StoneCrest Internal Medicine
300 StoneCrest Blvd, Suite 110
Smyrna,TN 37167
Office: 223-9233 Fax: 768-7833

Welcome To Our Practice!

You, the patient, are the most important person in our office. We are committed to providing you with the best possible medical care. Excellence is our goal. We have worked to provide a full range of services and have highly trained and knowledgeable staff.

Please review and familiarize yourself with our office policies:

Office Procedures

Phones: Telephones are answered Monday through Friday 8am to 5pm.
Emergencies: For life threatening situations, call 911. If you have an urgent problem, please call our office for instructions. After hours, our answering service will inform you of how to reach a physician on call.
Test Results: For test results, we will follow up with you within 5 to 7 days. Abnormal results will be followed up as soon as possible.
Prescriptions: All prescriptions and refill requests should be requested during normal business hours. **Please have your pharmacy fax your refill request to (615) 768-7833 for medication renewals.** Please allow 24 to 48 hours for completion of the request. Be sure to call the pharmacy to see if the prescription is ready. Under no circumstances will pain medicine be called in during weekend hours or after hours. All mail order prescriptions will be written out and given to the patient. It is your responsibility to mail or fax this to your pharmacy insurance plan.
Phone Messages: Messages will be returned in 24 to 48 hours. Repeated phone calls will only delay the processing of your request.
Form Requests: If you are requesting forms to be filled out, please schedule an appointment or a fee of $25.00 will be charged. Payment will be expected upon completion of the form.
Lab work: All lab work requires an appointment with the physician prior to labs being drawn.

Appointments For an appointment please call (615) 223-9233

- Please call in advance for routine office visits. Make follow-up appointments as you leave. We make every effort to stay on schedule, although emergencies arise. If we are seriously delayed, we attempt to notify patients beforehand.
- As a courtesy to other patients and staff, please notify our office as soon as possible if you are unable to keep your appointment. If you are **15 minutes** past your scheduled appointment time, we will need to reschedule. Multiple no-shows will result in termination from our practice.

Financial Policy

Co-payments and any outstanding balances are expected at the time of service. Insurance is filed as a courtesy; however, the patient is financially responsible for all services rendered. Patient accounts not paid promptly are subject to third part collections and/or legal procedures.

- If we are not a participating provider with your plan, we will provide you with a receipt for you to file with your insurance company.
- Any check returned from the bank will result in an additional **$30.00 charge** that will appear on your account.
- If your insurance carrier has not responded to a claim within 90 days, we reserve the right to formally transfer all associated liability for the claim to the patient/ guarantor. Failure to promptly resolve balances may result in third party collection and/ or legal procedures be taken. Please keep a close watch for carrier claim payment and contact the insurance carrier

or clinic patient accounts representative at (615) 223-9233 in the event a claim is not resolved within 60 days from the date of service.

- We realize that emergencies do arise that may affect timely payment of your account. If such extreme cases do occur, please contact a patient account representative at (615) 223-9233.
- Please always notify our office of any change in name, address, phone, or insurance information.
- We accept: ***Visa, MasterCard, and American Express, Cash, or Check.***

Insurance

Prior to your appointment, please check your insurance information so you will be informed about referrals, co-payments, and any deductible required at the time of the visit.

- For your first visit, please bring your insurance card and arrive early to complete necessary patient information forms.
- We accept Medicare as well as most insurers, however, please review all insurance information with our staff prior to services being rendered.
- Your health insurance contract is between you and your insurance company. Any complaints regarding your coverage should be directed to your carrier.
- Referrals: Please allow 48 hours for referral processing.

What do we need from you?

- To inform the medical practice staff of any pertinent changes in insurance, employment, demographic information, or relationships with other care/service givers.
- To arrive on time for scheduled appointments and cancel, when necessary, with a phone call.
- To provide payment for services requested and delivered by the medical practice not covered by insurance within 90 days.
- To notify the medical practice of any change in his/her health status.
- To follow the recommended treatment plans and inform the medical practice of any physical or mental impairment requiring special accommodation.
- To ask questions if directions and procedures are not understood.
- Bring all medicine bottles with you to every appointment.

Driving Directions

From downtown Nashville:
Take I-24 East to exit 66B. Turn right at the first traffic light onto StoneCrest Pkwy. The Physician Building is at the far right corner of the hospital.

From Murfreesboro:
Take I-24 West to exit 66. Turn right at the first traffic light onto StoneCrest Pkwy. The Physicians Building is at the far right corner of the hospital.

Patient Signature_____ **Staff Signature**_____

StoneCrest Internal Medicine

Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require you to read and sign prior to treatment.

Payment is due at the time of service. We accept cash, check, or Visa/ MasterCard.

Regarding Insurance

We file your insurance as a courtesy. The balance is your responsibility whether or not your insurance pays. We cannot file your insurance if you do not provide us with a copy of your insurance card. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If we should file a claim for your services and your insurance company has not responded within forty-five days, you will be expected to pay the balance in full at that time. Please be aware that some, perhaps all, of the services provided may not be covered under your insurance plan.

Self-Pay Accounts

If a patient does not have insurance coverage, they are considered "self-pay accounts." Payments for all services (office visit, lab work, injections, etc.) are due at the completion of each visit. A 20% discount is given at the time of service and when payment is collected.

Regarding insurance plans when we are a participating provider: All co-pays and deductibles are due at the time of service. In the event that your insurance coverage changes to a plan where we are not a participating provider, refer to the above paragraphs.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Minor Patients

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for payment. For unaccompanied minors, non-emergency treatment will be denied unless accompanied by an adult.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read the financial policy. I understand and agree to this financial policy.

Signature_____ **Date**_____

Patient Name_____ **DOB**_____

Patient Registration Form

StoneCrest Internal Medicine

Patient Information **Please Print**

__Dr. __Mr. __Mrs. __Ms. __Jr. __Sr. __Other_____

Patient's Name (Last)_____ (First)_____ (Middle)_____

Also Known As Name (Last)_____ (First)_____

Marital Status __ Married __ Single __Divorced __Widowed __Legally Separated __Other

Social Security Number_____-_____-_____ __Female __Male Date of Birth____/____/____

Email address_____

Phone Numbers: Daytime_____ __ Home __Work Cellular_____

Evening _____ __Home __Work Other_____

Address_____ City, State, Zip_____

Employment Status: __Employed __Full-Time Study __Part-Time Student __Retired __Self-Employed __Unemployed

Employer_____ Occupation_____

Emergency Contact Name_____ Relationship_____ Phone number_____

Do you have a living will? _____ How did you hear about our office? _____

Responsible party Information

Responsible Party Name (Last)_____ (First)_____ (Middle)_____

Also Known as (Last) _____ (First)_____ (Middle)_____

Social Security Number_____-_____-_____ __Female __Male Date of Birth____/____/____

Email address_____

Phone Numbers: Daytime_____ __ Home __Work Cellular_____

Evening _____ __Home __Work Other_____

Address_____ City, State, Zip_____

Employment Status: __Employed __Full-Time Study __Part-Time Student __Retired __Self-Employed __Unemployed

Employer_____ Phone Number_____

Relationship to Patient_____

Primary Insurance Information

Name of Subscriber _____Relationship to Subscriber _____

__ Male __ Female Subscriber DOB ____/____/____ Subscriber Social Security Number_____-____-_____

Insurance Company/Phone Number_____ (____) _____

Insurance Company Address _____

Subscriber/ Policy ID _____ Group ID_____ Co-pay $_____

Effective Date _____ Termination Date _____

Secondary Insurance Information

Name of Subscriber _____Relationship to Subscriber _____

__ Male __ Female Subscriber DOB ____/____/____ Subscriber Social Security Number_____-____-_____

Insurance Company/Phone Number_____ (____) _____

Insurance Company Address _____

Subscriber/ Policy ID _____ Group ID_____ Co-pay $_____

Effective Date _____ Termination Date _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient/ Responsible party Signature_____Date_____

StoneCrest Internal Medicine

Patient Consent Form

Please Read and Sign

I, the undersigned, hereby consent to the following treatment:

- Administration and performance for all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in my treatment
- Use of prescribed medication
- Performance of diagnostic procedures/ tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.
I understand that StoneCrest Internal Medicine may include consent at satellite offices under common ownership.
I, the undersigned, acknowledge that StoneCrest Internal Medicine will use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.
A photocopy of this consent shall be considered as valid as the original.

Medicare Patients: I authorize to release medical information about me to the social security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to StoneCrest Internal Medicine.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Patient (or Responsible Party) Signature ***Date***

I acknowledge that I have been given the StoneCrest Internal Medicine Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official. ***Patient Initials***_____

SYSTEM REVIEW:

Doc[illegible] the positive & pertinent negative responses
- Fo[illegible]XTENDED" system review - at least 2 systems
- For a "COMPLETE" system review - at least 10 systems (Dictate responses to pertinent systems, then state: "All other systems negative")

- CONSTITUTIONAL SYMPTOMS
  - Good general health lately ..... No Yes
  - Recent weight change ..... No Yes
  - Fever ..... No Yes
  - Fatigue ..... No Yes
  - Headaches ..... No Yes

- EYES
  - Eye disease or injury ..... No Yes
  - Wear glasses/contact lens ..... No Yes
  - Blurred or double vision ..... No Yes
  - Glaucoma ..... No Yes

- EARS/NOSE/MOUTH/THROAT
  - Hearing loss or ringing ..... No Yes
  - Earaches or draining ..... No Yes
  - Chronic sinus problems or rhinitis ..... No Yes
  - Nose bleeds ..... No Yes
  - Mouth sores ..... No Yes
  - Bleeding gums ..... No Yes
  - Bad breath or bad taste ..... No Yes
  - Sore throat or voice change ..... No Yes
  - Swollen glands in neck ..... No Yes

- CARDIOVASCULAR
  - Heart trouble ..... No Yes
  - Chest pain or angina pectoris ..... No Yes
  - Palpitation ..... No Yes
  - Shortness of breath with walking or lying flat ..... No Yes
  - Swelling of feet, ankles or hands ..... No Yes

- RESPIRATORY
  - Chronic or frequent coughs ..... No Yes
  - Spitting up blood ..... No Yes
  - Shortness of breath ..... No Yes
  - Asthma or wheezing ..... No Yes

- GASTROINTESTINAL
  - Loss of appetite ..... No Yes
  - Change in bowel movements ..... No Yes
  - Nausea or vomiting ..... No Yes
  - Frequent diarrhea ..... No Yes
  - Painful bowel movements or constipation ..... No Yes
  - Rectal bleeding or blood in stool ..... No Yes
  - Abdominal pain or heartburn ..... No Yes
  - Peptic ulcer (stomach or duodenal) ..... No Yes

- GENITOURINARY
  - Frequent urination ..... No Yes
  - Burning or painful urination ..... No Yes
  - Blood in urine ..... No Yes
  - Change in force of strain when urinating ..... No Yes
  - Incontinence or dribbling ..... No Yes
  - Kidney stones ..... No Yes
  - Sexual difficulty ..... No Yes
  - Male - testicle pain ..... No Yes
  - Female - pain with periods ..... No Yes
  - Female - irregular periods ..... No Yes
  - Female - vaginal bleeding ..... No Yes
  - Female - # of pregnancies _____ # of miscar[illegible]es _____
  - Female - date of last pap smear _____ _____

- MUSCULOSKELETAL
  - Joint Pain ..... No Yes
  - Joint stiffness or swelling ..... No Yes
  - Weakness of muscles or joints ..... No Yes
  - Muscle pain or cramps ..... No Yes
  - Back pain ..... No Yes
  - Cold extremities ..... No Yes
  - Difficulty in walking ..... No Yes

- INTEGUMENTARY (skin, breast)
  - Rash or itching ..... No Yes
  - Change in skin color ..... No Yes
  - Change in hair or nails ..... No Yes
  - Varicose Veins ..... No Yes
  - Breast pain ..... No Yes
  - Breast lump ..... No Yes
  - Breast discharge ..... No Yes

- NEUROLOGICAL
  - Frequent or recurring headaches ..... No Yes
  - Light headed or dizzy ..... No Yes
  - Convulsions or seizures ..... No Yes
  - Numbness or tingling sensations ..... No Yes
  - Tremors ..... No Yes
  - Paralysis ..... No Yes
  - Stroke ..... No Yes
  - Head injury ..... No Yes

- PSYCHIATRIC
  - Memory loss or confusion ..... No Yes
  - Nervousness ..... No Yes
  - Depression ..... No Yes
  - Insomnia ..... No Yes

- ENDOCRINE
  - Glandular or hormone problem ..... No Yes
  - Thyroid disease ..... No Yes
  - Diabetes ..... No Yes
  - Excessive thirst or urination ..... No Yes
  - Heat or cold intolerance ..... No Yes
  - Skin becoming dryer ..... No Yes
  - Change in hat or glove size ..... No Yes

- HEMATOLOGIC/LYMPHATIC
  - Slow to heal after cuts ..... No Yes
  - Bleeding or bruising tendency ..... No Yes
  - Anemia ..... No Yes
  - Phlebitis ..... No Yes
  - Past transfusion ..... No Yes
  - Enlarged glands ..... No Yes

- ALLERGIC/IMMUNOLOGIC
  - History of skin reaction or other adverse reaction to:
    - Penicillin or other antibiotics ..... No Yes
    - Morphine, Demerol, or other narcotics ..... No Yes
    - Novocaine or other anesthetics ..... No Yes
    - Aspirin or other pain remedies ..... No Yes
    - Tetanus antitoxin or other serums ..... No Yes
    - Iodine methiolate or other antiseptics ..... No Yes
  - Other drugs/medicatio[illegible] _____
  - Known food allergie[illegible] _____

Name _____ DOB _____

TRI STAR MEDICAL GROUP
StoneCrest Internal Medicine

Patient Name_____ DOB_____

Address_____

_____

Please provide us with names, addresses, and telephone numbers of any physician who has seen you as a patient within the last two years.

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300 StoneCrest Blvd. • Suite 110 • Smyrna, Tennessee 37167
Phone: 615-223-9233 • Fax: 615-768-7833

TRI STAR MEDICAL GROUP
StoneCrest Internal Medicine

May StoneCrest Internal Medicine and/or members of the office staff release medical information to specified persons other than you? Yes_____ No_____

If yes, please specify to whom this information may be released:

Authorized Person	Relationship to You
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

If we need to contact you regarding an appointment, may we leave a message on your answering machine? Yes_____ No_____

If we need to contact you regarding lab or test results, may we leave a message on your answering machine? Yes_____ No_____

May we leave a detailed message with the people listed above regarding lab or test results? Yes_____ No_____

If we are unable to reach you by phone, may we mail results to your home? Yes_____ No_____

I understand that as part of my continuing healthcare, my physician maintains medical records in his/her office, which contain my health history, symptoms, examination test results, diagnosis and treatment plans, to be used as a basis for planning my care and treatment, and that this information may be released to my other physicians/healthcare.

I understand that I have the right to request restrictions as to how my medical record may be used or disclosed.

I understand that my physician keeps on premises a copy of the "Notice of Privacy Practices for Protected Health Information" which provides a more complete description of the uses and disclosures of my medical record, and that I have been provided the opportunity to review this document prior to signing this consent, and that a written copy will be provided to me on request.

I understand that my physician has the right to change this policy and that I will be notified in writing prior to any changes taking effect.

I understand that this document is a part of my permanent medical record, and that I may make changes regarding the disclosure of my health information at any time and that I need to notify my physician in writing of these changes.

_____ _____

Patient Signature Date

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HCA

StoneCrest INTERNAL MEDICINE

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient's Name:	**Birth Date:**	**Social Security Number:**	
Provider's Name:	**Recipient's Name:** StoneCrest Internal Medicine **Physician:**		
Provider's Address:	**Address 1:** 300 Stonecrest Blvd Suite 110		
	Phone/ Fax: P: 615-223-9233 F: 615-768-7833		
Phone/ Fax: P: F:	**City:** Smyrna	**State:** TN	**Zip:** 37167

Expiration Date or Event: This authorization will expire on the following expiration date (or) expiration event:)
Date: **Event:**

Purpose of Disclosure:

Description of Information to be Used or Disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below.
☐ No, then you may check as many items below as you need.

Description:	Date of Service:	Description:	Date of Service:	Description:	Date of Service:
☐ All PHI in Medical Record		☐ Operative Information		☐ Labor/Delivery Summary	
☐ Admission Form		☐ Cath Lab		☐ OB Nursing Assess	
☐ Dictation Reports		☐ Special Test/Therapy		☐ Postpartum Flow Sheet	
☐ Physician Orders		☐ Rhythm Strips		☐ Itemized Bill:	
☐ Intake/Output		☐ Nursing Information		☐ UB-92 Claim:	
☐ Clinical Test		☐ Transfer Forms		☐ Other:	
☐ Medication Sheets		☐ ER Information		☐ Other:	

I understand that:

1. I acknowledge, and hereby consent to such, that protected health information may include information such as; alcohol, drug abuse, mental health, AIDS or HIV testing or treatment. _____(Initial)
2. I may refuse to sign this authorization and my treatment will not be conditioned upon signature of the authorization (except for non-health related services such as pre-employment testing, life insurance exams, or drug screenings.)
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
5. There may be a reasonable fee to obtain a copy the information being requested on this form.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing? ☐ Yes ☑ No
If yes, the health plan or health care provider must complete Section B; otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No
If yes, describe:

Section C: Required Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Guardian/ or Personal Representative:	**Date Signed:**