GREGORY BREWER, MD PLLC

REGISTRATION FORM----**please print**

Last Name: _____First Name: _____ Middle Initial: _____

Date of birth: _____ Social Security Number: _____

Home Phone: _____ Cell Phone: _____

Your email: _____ Marital Status (circle one) Married/Single/Divorced

Mailing Address: _____

City: _____ State: _____ Zip:_____

Do you have a Durable Power of Attorney for Healthcare? YES NO Do you have a Living Will? YES NO

Do you have a Legal Guardian: YES NO **Please provide a copy of these documents for your medical record.**

Your emergency contact name: _____ Phone: _____

Your Primary Care Physician: _____Phone: _____

Who referred you here: physician/friend/insurance: _____

Name of your employer: _____ Phone: _____

Name of your Pharmacy: _____ Phone: _____

We will need copies of your insurance information including your prescription coverage. You will still to complete the bottom of this form with that information for our records.

Your **primary** insurance company _____

ID Number: _____ Group Number: _____

Subscriber name (If other than yourself): _____DOB: _____

Name of **secondary** insurance company: _____

ID Number: _____ Group Number: _____

Subscriber name (If other than yourself): _____DOB: _____

Name of **prescription** insurance company: _____

ID Number: _____ Group Number: _____

Subscriber name (If other than yourself): _____DOB: _____

All professional services rendered are the financial responsibility of the patient. We will file claims to your insurance carrier as a courtesy to you. Your signature below authorizes our office to furnish information to insurance carriers concerning your treatment and you assign to the provider(s) all payments rendered for services received.

Signature: _____ Date: _____

GREGORY BREWER, MD PLLC PRACTICE POLICIES

CONSENT FOR MEDICAL TREATMENT: I, the undersigned, am the patient or the patients duly authorized representative, and do hereby voluntarily consent to and authorize medical care and treatment by Gregory Brewer, MD PLLC through its individual physicians, employees, and/or agents. This care and treatment encompasses all diagnostic and therapeutic treatments considered medically necessary or advisable in the judgment of the physician/providers. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations performed by the providers or their office.

PRIVACY PRACTICES: I acknowledge that I have been offered a copy of Gregory Brewer MD, PLLC's Notice of Privacy Practices to review. I understand this information is also posted in the office and on the practice website. I consent to be called on my cell phone or other numbers listed on my registration sheet regarding healthcare services provided to me.

OFFICE FORMS/APPOINTMENTS: Each year the office requires all patients to update their forms. This is a necessity and it ensures that we have current information in order to help serve our patients. Dr. Brewer has a Nurse Practitioner/Physician's Assistant to help meet the scheduling needs of office patients. Due to the amount of time he spends at the hospital, ***patients will often see the Nurse Practitioner during follow up appointments***. Dr. Brewer collaborates with the NP as well as personally reviewing every note. He is always involved in your care, however he cannot physically see all office visits. We try to make personal reminder calls about your appointments, but we do this as a courtesy, so it's important that you keep up with your appointments. Failure to keep a scheduled appointment may result in a "No Show" Fee which would be required to be paid prior to your next appointment.

MEDICATIONS: We need your help to ensure that we avoid possible side effects or complications. To provide the best possible care, we require that you bring all medications, vitamins, and supplements in the original bottles to every visit. If you are unable to bring these with you, please bring an accurate, up-to-date list including drug name, dosage, and how often you take it. If you do not have your medications or an accurate list with you, your visit may need to be rescheduled. Be sure to let us know if you take your medications differently than it is listed on the bottles. Proper medical care is very complicated. Many patients have multiple physicians and multiple medications. Some use different pharmacies to get the best pricing on their medications. It is impossible for us to know what has been prescribed to you, and by whom. There are drug interactions and side effects that can be caused by medications, it is **EXTREMELY IMPORTANT** that you bring medication bottles or an accurate list to **every visit.**

SAMPLES: If we start you on a new Cardiology related medication, we MAY have some samples to give you for the first couple of weeks (to ensure that there are no side effects, etc.,). **However, we cannot function as your pharmacy; if you have financial difficulty in paying for your prescriptions, there may be patient assistance plans that you could be approved for.**

NON-COMPLIANCE: We try very hard to maintain one of the few solo physician practices in the area. Unfortunately, the changes in health care reform and insurance plan coverage has put a great deal of stress on small medical practices. We want to maintain a professional setting here and to keep our patients informed of any new policies that we implement. *Failure to comply with any of these policies (including failure to remit payment for patient balances) can result in termination of the doctor/patient relationship and dismissal from the practice.*

PAYMENT POLICIES:

Copayments: We require copays prior to service (and reserve the right to refuse non-urgent treatment). We accept most credit cards, as well as personal check, debit cards, and cash.

No Insurance: If you have no insurance each visit with a provider will be $70.00 and is due prior to the visit.

Claims: We file claims to your insurance as a courtesy. Please keep in mind that payment remains your responsibility. We do not enter disputes over insurance benefits. We file insurance in accordance with all federal, state, and other contractual requirements in cases where we have an agreement with, or if we are a participating provider with the plan. We expect payment in full from you if your insurance company delays processing of your claim over 60 days. You agree to pay any portion of the charges not covered by insurance. If your insurance sends payments directly to you, send the payment to our office or bring it in and we will apply it to your account.

Payments: All balances and copayments/coinsurance/deductibles are due prior to each visit. We send patients 3 statements and then accounts are sent to an outside collection agency. If your account is sent to an outside agency, we add a 40% fee to the bill to cover the additional collection agency fees. We require acceptable payment arrangements be set up with our office for balances (or with collection agency for balances that have been turned over) in order to continue treatment for non-urgent issues. Failure to set up an accepted payment plan or failure to keep your agreed payment plan will result in terminating your relationship with our office. We would send this notification by letter to the address on file and it advises you that we could only see you for urgent cardiology needs for 30 days from the date of the letter. After that 30 days, our office would not be able to schedule appointments, call in prescriptions, or address any issues. We would provide you with a medical release form to have your records sent to your new Cardiology office. 30 days allows you ample time to make the transition if needed. Knoxville Indigent Care, Cherokee Health Services, and your local health department can provide treatment for financial hardship cases.

Appointments: We request a 1 business day notice (24 hours) cancellation of all office visits in order to avoid being charged a $40 late cancellation fee. Failure to give appropriate notice for cancelling or rescheduling a Nuclear Stress Test will result in a $250 fee.

Medicaid: We file Medicaid claims for the state of Tennessee. If you have assistance from another state, you will be responsible for payment of services you receive.

Referrals: If your insurance requires a referral, you are responsible for obtaining it from your primary care physician. Failure to obtain a referral can result in a lower payment or no payment from the insurance company and you will be responsible for payment.

Forms/Letters/Medical Records: We may bill $25 prepayment for forms or letters that a provider completes on your behalf. We are not disability providers and cannot fill out disability forms. We provide 1 copy of your medical records to you at no charge; any additional copies require prepayment and are billed at the amount determined by the State of Tennessee.

Your signature indicates that you understand the above information and any questions you have were answered.

Patient Printed Name: _____ Date: _____

Patient/Guardian Signature: _____

GREGORY BREWER, MD PLLC

COMMUNICATION OF PRIVATE HEALTH INFORMATION FORM

YOU CAN REVOKE THIS AUTHORIZATION AT ANY TIME BY NOTIFYING US IN WRITING. THE REVOCATION WILL ONLY BE EFFECTIVE FROM THE DATE IS IT RECEIVED IN THIS OFFICE AND WILL NOT APPLY RETROACTIVELY. THIS FORM MUST BE UPDATED ANNUALLY. IF YOU DO NOT LIST ANYONE, THEN WE CAN NOT DISCUSS YOUR HEALTHCARE WITH ANYONE (EVEN YOUR SPOUSE).

I give Gregory Brewer, MD PLLC permission to disclose my PHI (including but not limited to: results, diagnosis and appointment information) with the people I have listed below.

Please list all parties we may discuss this information with (spouse, other family members, etc.,)

PLEASE PRINT THEIR NAMES TO AVOID ANY CONFUSION.

Name(s) of people you authorize us to share your health information with: **Relationship:**

_____ _____

_____ _____

_____ _____

_____ _____

CONSENT FOR GENERAL HEALTH INFORMATION AND RESULTS: INCLUDES LEAVING MESSAGES, EMAILS, TEXTS

Home Yes No If yes, give phone number: _____

Work Yes No If yes, give phone number: _____

Cell Yes No If yes, give phone number: _____

Email Yes No If yes, give email address: _____

PRINTED PATIENT NAME: _____ **DOB: _____**

PATIENT/GUARANTOR SIGNATURE: _____ **DATE: _____**

IF GUARDIAN, DOCUMENTATION IS REQUIRED TO VALIDATE ALL PAPERWORK.

EMPLOYEE WITNESS SIGNATURE: _____ **DATE: _____**

This authorization expires 1 year from the date it is signed. This authorization will override any previous authorizations on file with this office.

GREGORY V. BREWER, M.D.
314 Prosperity Road
Knoxville, TN 37923

Name: _____DOB: _____ Date_____

HISTORY OF PRESENT ILLNESS

Reason for today's visit: _____

PAST MEDICAL HISTORY

Please circle if you have ever had any of the following:

Alzheimer's/Dementia	COPD	Hypertension
Anemia	Diabetes	High Cholesterol
Arthritis	DVT	Kidney Disease
A-Fib	Dysrhythmia	Leg Pain when walking
Asthma	Gallstones	Peripheral Vascular Disease
Bleeding Problems	GERD/Reflux/Heartburn	Sleep Apnea
Bronchitis	Heart Attack/MI	Stroke
Cancer	Heart Failure	Thyroid Disease
Cardiomyopathy	Heart Murmur	Tuberculosis
Carotid Artery Disease	Hepatitis	Varicose Veins

Any other problem/disease: _____

_____

Please circle if you have ever had any of these cardiac related services/procedures?

IF YES, PLEASE LIST DOCTOR, HOSPITAL, AND DATE

Holter Monitor _____

Stress Test _____

Echocardiogram _____

Cardiac Catherization _____

Cardiac Stents _____

If yes, how many stents: _____ Location: _____

Coronary Artery Bypass _____

Heart Attack _____

Pacemaker Insertion _____

If yes, what is the brand_____

Defibrillator Insertion _____

If yes, what is the brand_____

Please list all surgeries you have had (give details such as left/right and date it was performed):

_____

_____

_____

_____

_____

Please list all allergies you have and the reaction it causes:

_____

_____

_____

_____

_____

FAMILY HISTORY

Please check all that apply and indicate if the sibling was your brother or sister:

Relationship	Living? If Deceased, what age?	Anemic	Arrhythmia	Asthma	Clotting Disorder	Stroke	Diabetes	Heart Attack	Heart Disease	Heart Failure	Cholesterol	Hypertension
Mother												
Father												
Sibling---Brother or Sister												
Sibling---Brother or Sister												
Sibling---Brother or Sister												
Sibling---Brother or Sister												
Sibling---Brother or Sister												
Sibling---Brother or Sister												
Sibling---Brother or Sister												

SOCIAL HISTORY

Race: _____ Ethnicity: _____ Preferred Language: _____

Occupation: _____ Level of Education: _____

Marital Status: _____You live with: _____ # of Children: _____

Alcohol Use: NEVER NO YES _____# weekly Select Type: Wine/Beer/Liquor Quit Date: _____

Tobacco Use: NEVER NO YES _____# of Years _____ Packs per Day Quit Date: _____

Smokeless Tobacco: NEVER NO YES _____# of years Quit Date: _____

Any Recreational Drug Use: NEVER NO YES Quit Date: _____

REVIEW OF SYSTEMS

PLEASE CIRCLE ANY OF THESE THAT YOU HAVE HAD WITHIN THE PAST 2 MONTHS

CONSTITUTIONAL
Weight Change
Fever
Fatigue

EYES
Eye disease or injury
Wear glasses/contacts
Double/blurry vision
Glaucoma
Cataracts

ENT
Hearing Loss
Sinus problems
Nose bleeds
Bleeding gums

CARDIOVASCULAR
Chest Pains
Fast heart beat/changes
Palpitations
Swollen hands/feet

RESPIRATORY
Frequent Coughing
Spitting up blood
Shortness of breath
Asthma
Wake up smothering
Snoring
Daytime sleepiness

GASTROENTESTINAL
Loss of appetite
Nausea/Vomiting
Frequent Diarrhea
Bloody stool
Stomach ache
Frequent indigestion

GENITOURINARY
Frequent urination
Painful urination
Blood in urine
Kidney stones
Wake up at night to urinate

MUSCULOSKELETAL
Joint pain
Joint stiffness/swelling
Weak muscles/joints
Muscle pain/cramps
Back pain
Cold extremities
Difficulty walking
Painful legs when walking

SKIN
Rash or itching
Change in skin color
Change in hair/nails
Varicose veins

NEUROLOGICAL
Frequent/recurring headache
Dizziness
Seizures
Numbness or tingling
Tremors
Paralysis
Fainting episodes

PSYCHIATRIC
Memory loss/confusion
Nervous/anxious
Depression
Sleep Problems

ENDOCRINE
Excessive thirst
Heat or cold intolerance
Dry skin

HEMATOLOGIC/LYMPHATIC
Slow to heal after cuts
Easy to bruise
Anemia
Phlebitis
Past blood transfusion

Are you having any other problems? _____

MEDICATION INFORMATION (include over the counter medications)

Name of Medication	Strength & Frequency	Condition it is used for	Who prescribed?

I understand that I need to provide my provider with an accurate, complete medication list in order for them to be able to provide treatment to me. The above list is my complete list. I also understand that I need to bring all medications, in their original bottles, to every visit (or bring a complete medication list). Failure to provide this information may result in your appointment being rescheduled until you can bring this information.