

Bluegrass Legacy Healthcare
105 Glen Oak Blvd, 202
Hendersonville, TN 37075
P: 615-826-2265 F: 615-205-6868

PATIENT INFORMATION SHEET

Legal Name (print): _____ Date: _____

M ____ F ____ Marital Status: M S W D Do you have a living will? Y ____ N ____ (if yes, please provide to the office)

Address: _____ City/State/Zip: _____

() _____
Contact Phone Number

() _____
Work Phone Number

Patient Employer

Social Security Number (Required)

Date of Birth

Referred By

Spouse's Name

() _____
Spouse's Contact Number

Spouse's Date of Birth

Emergency Notification

() _____
Phone Number

Relationship

Insurance (Primary): _____ ID# _____ Group# _____

(Secondary): _____ ID# _____ Group# _____

Insured Name

Relationship

Date of Birth

I hereby acknowledge that I have carefully read and understand the "Financial Policy" "Office Guidelines" and "Notice of Privacy Practices for Health Information" describing how my medical information may be used and disclosed by the office of Bluegrass Legacy Healthcare as well as how I may obtain access to the information.

I agree to the terms and conditions of the "Financial Policy" and "Office Guidelines" a copy of which is available upon my request.

Signature

Date

I hereby authorize the office of Bluegrass Legacy Healthcare to release information concerning my medical history including insurance information, payments and billing in inquires solely to the person(s) listed below. **Other than myself.**

Name

Address/Phone

RESPONSIBILITY FOR PAYMENT/CONSENT TO TREAT

Patient/guarantor is responsible for all charges incurred. You are responsible for any copayments, deductibles, and/or unpaid percentage of what the insurance company does not pay. Unpaid balances are due and payable within 30 days of notice. Accounts that are 90 days past due will be placed in collections and patient agrees to pay all costs of collection, including, reasonable attorney's fees.

It is patient responsibility to assure that the most current insurance cards are presented at the time of service and are on file with this office.

If you're unable to keep your scheduled appointment, you are to notify this office within 8 hours prior to the appointment time. Failure to do so, will result in a charge of \$50.00 and is not billable to your insurance carrier. If you no show/late cancel for physical, the fee will be \$90.00.

I hereby consent to the care by all healthcare provider of Bluegrass Legacy Healthcare and I authorize to receive treatment as deemed necessary for my diagnosis. I understand that these services are voluntary and that I have the right to refuse these services.

Signature _____ Date _____

Witness _____ Date _____

Do you have a Living Will? Yes ___ No ___ . If so, please provide us with a copy.

Medicare certification for payment
(If applicable)

I certify that the information given to me in applying for payment under the title XV 11 of the Social Security Act is correct and I authorize any holder of my medical information to release to the Social Security administration or its intermediate or carriers any information needed for related Medicare claims. I request the payment of authorized benefits made on my behalf, and I assign the benefits payable for physicians' services to the provider furnishing the service to authorize such provider to submit a claim to Medicare for payment for me.

Signature _____ Date _____

Social Security# _____ Medicare Effective Date _____

Financial Policy

Thank you for choosing Bluegrass Legacy Healthcare as your healthcare provider. We are committed to your pleasant and successful treatment. Please understand paying your bill is considered part of your treatment. The following is a statement of our financial policy, which we require you to read prior to treatment. Our practice is committed to providing the best treatment for our patients and the charges are based upon usual and customary fees for our area. Thank you for understanding the need for the financial policy. Please let us know if you have questions or concerns.

Copayments- Contracts with your insurance company require the copayment to be collected at time of service. For your convenience we accept checks, cash and debit cards (Visa MasterCard). There is a \$2.00 charge for debit/credit cards. If you're unable to make this payment you will be rescheduled for a different time.

Insurance- You are responsible for assuring that this office has the correct insurance information for filing your claims. If you have Medicare as your primary insurance, please contact your secondary insurance through coordination of benefits for them to cross over for payment. Patients who are without insurance shall be responsible for payment of charges at the time of service. If you unable to make this payment please make your arrangements in advance of your appointment time.

Account Balances- Statements will be sent on a monthly basis and are due within 30 days. If you receive a statement that you feel is incorrect, please call our office immediately. Large account balances can be paid by monthly installments but must be approved by the office manager. Accounts that remain unpaid after 90 days with unsuccessful attempts to work out an acceptable payment plan, will be sent to collections and our healthcare relationship with you will be terminated. All cost of collections including reasonable attorney fees, will become the responsibility of the patient. Once your account is sent to collections, we cannot reconsider and make arrangements for you through the office. If this becomes necessary, as a courtesy to you we will take care of all of your non-narcotic, non-mood altering drug refills for 30 days to allow time for you to find another healthcare provider. We would prefer to work out of such satisfactory arrangement for you to pay rather than to send your account to collections.

Check Privileges- If you pay by check please assure that there are sufficient funds in your account to take care of the transactions. We must charge a fee to cover the cost against our account for any checks returned for insufficient funds. To pay off the return check the amount of the check plus the return check fee of \$30 must be paid by cash, money order or debit/credit card.

Letters/Forms- These items require research and documentation by the doctor and are very time-consuming creating additional cost to the office. Therefore a fee of \$25-\$50 depending on the amount of information requested for any letters or forms requested by patients to be filled out by the provider. These fees must be paid in advance before letters or forms are released. The fee for family consultations is \$90 payable of time of consult.

Patient name or responsible party

Date

Office guidelines

Thank you for choosing Bluegrass Legacy Healthcare as your healthcare provider. We are committed to your pleasant and successful treatment. The Bluegrass Legacy Healthcare is committed to operating its business based on honesty and integrity. We have developed the following guidelines to insure that patients and staff meet these criteria.

Patient information-Federal law (HIPAA) requires that no patient information will be given to anyone but the patient unless authorized by the patient in writing. We will follow this law without exception. In addition authorized persons must be prepared to give the name and Social Security number and/or date of birth of patient you were calling about. Please inform your authorized person of this policy.

Medicine/Refills-Please bring all medication to your office visit so the doctor can review dates, quantities and refill needs at that time. Phone calls on refills are NOT permitted on pain, antibiotic or mood altering drugs. It's your responsibility to monitor your prescription refill meds between visits. Please do not wait until you have taken your last dosage to get a refill. Except for emergencies, ***please allow 5 business days for processing prescription refills that you have faxed or phoned in, please inform your pharmacy of this policy to avoid multiple faxing. There will be a \$5.00 charge for any prescription refills not obtained at office visits.***

Physicals-Our nurse practitioner performs all physicals and all prostate examination. When you call to schedule your physical, please ensure that your insurance will pay for the service. Some insurance companies will not pay for preventative care. As a result, you may be asked to sign a waiver ABN in which will allow our office to bill you directly for the service. Please contact your insurance carrier to confirm coverage will be available.

Referrals-If your insurance requires a referral, we will gladly do so. Due to the many insurance changes regarding the referral policy please keep in mind that there will be an increased demand for referrals and prior authorizations. Depending on your insurance, please allow at least 5 business days to process your referral. You will be contacted by phone when referral is complete, at which time you may call the specialist's office to set-up your appointment at your convenience. Same day referrals can only be done for emergencies or directed by the nurse practitioner. It is patient's responsibility to ensure that all referrals are up-to-date before seeing a specialist. As a policy at the office we do not back date referrals.

Calls-Please give your name and the purpose of your call, so that we may direct you to the correct person in a timely manner. We strive to minimize inconveniences to a patient who are waiting to be seen. Except for emergencies, calls for drug refills, and answers to patient concerns are only done after all patients have been seen for the day, which at times can be very late. We asked that you please help us to minimize phone calls and inconveniences to everyone by covering all your questions and medicine needs during your regular office visit.

Appointment changes-Once an appointment is made we require at least an 8 hour notice to change/cancel, unless the need is deemed an emergency. After hours, messages can be left for the answering service and still qualify for sufficient time. Patients who change/cancel or fail to keep their appointments under this criteria three times may be discharge from practice. At times, the office schedules appointments 3 to 4 weeks in advance, therefore, it may take several weeks to get you back on the schedule if you change/cancel your appointment.

Inappropriate behavior and or verbal abuse-Including but not limited to, loud and/or vulgar language, sexual or racial comments, making false statements or asking this office to make false statements regarding your health information. This behavior via phone or in person to any member of the office staff is grounds for discharging a patient from his practice. Our staff is here to help and should be treated with respect.

Waiting area-As always we try to see patients as quickly as possible. However; there are times that we have delays, please be patient with us. If this occurs and you want to reschedule your appointment, we will work with you as best we can to get you schedule in a timely manner. We want to give all patients the time and attention they deserve. Please do not call the office and ask for a provider to call back. The provider is visiting with patients in the office and can't stop to take a call.

Patient name

Date