REGISTRATION FORM

Date_____

Patient Name_____
Last First Middle Suffix
Sex: Male_____ **Female**_____ **Patient's Social Security Number**_____
Birth date _____**Single** ___ **Divorced** ___ **Married** ___ **Widowed** ___ **Separated** ___

Home Street Address_____
City_____**State**_____**Zip**_____
Home Phone (_____**)**_____ **Cell Phone (**_____**)**_____
Cell Phone Company_____ **email address** _____
Name of Primary Care Physician_____ **Phone #**_____
Referral Source_____ **Patient's Driver's License Number**_____
PHARMACY **Pharmacy Name, Address, and Phone Number** _____
_____

EMPLOYER OF PATIENT
(or Guardian if patient is minor)

Company Name_____
Address_____
City _____**State** _____**Zip**_____
Occupation _____ **Phone Number(**_____**)**_____

Circle appropriate answer:
Race: **American Indian** **Asian** **Black** **Caucasian** **Other** **Declined**
Ethnicity: **Hispanic** **Non-hispanic** **Declined**

Primary Language Spoken_____

Name of Parent or Guardian (if patient is a minor)_____
Date of birth of Guardian_____ **SSN of Guardian** _____
Driver's License # of Guardian_____

SPOUSE OF PATIENT
(or Guardian if patient is minor)

Name_____
Birthdate _____**Social Security Number**_____
Employer Name_____
Address_____
City_____**State**_____**Zip**_____**Phone**_____

REASON FOR VISIT

Condition related to: Illness_____ **Well visit**_____**Accident**_____
Other_____ **Date of Accident, if applicable**_____

INSURANCE INFORMATION

Insurance Company_____
Insured Name _____**Relationship to Patient**_____
Group or Policy Number_____ **ID #**_____

Westbrook Medical Center
930 Adell Ree Park Lane
Knoxville, TN 37909

PATIENT HEALTH QUESTIONNAIRE

Patient Name_____ DOB_____

Review of Systems: (Check all that apply)

Head & Neck
___ Eye Disease
___ Double vision
___ Blurred vision
___ Prior-Ear Surgery
___ Ear Ache
___ Hearing loss
___ Dizziness
___ Nosebleeds
___ Sinusitis
___ Allergies
___ Nasal Polyps
___ Snoring
___ Excessive sleepiness
___ Facial pain
___ Pain with chewing
___ Lumps in the neck

Respiratory System
___ Hoarseness
___ Chronic cough
___ Coughing up blood
___ Shortness of breath
___ Wheezing
___ Asthma
___ Chronic bronchitis
___ Emphysema
___ Tuberculosis
___ Lung cancer

Endocrine
___ Diabetes
___ Thyroid imbalance
___ Menstrual disorder

General
___ Night Sweats
___ Fevers
___ Skin diseases
___ Arthritis
___ Bleeding Disorder
___ Bruising Easily
___ HIV infection or AIDS
___ Psychiatric Diseases
___ Weight Loss
___ Depression
___ Anxiety
___ Bipolar Disease
___ Suicidal Thoughts

Neurologic
___ Headaches
___ Numbness or tingling
___ Transient vision loss
___ Seizures
___ Back pain
___ Muscle Pain
___ Strokes

Cardiovascular
___ Hypertension
___ Heart disease
___ Chest pain w/exertion
___ Swelling of the ankles
___ Heart surgery
___ Pacemaker
___ Anemia

Gastrointestinal
___ Difficult swallowing
___ Diarrhea
___ Constipation
___ Jaundice
___ Liver disease
___ Hepatitis
___ Kidney Disease
___ Bloody stools
___ Diverticulosis
___ Gall bladder disease
___ Heartburn or ulcers
___ Nausea/Vomiting
___ Black Stools

Urologic
___ Difficulty on urination
___ Frequent urination
___ Blood in the urine
___ Prostate problems

Other
_____

Past and present medical problems:	Previous surgeries and dates (month/year)	List all current medications and dosages (including OTC):
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you smoke?
___ Yes ___ No
If yes, how much ?_____

Do you drink alcohol?
___ Yes ___ No
If yes, how much ?_____

Please list all allergies: _____

Patient Signature_____ Date_____

Westbrook Medical Center

"Consent for Purposes of Treatment, Payment & Healthcare Operations"

(In this document, "I" and "my" refer to the patient, and "facility" refers to Westbrook Medical.)

I consent to the use or disclosure of my protected health information by Westbrook Medical Center for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct the health care operations of Westbrook Medical Center. I understand that analysis, diagnosis or treatment of me by this facility may be conditioned upon my consent which is evidenced by my signature below. Diagnostic testing may be required so a thorough analysis can be completed.

I understand that payment is due at the time services are rendered unless other arrangements have been approved in advance by the staff. I understand that Westbrook Medical Center may accept insurance assignments when the insurance coverage is through a group with whom they participate. If applicable, my consent for an assignment of my benefits to Westbrook Medical Center is designated by my signature below. Deductibles and co-payments must be honored at the time services are rendered. A finance charge will be added to outstanding balances. I understand that Westbrook Medical Center accepts cash, Visa, and MasterCard.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Westbrook Medical Center is not required to agree to the restrictions that I may request. However, If Westbrook Medical Center agrees to a restriction that I request, the restriction is binding to the facility.

I have to right to revoke this consent, in writing, at any time, except to the extent that Westbrook Medical Center has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health condition.

_____ _____

Signature of Patient or Representative | Print Name of Patient or Representative

_____ _____

Date of Signing | Description of Representative's Authority

CONSENT FOR PATIENT TESTING AFTER HEALTHCARE WORKER EXPOSURE

Westbrook Medical Center health care workers handle blood and other body fluids for many reasons such as when performing lab tests and cleaning equipment. It is the policy of Westbrook Health Center to test a patient for Hepatitis B, Hepatitis C and HIV (the virus that causes AIDS) if any employee or health care worker is exposed to a patient's blood or other body fluid in such a way that transmission of these infections could occur. Should an accidental exposure occur, the tests would be conducted at no cost to you. We are requesting that you consent to these tests prior to treatment. My signature below indicates my consent to test my blood or body fluid for Hepatitis B. Hepatitis C, or HIV.

_____ _____

Signature of Patient or Representative | Date

I decline to authorize the above testing:

_____ _____

Signature of Patient or Representative | Date

ASSIGNMENT – AUTHORIZATION & LIEN

I hereby irrevocably authorize and direct my insurance company, my attorney, and/or any third party payers to pay directly to the provider, Westbrook Medical Center, PLLC, all sums of money due for any and all services rendered to me (or a minor child for which I m responsible) by reason of accident, illness or any and all reasons. I further direct said insurance company, attorney, or third party payer to withhold such sums from any payment, including but not limited to health and accident benefits, disability benefits, workers' compensation benefits, medical payment benefits, no fault benefits, foundation grants, government or agency benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately provide for any financial obligation owed this office and assignees.

I further agree that this agreement acts as an assignment of my rights and benefits to the extent this office rendered services; therefore if my insurance company and/or attorney obligated to make payment to me for the charges incurred at this office refuse to make such payment, I hereby assign and transfer to this office and assignee any and all causes of action that I might have or that might exist in my favor against such company and authorize this office and assignee to prosecute said cause of action either in my name or in the assignee's name. This office is also authorized to settle or otherwise resolve said claim or cause of action as they see fit. I understand that this does not relieve me of my personal responsibilities for all such charges in the event there is no recovery or if the recovery is insufficient to satisfy such charges. I hereby agree to give a full lien to said office against any and all insurance benefits named herein, or any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of injuries or illness for which I have been treated by said office and assignees. I further agree that the assignee's right for payment shall not be bound by a statute of limitations until a reasonable time has lapsed after either negotiations or litigation between third parties and myself are resolved. A photocopy of this assignment shall be considered as effective and valid as the original. I voluntarily waive the statute of limitations regarding my doctors and/or this office's rights to recover and, and I agree to be held fully responsible for all debts I incur in this office.

It is further agreed that I shall remain personally responsible for the total amount due this office and assignee for its services. I further understand and agree that this Assignment, Authorization, and Lien does not constitute any consideration for the office to wait for payment(s) and that they may demand full payment from me immediately and at any time upon rendering service at their option. Such option requires that I pay for all sums due and owing in full within ten (10) days of demand. I further understand that a monthly service charge is computed by a periodic rate of 1% per month which is an annual percentage rate of 12% applied to the previous balance after deducting current payments and that the service charge may change without notice. I understand that all money due this office will be paid in a timely manner with no amount of money due past 90 days from the date of service, regardless of attorney liens, representations of any attorney, pending settlement(s) or other matters unless approved in writing by this office in advance of the 90 day limit. I further agree and understand that, if the need arises, accounts delinquent may be placed for collection and that I am fully responsible for all court costs, filing fees, attorney costs, and all associated collection costs.

I further understand and agree that, as necessary, this office and its staff may submit, prepare or complete medical records, consultations, depositions and/or court appearances on my behalf which I understand must be paid in full in advance and are not considered part of my account. I authorize this office to release any information pertinent to my case to any insurance company, adjuster, attorney or legal service bureau to facilitate collections under the terms of this document. I agree that Westbrook Medical Center, PLLC is given full power of attorney to endorse and/or sign my name on any and all checks for payment of any indebtedness owed this office and assignee. I understand that this office, the doctors and the staff are accepting my case based on examination findings and believe the outlined treatment should produce change and/or improvement. However, as with any doctor's treatment, a guarantee of improvement or complete recovery cannot be made and it is even possible that no change will occur. I do agree that I am fully obligated to pay for all charges for all services rendered to me.

Print Name_____

Signature _____ Date _____

WESTBROOK MEDICAL CENTER

930 Adell Ree Park Lane
KNOXVILLE, TN 37909
(865) 769-2600
865/769-2616 FAX

CONSENT TO RELEASE/RECEIVE CONFIDENTIAL INFORMATION

I _____ authorize Westbrook Medical Center located at the address above to receive my medical history information or treatment records from any source needed to enhance my care with their facility.

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken in reliance on it. This consent will last while I am being treated by providers at this facility unless I withdraw my consent during treatment. This consent will expire 365 days after I complete my treatment, unless the facility specified above is otherwise notified by me.

I understand that the records to be released may contain information pertaining to confidential information about communicable diseases including HIV (AIDS) or related illness. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2) which prohibits the recipient of these records from making any further disclosures to third parties without the express written consent of the patient.

I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment information/records under 42 CFR Part 2, and I further acknowledge that I understand those rights.

Unless otherwise specified, please release ALL records related to my care.

_____	_____	_____
Printed name of Patient	Patient Date of Birth	Patient Social Security Number

_____	_____
Patient Signature	Patient Signature Date

If you have received this form in error, please notify the above office immediately.

Please fax records as soon as possible unless noted otherwise.

Note: Faxed to _____ *at fax #* _____
FACILITY/PROVIDER *NUMBER*

WESTBROOK MEDICAL CENTER

Authorization for Medical Care

COMPLETE THIS SECTION IF PATIENT IS BELOW 18 YEARS OF AGE:

I _____authorize the following people to bring my child_____ Birthdate_____in for, and consent to, treatment, or to receive medical advice over the phone if they are taking care of my child in my absence. I understand telephone triage and advice services regarding direct patient care will be extended to the above persons only when the child is in their care. This does not allow them to have access to confidential health information that is not relevant for that particular visit. In the event of an emergency or other illness, I understand that the physicians and staff of Westbrook Medical Center will deliver any medical care deemed necessary regardless of the accompanying adult.

1) Name:_____

Relationship to patient:_____ Phone #:_____

2) Name:_____

Relationship to patient:_____ Phone #:_____

3) Name:_____

Relationship to patient:_____ Phone #:_____

If a document is to be picked up by a non-legal guardian, Westbrook must have written consent from the legal guardian. This authorization serves as consent for any medical treatment Westbrook deems medically necessary and appropriate. This will remain in effect until revoked by written consent.

_____ _____

Legal guardian signature Print Name

Date _____ _____

Relationship to patient

COMPLETE THIS SECTION, IF APPLICABLE, IF PATIENT IS 18 OR OLDER:

I _____ Birthdate_____authorize the following people to have access to my treatment information and appointment dates. This will remain in effect until revoked by written consent.

1) Name:_____

Relationship to patient _____Phone #_____

2) Name:_____

Relationship to patient _____Phone # _____