consent to photographic/video documentation of the patient's medical treatment as the patient's treating professional finds medically necessary. There are potential risks and hazards to any medical treatment or service, and there is no guarantee any particular treatment or service furnished by the Practice or its professionals will be successful. It is the Practice physician's responsibility to provide adequate information concerning a proposed treatment or service and to obtain any additional necessary consent before proceeding except as limited by emergency or other time-sensitive circumstances. The Practice's staff may obtain signature for such consent. The patient has the right to question and refuse treatment; however, if a proposed treatment is refused, the undersigned agrees CMG, the Practice, and their associated professionals and staff shall be released from any and all liability for failure to provide treatment to the patient.

TELEMEDICINE: The Practice and its associated professionals deliver certain health care services by virtual means, including without limitation, through telehealth (interactive audio and video), patient portal communications, and by telephone (collectively, "Virtual Services"). **RISKS AND BENEFITS:** Benefits of Virtual Services include enhanced access to care, patient convenience, and reduced risk of exposure to communicable disease. Medical information is protected to the same extent as in a face-to-face visit, although confidentiality and privacy at the patient's location is not controlled by the Practice. There are risks and limitations to Virtual Services. Virtual Services and care may not be as complete as face-to-face services as a result of a practitioner's potential lack of access to all diagnostic modalities/medical equipment necessary to obtain vital signs, labs, and other pertinent health information to treat the patient, lack of access to complete medical records, and problems with information transmission, including missed information or inaccurate information being transmitted, that could affect a practitioner's medical decision-making. Further, although the Practice uses available encryption and privacy modes for Virtual Services, it is also possible security protocols could fail, causing a breach of privacy of medical information. The alternative is a face-to-face visit, which the patient may request at any time, but an equivalent in-person service may not be available at the same location or time as a Virtual Service. During a Virtual Service, a practitioner may perform a physical exam through the use of technology or a facilitator in the room with the patient. Not all medical conditions can be treated as effectively through a Virtual Service, including emergency conditions. If a practitioner determines a face-to-face evaluation is needed, the patient will be referred to an appropriate location for such evaluation. A practitioner can withdraw from a Virtual Service for any reason, including when, in the practitioner's medical judgment, treatment is not safe, private, or effective. In such event, the practitioner can instruct the patient to seek in-person care and the patient agrees to follow such instruction, including for emergency care. Virtual Services are subject to charges, copayments, and deductibles consistent with this Agreement. **CONSENT TO TREATMENT VIA VIRTUAL SERVICES:** By electing to proceed with a Virtual Service, the undersigned has been informed of the risk and benefits of Virtual Services, understands and agrees to the above, and consents to medical treatment or consultation by means of a Virtual Service.

II. CONSENT TO COMMUNICABLE DISEASE TESTING: The below-signed individual consents for the patient to be tested for hepatitis, human immunodeficiency virus infection, or any other blood-borne infectious disease, as well as for any other communicable disease or condition, if and when another patient, a health care practitioner, or other individual furnishing services to patient at the Practice, a Practice employee, or an emergency aid worker has a potential exposure from the patient. If such testing becomes necessary, it will be performed at no charge to the patient.

III. CALCULATION AND PAYMENT OF CHARGES: The patient is liable and individually obligated for payment of the Practice's charges on the patient's account and the undersigned individual understands and agrees to the following: (1) The Practice's charges are set out in a chargemaster, the relevant portions of which may be examined for purposes of verifying the patient's account during regular business hours in our billing office. The Practice reserves the right to change the rates in the chargemaster. Charges on the patient's account are calculated based on chargemaster rates in effect as of the date charges for items or services are accrued. (2) The patient is liable for the uninsured portion of the Practice bill, which is due in full when services are rendered. Any amount not paid in full by insurance, for any reason, is the responsibility of the patient. (3) The Practice has both an uninsured patient discount policy and an indigent care policy. If the patient is uninsured, the patient is automatically entitled to a discount on chargemaster rates in accordance with the Practice's uninsured patient discount policy. In addition, if the patient is uninsured and meets certain criteria set forth in the Practice's indigent care policy (including, without limitation, income criteria), the patient may be entitled to further discounts to chargemaster rates. Please contact the Practice's financial counselors in our office or the CMG billing office at 865-374-5200 for more information. (4) The amount of the patient's Practice charges may differ from amounts other patients are obligated to pay based upon each patient's insurance coverage, Medicare/Medicaid coverage, or lack of insurance coverage. The amount of any discount from charges varies based on the circumstances applicable to each individual under the Practice's policies. (5) After reasonable notice, delinquent accounts may be turned over to a collection agency and/or attorney for collection. The patient agrees to pay the costs of collection, including court costs, reasonable attorney fees, collections charges, and reasonable interest charges, associated with Practice's efforts to collect amounts due.

IV. MEDICARE/MEDICAID PATIENT CERTIFICATION AND ASSIGNMENT OF BENEFITS: The undersigned individual certifies that the information provided in applying for payment or reimbursement under Titles XVIII and XIX of the Social Security Act is true and correct. Further, the undersigned certifies that correct and complete information has been provided regarding the patient's insurance, HMO, health plan, workers' compensation, or other coverage for services and items furnished to the patient by the Practice, and the undersigned consents to the Practice's billing such payers for items and services furnished by the Practice to patient. The undersigned hereby irrevocably assigns to CMG (or, if Practice professionals are not CMG employees, to Practice) all rights, title, and interest in compensation or payments otherwise payable to the patient, or received by or on behalf of the patient, for Practice items or services from any source or payer on file for the patient's account,

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including Medicare/Medicaid/TennCare, insurance companies, HMOs, and any other third-party payer or financially responsible person, not to exceed charges for services or items rendered. Any person, corporation, or government entity having notice of this assignment is authorized and directed to pay directly to CMG (or, if Practice professionals are not CMG employees, to Practice) all amounts due for health care items and services provided to the patient by the Practice. Except as provided in Section III or by law, the patient is financially responsible to the Practice for the charges not covered by these authorizations. The undersigned understands there are certain items and services for which payers, including Medicare and TRICARE/CHAMPUS/CHAMPVA, do not pay. Any sums not paid by a third-party payer are the patient's obligation. **The patient is responsible for all health insurance or health plan deductibles and co-insurance, as well as noncovered or excluded items or services.** If it is later determined the patient has an HMO or other health plan primary to Medicare and failed to inform the Practice prior to service of such election, the patient shall be responsible for paying the account. In the case of series services furnished to the patient by Practice, this Agreement shall remain in full force and effect for all such series services until specifically revoked in writing. The undersigned agrees to sign such further documents as may be reasonably requested to confirm and substantiate the Practice's or CMG's rights hereunder. The undersigned further agrees that a copy of this assignment may be used in place of the original copy.

V. RECEIPT OF NOTICE OF PRIVACY PRACTICES; CONSENT TO USE AND DISCLOSE HEALTH INFORMATION: The undersigned acknowledges receipt of the Practice's Notice of Privacy Practices, which is provided at https://www.covenanthealth.com/privacy-notice/ and incorporated into this Agreement by reference, and consents to use and disclosure of the patient's protected health information and other patient records (a) consistent with such Notice, including without limitation, for purposes of the treatment, payment, and health care operations functions described in such Notice, whether through electronic health information exchange or otherwise; and (b) as authorized or permitted by federal or state law. Consistent with the above, the undersigned agrees to the Practice's disclosure of all or part of the patient's medical record for treatment purposes and to any person, corporation, or agency that is or may be liable for charges incurred at the Practice or for determining the necessity, appropriateness, amount, or other matter related to such services or charges, including, without limitation, insurance companies, HMOs, PPOs, workers compensation carriers, welfare funds, governmental health plans, the Social Security Administration, the Centers for Medicare & Medicaid Services, or any contractors of the same. The undersigned also consents to release by the patient's health plan or other insurance carrier to the Practice and CMG of any eligibility, utilization, or plan data concerning the patient's coverage that may be required.

VI. PATIENT IDENTIFICATION; PERSONAL VALUABLES: The undersigned consents to photographic documentation of the patient for purposes of identification and registration. Further, the undersigned agrees that Practice is not responsible for loss of or damage to any money, jewelry, eyeglasses, clothing, hearing aids, or other personal property.

VII. HEALTH PLAN NOTIFICATION/AUTHORIZATION; APPOINTMENT: If the patient's health plan, insurer, or other coverage requires notification/authorization as a condition of payment for services, the patient must provide such notification and obtain such authorization. The patient hereby assumes full financial responsibility for charges incurred as a result of failure to comply with prior notification/authorization requirements. Notwithstanding the foregoing, the undersigned hereby appoints Practice as patient's agent for purposes of requesting prior authorization for services Practice professionals order at a Covenant Health hospital (e.g., lab services) and agrees Practice may delegate such appointment to such hospital. The undersigned acknowledges there is no guarantee or assurance authorization will be obtained.

VIII. AMENDMENTS: Revisions to this Agreement are not effective or enforceable unless accepted in writing by a CMG corporate officer.

IX. CONTACTING PATIENT. Patient may be contacted at the following number: ________________. In addition, ***please check one of the following***:

☐ Practice may contact or leave messages regarding appointments and lab/test results with the following:

Name:____________________ Relation to patient:______________________ Phone:________________

Name:____________________ Relation to patient:______________________ Phone:________________

☐ Practice may not leave messages regarding appointments and lab/test results with anyone other than patient.

I HAVE READ AND UNDERSTAND THIS REGISTRATION AGREEMENT AND BY SIGNING BELOW, AGREE TO ITS TERMS. IF THE UNDERSIGNED IS NOT THE PATIENT, SUCH INDIVIDUAL HEREBY CERTIFIES THAT HE/SHE IS THE PATIENT'S AUTHORIZED REPRESENTATIVE AND HAS ALL NECESSARY LEGAL AUTHORITY TO ENTER INTO THIS AGREEMENT ON THE PATIENT'S BEHALF.

SIGNATURE: PATIENT (OR PATIENT'S LEGALLY AUTHORIZED REPRESENTATIVE)

SIGNED ____________________ PRINTED NAME ____________________

PATIENT NAME ____________________ RELATIONSHIP TO PATIENT ____________________

DATE and Time ____________________

A copy of this agreement will be provided on request.

APPOINTMENT CANCELLATION AND NO-SHOW POLICY

Last minute cancellation and same day no-shows make it difficult to serve other patients who are waiting to be scheduled. We ask that you give a twenty four (24) hour notice of cancellation or reschedule prior to your appointment if you will be unable to keep that appointment. We will be happy to reschedule your appointment. Scheduled appointments that you do not show up for, will result in a $25.00 fee. No show fees are the sole responsibility of the patient and will be billed to the patient.

Patient Printed Name:_________________________________ DOB:____________________

Patient Signature:_____________________________________Date:____________________

Prescription Refill Policy

Stephanie S. Becker, MD

Jeffrey S. Boruff, MD

Andrew D. Goins, DO

Karen T. Rader, MD

Marianne K. Solomon, MD

Jennifer J. Farmer, NP

Michelle E. Smith, NP

Tricia Underwood, NP

Holly M. Webb, NP

Our first concern is your safety. Prescription refills by telephone can only be granted during regular office hours allowing us to review your chart and ensure you receive the proper medication. While some prescriptions can be refilled without a re-evaluation in the office, a number of medications do require a periodic examination in the office and / or blood work to monitor the effectiveness and safety of your medication. All medication refills require an in-office evaluation within the last 12 months.

We have established the following guidelines to assist in the refill process:

1. Please contact your pharmacy for prescriptions that may be on hold before contacting our office.
2. Prescription refills will only be granted during office hours.
3. Controlled substances will only be prescribed at an office visit.
4. Antibiotics can only be prescribed after an in-office evaluation.
5. ***All prescription refill request received in our office will be processed within 24 to 48 hours***. We recommend you call your pharmacy prior to going to pick up the prescription to ensure the refill request has been processed. In the event a prescription refill cannot be renewed, you will be contacted by our office.
6. When prescribing medications we are bound by and comply with the laws of the State of Tennessee and the Federal Drug Administration. Mail order pharmacies operating outside The State of Tennessee, may be governed by a different set of laws and regulations. We will comply with any and all regulations or laws under which we are licensed.

All prescription refill requests require the following information for your safety:

1. Full name as it appears on your insurance card;
2. Date of Birth;
3. A telephone number where you can be reached;
4. The complete name of the medication, dosage and frequency;
5. The name and telephone number of your pharmacy;
6. Any medication allergies.

****Keep this copy for yourself****

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Physician Referral Policy

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Tricia Underwood, NP
Holly M. Webb, NP

Many employers select health insurance plans that require a patient's primary care doctor to submit a referral before the patient can see certain specialists, undergo diagnostic testing or be admitted to the hospital. While the primary care physician is required to request a referral, we do not have the authority to approve the request. The approval of the referral is granted solely at the discretion of the insurance company. In an effort to better serve you, our patient, we have established guidelines to ensure the referral process is accomplished in a smooth and timely manner.

Referrals will only be made for established patients. An individual must be seen and evaluated by our providers prior to the processing of any referral request.

If appropriate, we will be glad to assist you in locating a specialist in your network.

If you are requesting to continue care with a specialist, you must call our office to initiate renewing your referral at least five business days prior to your appointment with the specialist. You will need to contact the specialist and have them provide a written request documenting the continued care plan. Once all the information has been received, our providers will make a decision to either initiate the renewed referral or ask you to be seen by us prior to the renewed referral. When a specialist schedules an appointment for you with another provider it is their responsibility to ensure the appropriate referral process is initiated. If the specialist fails to initiate the referral, we will not be responsible for the referral process.

Same day referrals will only be done on an emergency basis.

*****Keep this copy for yourself*****

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www.imwknox.com

Welcome To Our Office!

Visit us on the web at: www.IMWKnox.com

Please answer all questions. This information is important for your health and our records.

Name: ______________________________

Date of Birth: ______________________

Employer: __________________________

Whom may we thank for referring you to our office? ______________________

In your own words, describe your problem and what brings you into our office today?

____

____

____

____

____

____

List all your present physicians:

	Physician	(2)	(3)
Name:	________	________	________
City:	________	________	________
Telephone:	________	________	________
Specialty:	________	________	________

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Medical History- Please list all of your medical problems; add any details that you feel may be helpful. (Additional space on back if needed)

Problem	**Problem**
1. ______	6. ______
2. ______	7. ______
3. ______	8. ______
4. ______	9. ______
5. ______	10. ______

1. MEDICATIONS

Medications – Please list medications & supplements, dosage of each and the frequency taken.

	Medication	**Dose**	**Directions/Frequency**
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Preferred Pharmacy

Name: ______________________ Phone: ______________

Address: ____________________________

Allergies

List any medications, food, or other substances to which you have had an allergic reaction, and describe the allergic reactions.

☐ No Known Allergies

Medication/Other	Allergic Reaction
______________________	______________________
______________________	______________________

Surgeries – List any surgeries you have had, the reason for surgery, at what hospital your surgery was performed, and the year of the surgery:

☐ No Previous Surgeries

	Surgery	Reason	Hospital & State	Year
1.	____________	____________	____________	____
2.	____________	____________	____________	____
3.	____________	____________	____________	____
4.	____________	____________	____________	____
5.	____________	____________	____________	____

Social History

1. Are you? ☐ Single ☐ Married ☐ Widowed ☐ Divorced

2. How many children do you have? ________________

3. Are you currently employed outside the home? ☐ Yes ☐ No
   Are you retired? ☐ Yes ☐ No If yes, Previous Occupation: ____________________

4. Have you ever smoked? ☐ Yes ☐ No If yes, the number per day? ______________
   How many years did you smoke? _____ Have you quit? ______ If so, when?_______

5. Do you drink alcoholic beverages? ☐ Yes ☐ No
   Amount per week? ____________________________
   If you previously drank heavily, how much? ___________________________________
   And when did you quit? ________________

6. Do you use illegal substances or drugs? ☐ Yes ☐ No If yes, which one(s)? ___________

Family History—List any relatives who have or had medical conditions including, but not limited to: Heart Attack, Stroke, Diabetes, Cancer, Thyroid Disease, Etc.

Relative	Medical Problems	Age at diagnosis	If deceased, reason?
Mother			
Father			
Siblings			
Paternal Grandfather			
Paternal Grandmother			
Maternal Grandfather			
Maternal Grandmother			

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Preventive History

MALE AND FEMALE

Please enter the most recent dates below (to the best of your knowledge- the year is okay)

Last physical	________	**Immunizations**	
Colonoscopy	________	Influenza (Flu shot)	________
Eye exam	________	Pnemovax 23 (traditional pneumonia vaccine)	________
Hepatitis A/B		Prevnar 13 (new pneumonia vaccine)	________
screening	________	Zostavax (shingles)	________
HIV Screen	________	Tetanus	________
		HPV (cervical cancer)	________

Women

What is the date of your last Pap-Smear?

____

Was it normal? ☐ Yes ☐ No

Have you had a hysterectomy?

☐ Yes ☐ No

If yes, what year? ________

If yes, were your ovaries removed?

What is the date of your last mammogram?

____

Was it normal? ☐Yes ☐ No

What is the date of your last bone density (DEXA)? ________

Men

PSA ________

Abdominal Ultrasound ________

Do you have a living will or advance directive?

☐ **Yes** ☐ **No**

Controlled Substances Policy

If you are taking controlled medications (i.e. pain, sleep or anxiety medications) on a regular basis, *please be advised that no controlled substances will be prescribed at your first visit with us.*

During your first visit we will decide whether we will be able to prescribe those medications for you in the future. We will need to review records from your prior prescriber.

If you have any questions regarding this policy, please do not hesitate to contact us prior to your first visit to clarify all uncertainties.

All patients who receive prescriptions for controlled substances from this office are subject to our drug screening policy at any or every visit. Effective October 1, 2013, a new Tennessee law (T.C.A. § 53-11-308) requires us to do regular mandatory urine drug testing.

If you take pain medications on a regular basis be aware that **we DO NOT treat chronic pain** at this office.
Please note that we **DO NOT** prescribe the following medications at this office:
Opana, Methadone, Dilaudid, Morphine, Oxycontin, **Fentanyl and Suboxone**.

Please sign this page to indicate that you have read and understood this controlled substance policy.

Patient Signature: ______________________________ Printed Name: ____________________

Date: ______________________________ Date of Birth: ____________________

NO SHOW POLICY

New patients will not be re-scheduled after a no show to their appointment.
*Please give our office at least 24 hour notice if you need to cancel or reschedule an appointment. Cancellations without 24 hour notice will be counted as a no show.
After three no shows in a year, we will unfortunately no longer be able to see you. Please sign below that you understand this policy

Patient signature: ____________________________ Date: ________________