HEALTHSTAR
PHYSICIANS, P.C.
www.HealthStarTN.org

New Patient Request Form

Patient's Name: _____ **DOB:** _____

Provider Requested: _____ **Current PCP:** _____

Date Requested: _____

Reason for wanting to be seen: _____

Please list ALL current medications:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Please list all medical conditions:

_____ _____
_____ _____
_____ _____
_____ _____

Please list any recent hospitalizations/outpatient procedures:

_____ _____
_____ _____
_____ _____
_____ _____

QM/May 2015

Please list any Specialists seen:

_____ _____

_____ _____

_____ _____

Comments:

_____

_____

_____

_____

_____

Patient Signature

Administrative use only below this line

_____

HS Account # _____

Approved □ **Declined** □

Reason for being declined:

_____

Insurance

_____

Signature _____ **Date** _____

Once determination is made, send a copy of this sheet to Administration for tracking purposes

HEALTHSTAR PHYSICIANS, P.C.
PATIENT INFORMATION SHEET

PLEASE PRINT

Date _____ Home Phone _____

Patient _____
Last Name First Name Middle Name

Street Address _____ City _____ State _____

Zip _____ Social Security Number _____

Sex ☐M ☐F Age _____ Birthday _____ ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐YES ☐NO IF YES, WHAT ARE THEY? _____

Patient's Employer (If child, mother's name and employer) _____ Employer _____

Business Address _____ Occupation _____ Phone _____

Spouse's Name (if child, father's name and employer) _____ Employer _____

Business Address _____

Who is responsible for this account _____ Relationship to Patient _____

Social Security # _____ Spouse's Social Security # _____

Do you have Medical Insurance? ☐NO ☐YES If yes, _____

Name of Primary Insurance _____ Insured Name _____ Birthday _____

Contract # _____ Group # _____ Insured SS # _____

Name of Secondary Insurance (if any) _____ Insured Name _____ Birthday _____

Contract # _____ Group # _____ Insured SS # _____

☐ Medicare ☐ Medicaid/TennCare Claim ID# _____

In case of emergency, who should be notified? _____ Phone _____

Have you ever been seen by a Healthstar Physician before? ☐YES ☐NO If yes, which physician? _____

How did you learn of our practice? _____ Former Physician _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____
Name of Insurance Company

and assign directly to HEALTHSTAR PHYSICIANS, P.C. all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

I, the undersigned, authorize Healthstar Physicians or any agents thereof, to notify me by telephone answering machine, mail, etc. regarding appointment, lab/diagnostics, billing and collection information.

_____ _____
Signature of Insured/Guardian Date

MEDICARE AUTHORIZATION AND RELEASE

I request the payment of authorized Medicare benefits be made either to me or on my behalf to HEALTHSTAR PHYSICIANS, P.C. for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA 1500 form, of elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

I, the undersigned, authorize Healthstar Physicians or any agents thereof, to notify me by telephone, answering machine, mail, etc. regarding appointment, lab/diagnostics, billing and collection information.

_____ _____
Signature of Insured/Guardian Date

Authorizations

I, hereby authorize the following individuals, other than myself, to receive information regarding my health care, lab/diagnostic results, appointments, billing and collections.

_____

_____ _____

Signature of Patient or Authorized Representative Date

I, hereby authorize Healthstar Physicians to submit a blood sample for HIV and or HBV testing as deemed necessary by my physician.

_____ _____

Signature of Patient or Authorized Representative Date

Medication History Authority:

I hereby give HealthStar Physicians, P.C. authority to download my prescription history from Surescripts/RxHub. I understand the prescription history will solely be used for medical purposes.

Signature:_____ Date:_____

Healthstar Physicians-Family Practice
420 W. Morris Blvd. Suite 400-B
Morristown, TN 37813
P-(423) 586-2410 F-(423) 581-9692

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(All sections must be completed)

I hereby authorize_____and its physicians employees and agents to release or disclose to the below-named recipient all of my medical records including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, sexually transmitted disease, or HIV/AIDS infection.

Patient Name: _____Date of Birth: _____

I hereby authorize the release of medical records to: _____

_____

Purpose of disclosure: _____

The authorization will expire on: _____
Date or Event may not exceed one year

This request and authorization applies to:

_____ All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, impatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge, test results, statements, questionnaires/histories, photographs, videotapes, telephone messages, and records received by other medical providers.

_____ Health care information relating to the following treatment, condition, or dates of treatment:

_____

_____ Specific records to be released (eg. Labs, imaging reports, other):

_____

I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.

_____

Signature of Patient or Authorized Representative Date Signed

_____

Relationship to Patient