Bruce Pendley, M.D. Randy Heisser, M.D. Saundra Williams, M.D. Deanna Duncan, M.D.
Andre Hardy, M.D. Laurie Davis, FNP Ardyce Ridolfo, FNP Greg Joyner, FNP
Meghan Oakley, FNP Tina Fox, FNP Marcile Leaf, FNP
Holly Walker, FNP Jennifer Eaves, PA-C

1508 Tombras Ave
East Ridge, TN 37412
Phone: 423-867-4969 Fax: 423-867-4971

We would like to first thank you for choosing In Good Health for you or your family's healthcare needs. Attached you will find our new patient paperwork with a checklist for you to complete. In order to get the new patient process started, we ask that you fill out the packet in its entirety and return to our office via fax, e-mail, or mail. If you wish to e-mail the information back to us, you may send them to one of the following email addresses:

-Cassie Nichols, MA - cnichols@alwaysingoodhealth.com
-Sarah Webb, MA - swebb@alwaysingoodhealth.com

If at all possible, please include front and back photos of your insurance cards, along with POA paperwork if applicable. Once your paperwork is received, it will then be reviewed by our providers to ensure that we will be able to provide the care that you or your family member may need. Once reviewed and approved, we will contact you regarding an appointment date and time. If you happen to have any questions or concerns, please do not hesitate to call our office. We will be glad to assist you in any way possible! We look forward to hearing from you and thanks again!

With Warmest Regards,

Cassie Nichols, MA
Sarah Webb, MA

In Good Health
1508 Tombras Avenue
East Ridge, TN 37412
Phone: (423) 867-4969 Fax: (423) 867-4971

New Home Patient Checklist

*Copies of Insurance Cards?

*Did you complete the entire packet?

- *Did you complete the first page with all of your contact and insurance information?
- *Did you complete the second page with all of your family medical history?
- *Did you complete the third page with YOUR medical history?
- *Did you sign all of the pages that ask for your signature?

*Medication List – Did you include the dose and frequency? Do you require a 90 day supply? What pharmacy do you use?

---

*Home Health – Have you had or currently have home health? If so, which one?

---

*Is there a specific reason you need to be seen? If so, what is it?

---

*Do you use Durable Medical Equipment? If so, what company did you use?

***Power of Attorney – We will be unable to Honor the POA unless we have a copy of it to keep on file, so please include a copy if applicable. ***

In Good Health

Patient Name Last _____ First: _____ MI _____ DOB: _____

Street Address: _____ Sex: _____

City: _____ State: _____ Zip _____ Marital Status: _____

Phone(s): Home _____ Work: _____ Cell: _____

E-Mail: _____ Age: _____ Social Security #: _____

If Minor Child: Name of School: _____
Father's Name: _____ Employer: _____ Phone: _____

Mother's Name: _____ Employer: _____ Phone: _____

Employer: _____ Spouse's Name: _____

Employer address: _____ Spouse's Employer: _____

Emergency contact: _____ Phone: _____

Please Check All That Apply:
I authorize In Good Health to:

_____Leave a message on my answering machine regarding appointments.

_____Mail information to my home address regarding appointments.

_____Speak with a family member or other individual when returning your call or concerning appointments. Please specify whom we may speak with _____

Insurance Information:

Primary Insurance
Company Name _____

Address _____

Policy in name of _____

DOB _____ SS# _____/_____/_____

Group # _____

Policy # _____

Secondary Insurance
Company Name_____

Address _____

Policy in name of _____

DOB _____ SS# _____/_____/_____

Group #_____

Policy #_____

Do you currently have any Advanced Directives? Yes No

Are you interested in information about Advanced Directives? Yes No

In Good Health, LLC

PATIENT HISTORY

Patient Name: _____ Date: ____/____/_____

Date of Birth: _____ Current PCP: _____

Social History: Please CIRCLE your response

Marital Status: SINGLE MARRIED DIVORCED WIDOWED

Alcohol: NONE SOCIALLY MODERATE HEAVY

Education: ELEMENTARY MIDDLE SCHOOL HIGH SCHOOL COLLEGE

Your Habits: CAFFEINE ILLICIT DRUGS TOBACCO (if yes, how much? _____)

Employment: STUDENT PART TIME FULL TIME RETIRED UNEMPLOYED

Exercise: 3 TIMES A WEEK OR LESS GREATER THAN 3 TIMES A WEEK DOES NOT EXERCISE

FAMILY HISTORY: (Mother, Father, Siblings, Children, Grandparents)

Please Circle:

Alcohol Alzheimer's Arthritis Asthma Bleeding Disorders Blood Clots Cancer,

What Type? _____ Circulatory Problems COPD Depression

Diabetes GERD Stomach Problems Heart Disease Hepatitis High Cholesterol

HIV/AIDS High Blood Pressure Kidney Disease Liver Disease Low Blood Sugar

Lung Disease Migraines Obesity Psychiatric Disorders Seizures Stroke

Substance Abuse TB Thyroid Disorder Ulcers

Other: _____

MY MEDICAL HISTORY: Please Circle

Anemia Aneurysms Angina Anxiety Arrhythmia Arthritis Asthma

ADD Autoimmune Disorder Bells Palsy Bipolar Disorder Bleeding Disorder

Blood Clots Bronchitis Cancer, What Type? _____

Circulatory Problem Congestive Heart Failure Chrohn's Disorder Constipation

COPD Coronary Artery Disease DVT Depression Diabetes Elevated Liver

Enzymes Emphysema Erectile Dysfunction GERD Headaches Heart Disease

Heart Murmur Hepatitis A, B, or C High Cholesterol HIV/AIDS High Blood Pressure

Kidney Disease Liver Disease Low Blood Sugar Lung Disease Mental Disorders

Migraines Mitral Valve Prolapse Nervous Disorder Obesity Panic Disorder

Parkinson's Seizures Stomach Disorder Stroke Substance Abuse

Thyroid Disorder Tuberculosis Unexplained Weight Loss of More Than 10 Pounds.

ALLERGIES:

_____

Operations/Hospitalizations: What Hospital, When, and Why?

1._____ 3._____

2. _____ 4. _____

Patient Name: _____ **Date:** _____

Patient Name: _____

AOB / Financial Policy for In Good Health

The information in this financial policy is meant to educate the patients of the requirements regarding payment for services rendered. If you have any questions please feel free to speak to the office manager.

Insurance and Demographic Information

Please notify our staff if you need to update your demographic or insurance information at each visit. We will need a copy of your insurance card if there are any changes. IGH asks that you let us know if there are any changes in name, address, phone numbers, or insurance. If so, it will be necessary to complete a new patient information form. If we do not get the correct insurance information and your claim for service is denied, you will be responsible for the entire amount due. You will then need to work with your insurance company to get reimbursed for what you have paid to IGH. You will also be required to update a patient information form and insurance information every year. This gives IGH permission to bill your insurance and release information to your insurance company in order to get payment for services rendered and to continue treatment.

What Payment is Required?

You will be required to pay for any co-pays or deductibles not met at each office visit. If you do not have insurance you will be required to pay the full amount due at each visit.

Forms of Payment

We accept cash, check, check card, money order, cashier's check, Visa, MasterCard, Discover card, and American Express.

Broken Appointment Charge and Policy

There is a $25.00 charge for appointments not cancelled 24 hours before the scheduled appointment time. This must be paid before the patient is seen at the next office visit along with any applicable co-pay. Insurance does not pay for this charge and it will not be billed to them.

Patient is responsible for total charge. We do not look to a third party for payment.

As a courtesy to our patients, we will gladly file a claim to your insurance carrier. However, if the insurance company does not pay your claim, in a timely manner, you are responsible for any amount due. The insurance you carry is a contract between you and your insurance carrier and IGH is not a party to the contract. We will be glad to assist you to get the full benefit of your insurance.

Medicare

Currently we are not accepting any new Medicare patients in the office; however, we are accepting new HOME PATIENTS with Medicare. For existing Medicare patients we do accept Medicare assignment and agree to comply with the agreement of such; however you will be responsible for any deductible or coinsurance, if you do not have a supplement to your Medicare coverage.

Office Policy on Insurance Assignment

We will verify your insurance before your appointment and periodically afterwards to be sure your coverage is active. We will collect your deductible and co-pays as appropriate. We will file a claim to your insurance company on your behalf, however please understand this is done as a courtesy to our patients and if the insurance does not pay the claim the patient becomes responsible for any unpaid balance due for services rendered. Ultimately it is the responsibility of the patient to make sure our providers are on your insurance network. If we are not on the network for your insurance carrier you will be notified before your visit and you will be responsible for payment in full or an estimated amount that is not covered if you have out of network benefits.

*Patient Name:*_____

Fees Due if Your Account is Sent to Collections
You will be responsible for any collection fees and/or attorney fees in the event your account is turned over for collections. This amount will be up to 50% of the amount due in addition to your balance and any attorney fees or court costs. If your account is turned over to collections you will be dismissed from IGH and you will have to find another primary care physician for treatment. You will not be able to return to IGH until proof of the entire amount owed is paid in full.

Fee for Random Drug Screens
IGH does reserve the right to perform random drug screening and this is not covered by most insurance companies. When it is time for a random screening you will be asked to sign a waiver stating that you understand that your insurance company does not pay for this service and you will be required to pay $25.00 for this test.

If You Are Referred to Another Specialists or Provider
If you are referred for treatment to another provider, for continuum of care, please understand that you will be billed separately by that provider and/or facility. It is ultimately your responsibility to make sure that provider is on your insurance network. If the provider is not you should call your insurance company and get a list of providers that are on your network and we will refer you to a different provider that is covered by your insurance.

Charge for Insufficient Funds Check
If a patient writes a check that is returned unpaid by the bank there will be an additional charge of $30.00, which is due before that patient is seen again. No checks will be accepted 6 months from that patient if it is the first time a check is returned. If this is the second time, the fee of $30.00 must be paid before the patient is seen and we will no longer accept checks at all. The patient must pay by cash, money order, or credit card from that point forward.

Payment Arrangements
If it becomes necessary for payment arrangements to be made on balances of coinsurance amounts due, please see the billing manager to discuss this matter. If at any time your account becomes delinquent over 90 days and you have not made consistent payments every 30 days your account will be turned over to collections and you will be required to find another primary care physician.

****I have read and understand the Financial Policy of IGH. I agree to comply with the policy. I understand if I have any questions I can speak with the billing manager or office manager.****

_____ _____

Signature of Patient or Guarantor **Date**

USE AND DISCLOSURE OF PROTECTED HEATLH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of your health facts and to provide you with the notice of our legal duties and privacy practices. We must follow the terms of the notice in effect right now, but we reserve the right to change the terms. If there is a change, we will provide you with a written, revised notice upon request.

As a client of ours, facts about you must be used and disclosed to other parties for treatment, payment and health care operations. These uses and disclosures require your consent, and include, but are not limited to the following information:

- A release of information contained in financial and or medical records;
- Diseases spread person to person, such as Human Immune Deficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS);
- Drug and or alcohol abuse;
- Psychiatric diagnosis and treatment records;
- Laboratory test results;
- Medical history;
- Treatment progress;
- Data from the OASIS data set (home health);
- Any other related facts.

We may release the above to:

1. Your insurance company, Medicare, Medicaid, or any other person who will pay your bill for services or who will process your bill for services in order for us to receive payment;
2. Any person from a program or an insurance company, who performs billing, quality and risk management tasks, such as insurance auditors and state Risk Management;
3. Any hospital, nursing home, or other health care facility where you may have testing done or to which you may be admitted;
4. Any assisted living or personal care facility where you live;
5. Any doctor providing your care;
6. Family members and other people who are part of your plan for service, in such programs as CSHP, EPSDT, home health, hospice, etc.;
7. State and or Federal agencies acting on behalf of programs, Medicare and or Medicaid, including state surveyors or auditors for programs such as CSHP, EPSDT, PCS, WIC, STD/HIV, home health, hospice, etc.;
8. Other health care people to start treatment.

We may contact you to:

1. Provide appointment reminders or news about other health programs we provide;
2. Discuss diagnostic results or treatment plans regarding your health care;

We are allowed to use or disclose facts about you without consent in the following situations:

1. In emergency treatment situations, if we try to obtain consent as soon as possible after treatment;
2. Where significant barriers to communicating with you exist and we determine that the consent is clearly inferred from the situation;
3. Where we are required by law to provide treatment and we are unable to obtain consent;
4. Where the use or disclosure is required by law;
5. For certain public health activities, such as reporting births, deaths, injuries, diseases, etc.;

6. Where we reasonably believe you are a victim of abuse, neglect, or domestic violence to a government agency authorized to receive abuse, neglect or domestic violence reports;
7. Health care oversight activities;
8. Certain legal administrative proceedings;
9. Certain law enforcement purposes;
10. To coroners, medical examiners and funeral directors in certain situations (home health, hospice, etc);
11. For organ, eye or tissue donation purposes (home health, hospice, etc.);
12. For certain research purposes;
13. To avoid a serious threat to health and safety;
14. For specialized government functions, including military and veterans' activities, national security and intelligence activities, protective services for the President and others, medical suitability determinations, correctional institution and custodial situations;
15. For Workers' Compensation purposes.

We are allowed to use or disclose facts about you without consent or authorization provided you are informed in advance and given the chance to agree to, restrict or forbid the disclosure in the following situations:

1. The use of a directory of people served by us (clinic schedules, patient schedules);
2. To a family member, friend or other person you choose who may assist in your care or payment for care.

Other uses and disclosures will be made only with your written approval. That approval may be withdrawn in writing at any time, except in limited situations.

YOUR RIGHTS

You have the right, subject to certain conditions, to:

1. Request restrictions on certain uses and disclosures of facts about you by filling out our Request form. However, we are not required to agree to the requested restrictions.
2. Receive confidential communication of protected health data by giving us another address or means of receiving health data.
3. Inspect and copy protected health data by filling out our request form.
4. Amend protected health data by filling out our form.
5. Receive a list of disclosures made of your protected health data by filling out our request form.
6. Obtain a paper copy of this notice upon request, if you agreed to receive this notice by e-mail, fax, or website.

COMPLAINTS

You may complain to us and the Secretary of the U.S. Department of Health and Human Services if you believe that your privacy rights have been violated. There will be no retaliation against you for filing a complaint. The complaint must be filed in writing with us and must state the specific incident(s) including the date, what happened and details of the incident. You may also contact our Compliance Officer at this office.

For details about filing a complaint with us, contact:
HIPAA Compliance Officer, phone number 423-867-4969.

In Good Health
Notice of Privacy Practices

Patient's Name: _____ Date:_____

ACKNOWLEDGMENT

I have read this Notice or have had it explained to me. I understand if I have further questions regarding this notice I can contact the Secretary of the U.S. Department of Health and Human Services.

_____ _____

Signature Date

This Notice goes into effect 03/01/2003.

For Office Staff Use Only

The following good faith efforts were made to obtain acknowledgement:

1. A copy of the Privacy Notice was offered to the patient
2. The Privacy Practices of IGH were discussed with the patient

However, acknowledgement was not obtained because:

1. The patient refused to sign acknowledgement
2. Other:

_____

Admitting Medication List

Patient Name: _____ DOB: _____

Medication Name	Dosage	How is it Taken	Why Taking

Patient's Name: _____ DOB: _____

Assignment of Benefits / Financial Responsibility

1. I understand that I am responsible for charges not covered or reimbursed by my current insurance agents. I agree, in the event of non-payment, to assume the cost of interest, collection and legal action (if required).
2. I authorize my insurance carrier to release information regarding my coverage to In Good Health, LLC (IGH). I also authorize agents of any hospital, treatment center or previous physicians to furnish IGH copies of any record of my medical history, services or treatments. I also authorize for the release of any medical information and/or reports related to my treatment to any federal, state, or accreditation agency or any physician (_____**Patient's Initials**) or insurance carrier as needed. I also agree to a review of my records for purpose of internal audits, research and qualified reviews within IGH.
3. My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to IGH. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my payment as claims for service. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representatives, I will endorse such payments to IGH.

This agreement / consent will remain in effect unless revoked by me in writing. I have read the above statements and accept the terms.

I acknowledge that I have been given the opportunity to read and understand the Notice of Privacy Practices.

Patient Signature:_____ **Date:** _____

Responsible Party Signature: _____

Date: _____

In Good Health
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East Ridge, TN 37412
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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

RE: _____
Patient's Name

_____
Date of Birth

_____
Social Security Number

Pursuant to federal HIPPA guidelines concerning my right to confidentiality, I hereby authorize the release of my medical records to:

__X__ IN GOOD HEALTH

_____ Other: _____

Please include the last 3 office visit notes, all imaging & lab reports for the past year, a copy of my insurance card(s), and my patient information (demographic) sheet.

If I have been dismissed from your practice, please send documentation stating the reason for the dismissal from your practice.

I understand no information may be disclosed by either agency to any other individual or agency unless by written consent. This statement may be revoked at any time by my written statement. I further understand there is a 10 workday turnaround time to pick up or send any records.

_____ _____
Signature of Patient or Legal Guardian of Patient Date

_____ _____
Signature of Witness Date