GREGORY BREWER, MD PLLC REGISTRATION FORM----**please print**

Last Name: _____First Name: _____ Middle Initial: _____

Date of birth: _____ Social Security Number: _____

Marital Status (circle one) Married/Single/Divorced Race (circle one) White/Black African American/Asian/Other

Language: _____ Ethnicity (circle one) Hispanic/Non-Hispanic/Other

Mailing Address: _____

City: _____ State: _____ Zip:_____

List **ONLY t**he contact phone numbers that you wish to be contacted at:

Primary #_____ is this home or cell?

Secondary # _____ is this home or cell?

List your email if you give consent to receive info from our portal: _____

Do you have a Living Will/Power of Attorney? Circle one: Yes/No If yes our office will need a copy.

Emergency contact name: /Relationship_____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 can obtain a copy of Gregory Brewer MD, PLLC's Notice of Privacy Practices to review (these are on our website and in our office).

OFFICE FORMS: **Each year our 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. This is a standard requirement for all medical practices. Please understand this is not optional. Our receptionists are only doing their job when they relay this information to you.

APPOINTMENTS/NO SHOW FEES: We require a 24-hour notice of cancellation; failure to give 24-hour notice will result in a $40 "no show" fee for office visits. If you fail to give 24-hour cancellation for a Nuclear Stress Test, there will be a $250 "no show" fee.

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. It is impossible for us to know what has been prescribed to you, and by whom. We do not have access to all other physicians/hospitals medical records. **It is your responsibility to provide current, accurate, complete medication lists at every visit.**

SAMPLES: Our office does not provide samples.

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 or failure to follow medical advice) can result in termination of the doctor/patient relationship and dismissal from the practice.*

PATIENT/PROVIDER RELATIONSHIP: In order to maintain a professional, courteous environment for our patients and our staff: disrespectful or derogatory language or conduct can result in termination from the practice. In this event, you would be given notice to establish other cardiology care and would be dismissed from the practice. We value our patients and we value our staff. This requires maintaining professional respect/behaviors in the office.

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 $100.00 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**. Knoxville Indigent Care, Cherokee Health, and your local health department can provide treatment for financial hardship cases.

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 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.

Network Participation: Insurance companies are often adding new plans, changing names, etc., There is no way for us to know all these plans. It is your responsibility to contact your insurance and make sure we are "in network." If we are out of network, you would be billed the full amount for all services and would be a self-pay patient for any future visits.

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, financial 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:**

_____ _____

_____ _____

_____ _____

_____ _____

Health information exchange: TN is an "opt-in" state—this means that your physicians are allowed to share your medical information with each other to help foster quality of care. This is completed thru a secure electronic transmission that is HIPAA approved (not via regular email). YOU CAN CHOOSE TO "OPT-OUT" AND NOT ALLOW THIS ELECTRONIC EXCHANGE BY SIGNING AND DATING BELOW.

SIGNATURE: _____ DATE: _____

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

Home 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 BREWER, MD PLLC

RELEASE FORM TO HAVE YOUR MEDICAL RECORDS SENT TO OUR OFFICE. THEY CAN BE FAXED TO: 865-531-6587 OR MAILED TO: 314 PROSPERITY ROAD, KNOXVILLE TN 37923. OFFICE PHONE: 865-691-8011

1. **I AUTHORIZE MY PROTECTED HEALTH INFORMATION (PHI) AS LISTED BELOW IN SECTION 2, TO BE SENT TO GREGORY BREWER, MD PLLC.**
2. **INFORMATION TO BE DISCLOSED: CHECK AS MANY AS APPROPRIATE:**

_____ COMPLETE RECORDS

OR ONLY SEND THE BELOW INDICATED SECTIONS

_____HISTORY & PHYSICAL EXAM _____OFFICE VISIT NOTES _____BILLING/FINANCIAL

_____OPERATIVE NOTES _____LAB RESULTS _____REFERRAL INFORMATION

_____IMAGING/RADIOLOGY REPORTS _____CONSULT REPORTS (INCLUDING INPATIENT/OUTPATIENT)

_____(INITIALS) I SPECIFICALLY CONSENT TO THE RELEASE OF ANY INFORMATION RELATED TO TESTING ANDTREATMENT OF HIV, AIDS, MENTAL HEALTH/PSYCHIATRIC CARE, OR ALCOHOL AND/OR DRUG ABUSE IF SUCH IS CONTAINED IN THE MEDICAL RECORDS. THIS PROVISION MUST BE INITIALED BY THE PERSON GIVING CONSENT OR THIS INFORMATION WILL NOT BE RELEASED.

3. **INFORMATION TO BE RELEASED FROM THE BELOW PERSON(S)/ORGANIZATION(S):**

PHYSICIAN NAME (PLEASE PRINT) PHONE NUMBER/ADDRESS

_____

_____

_____

_____

4. REASON FOR RECORDS REQUEST: _____OR INITIAL HERE IF AT YOUR REQUEST _____.

5. THIS AUTHORIZATION WILL EXPIRE NO LATER THAN (1) YEAR FROM TODAY. I UNDERSTAND THAT THIS AUTHORIZATION MAY BE REVOKED IN WRITING AT ANY TIME, EXCEPT TO THE EXTENT THAT ACTION HAS ALREADY BEEN TAKEN. IF YOU CHOOSE TO HAVE THIS AUTHORIZATION EXPIRE SOONER THAN (1) YEAR, PLEASE INDICATE THE DATE YOU WANT THE AUTHORIZATION TO EXPIRE:_____

6. IN THE EVENT THAT MY INFORMATION HAS ALREADY BEEN SHARED BY THE TIME MY AUTHORIZATION IS REVOKED, IT MAY BE TOO LATE TO CANCEL PERMISSION TO SHARE MY HEALTH DATA.

PRINTED PATIENT NAME: _____ DOB: _____

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

IF GUARDIAN, DOCUMENTATION IS REQUIRED TO VALIDATE ALL PAPERWORK.

OFFICE STAFF WITNESS SIGNATURE: _____ DATE: _____

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

CARDIAC:
Heart Murmur
Palpitations
Rapid Heart Beat
Swollen Extremities
Cold Extremities
Chest Pain
Chest Tightness/Pressure
Varicose Veins
Blood Clots
Blue Extremities
Elevated Blood Pressure

CONSTITUTIONAL:
Weight Gain
Weight Loss
Fever
Chills
Dizziness

EYES:
Floaters
Blurred Vision
Double Vision
Eye Pain

ENT:
Sore Throat
Hearing Loss
Ear Pain
Nosebleeds
Trouble Swallowing
Ringing in Ears

RESPIRATORY:
Trouble Breathing/Rest
Cough
Trouble Breathing/Exertion
Coughing up blood

GI:
Nausea/Vomiting
Abdominal Pain
Vomiting Blood
Diarrhea
Constipation
Indigestion
Blood in Stool
Black Stool

GU/URINARY:
Painful Urination
Bloody Urine
Urinary Incontinence
Excessive urination/Night
Discharge
Flank Pain

MUSCLE:
Back Pain
Muscle Pain
Joint Pain
Arthritis
Painful Legs/Walking

NEUROLOGIC:
Headaches
Slurred Speech
Tremors
Seizures
Paralysis
Numbness

ENDOCRINE:
Extreme Thirst
Excessive Urine
Cold Intolerance
Heat Intolerance
Excessive hair loss

ALLERGY:
New Allergies
Runny Nose
Sneezing
Itchy Eyes

HEMATOLOGY:
Bleeding Easily
Bruising Easily
Anemia
Blood Clots

PSYCH:
Memory Loss
Confusion
Depression
Anxiety

SKIN:
Rashes
Lumps
Masses
Discharge

Have you had a flu shot: YES/NO If yes, what month/year?_____
Have you had a pneumonia shot: YES/NO If yes, what month/year? _____

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 it is my responsibility to provide my medical provider with an accurate, complete medication list in order for them to be able to make clinical decisions. The above list is my complete list. I 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 my appointment being rescheduled until I can provide this information. I understand that I can not expect my provider to make clinical decisions if I can't provide them an accurate up-to-date medication list (as medical interactions are always changing, etc.,) .