University of Tennessee Graduate School of Medicine
UT OB/GYN Center
1928 Alcoa Hwy Building B, Suite 127
Knoxville, TN 37920

## Welcome and thank you for choosing UT OB/GYN Center!

We look forward to serving your health care needs. Our office is associated with the University of Tennessee's Graduate School of Medicine and our providers include Nurse Practitioners and Physicians that are Resident Doctors continuing their training in obstetrics and gynecology. Experienced Faculty of the Graduate School of Medicine, OB/GYN Department, directly supervises the Resident doctors.

The office is open from 7:30 am to 4:30 pm. Monday through Friday except for state holidays. Selected time is set aside for your care, and we expect that you will honor your appointments. Please kindly give 48 hours' notice if you will be unable to keep an appointment. Patients who frequently fail to show up for appointments will be dismissed from the practice. Medications for chronic conditions unrelated to obstetrics and gynecology are never written or refilled from this office and this includes narcotics or mood-altering medications.

**Even though the pandemic is past us, we are allowing ONLY ONE visitor and newborn babies with post postpartum moms. Patients are expected to wear a mask if you have any signs of fever, ough and any other respiratory symptoms. Please be mindful of the staff and providers who take care of you.**

If you feel you have a health emergency when our office is closed, we urge you to go to the nearest emergency room or call 911. The nurse handles non-emergency calls by the end of the business day. For non-emergency problems that cannot wait until business hours, you may contact the physician on call at (865)305-8787.

Please ask your physician to write prescriptions with enough refills to last until your next office visit. If you should run low or run out of medication before your next visit, most pharmacies will fax refill requests to your physician's office on request. However, you may still be required to schedule an appointment in order to receive more medication. **Please allow at least 72 hours for refills on medications. Any phone messages to the nurses after 3.00pm will be addressed on the next business day.**

Our OBGYN Resident clinic is now a Patient Centered Medical Home. The focus is on coordinating care as a team across the health system, prevent frequent ER visits or hospital readmissions and to be your primary care providers for all your needs. Our practice practices evidence-based medicine as defined by the American College of Obstetricians and Gynecologists

Thank you for choosing UT Internal Medicine Center. Our Physicians, Nurse Practitioners, and staff are committed to providing you with their best medical service. If you have questions or concerns, please contact our office for assistance at (865)305-8787. For any educational Resources please visit our Health Information Center https://www.utmedicalcenter.org/locations/health-information-center

Please visit our website: gsm.utmck.edu/imobgynclinic.cfm for further information or visit our utmck patient portal https://www.utmedicalcenter.org/patients-visitors/patient-portal.

# UT Internal Medicine and OB/GYN Clinic

**PATIENT INFORMATION** **Today's Date**: _____ **MRN #:** _____

**Patient's Name**: _____
(Last Name) (First Name) (Middle Name) (Preferred)

**SS#**: _____-_____-_____ **Sex**: Male☐ Female☐ Othe☐ **DOB**: ____/_____/_____ **Language**: _____

**Race**: *(Select all that apply)* ☐White ☐Black or African American ☐American Indian/Alaskan ☐Asian ☐Hispanic

☐Hawaiian or Other Pacific Island Other_____ **Education Level**: _____

**Ethnicity**: (*Select one*) ◯ Hispanic/Latino ◯ Not Hispanic/Latino **Marital Status:** _____

**Address**: _____ **City**: _____ **State**: _____ **Zip**: _____

**Home Phone #**: (____) _____ **Cell Phone #**: (____) _____ **Preferred Phone (***select one)*:◯ Home ◯ Cell

**Email Address**: _____

*UT IMOBGYN Clinic is contractually obligated to ask patients gender related questions as part of the National Committee for Quality Assurance{NCQA) requirements. Should you choose not to disclose this Information to us, please select the option "choose not to disclose". The Information requested on this demographic form may help us to ensure the highest quality care by our clinic.*

**GENDER IDENTITY**:
- ◯ IDENTIFIES AS MALE
- ◯ IDENTIFIES AS FEMALE
- ◯ TRANSGENDER MALE/FEMALE TO MALE (FTM)
- ◯ TRANSGENDER FEMALE/MALE TO FEMALE (MTF)
- ◯ GENDER NON-CONFORMING
- ◯ ADDITIONAL GENDER CATEGORY/OTHER, PLEASE SPECIFY _____
- ◯ CHOOSE NOT TO DISCLOSE

**SEXUAL ORIENTATION:**
- ◯ STRAIGHT OR HETEROSEXUAL
- ◯ LESBIAN, GAY OR HOMOSEXUAL
- ◯ BISEXUAL
- ◯ SOMETHING ELSE, PLEASE DESCRIBE: _____
- ◯ DON'T KNOW
- ◯ CHOOSE NOT TO DISCLOSE

**INSURANCE INFORMATION** ***(Please provide card(s) to receptionist to photocopy at every visit)***

**Occupation**: _____ (*Select one*): ◯ No Insurance ◯ SELF PAY

**Employment Status**: (*Select one*) ◯Retired ◯Employed ◯Student ◯Disabled ◯Unemployed

**Patient's Employer:** _____ **Work Phone #:** _____

**Name of insurance companies**: #1 _____#2_____

**Insurance ID number for**: #1_____ #2 _____

**Name of insured**: _____ **DOB**: _____/_____/_____ **SS#**: _____/_____/_____

**Address**: _____ **City**: _____ **State**: _____ **Zip**: _____

**GUARANTOR INFORMATION: (Person Responsible for payment of balance)** **SAME AS PATIENT:** ☐

**Guarantor:** _____ **DOB**: _____/_____/_____ **SS#**: _____-_____-_____

**Relationship to Guarantor**: *(Select one)* ◯Self ◯Spouse ◯Child ◯Dependent ◯other

**Address**: _____ **City**: _____ **State**: _____ Zip:

**Guarantor's employer**: _____ **Work Phone #**:

**Referral Source**: *(Select one)*◯Physician Referral ◯ Patient Referral ◯ Internet Search ◯ Other_____

**Emergency Contact:**
**Name:**_____**Date of Birth:**_____**Phone #:** _____**Relationship:** _____

✖ **Signature (Patient or Guardian)**: _____ **Date signed**: _____

**UT GRADUATE SCHOOL OF MEDICINE**
**UT Internal Medicine and OB/GYN Center**
**1928 Alcoa Hwy, Suite 127**
**Knoxville, TN 37920**

Patient Name: _____

Date of Birth: _____
MRN #: _____

**ADDITIONAL INFORMATION**

**Do you have a Primary Care provider (PCP): ◯ Yes ◯ No If Yes, Name of PCP: _____**

**Are you on the UTMCK Patient Portal: ◯ Yes ◯ No If No: Do you want to be added to the Portal: ◯ Yes ◯ No**

**Do you have capability for Telehealth (like iphone, android, tablet or computer) : ◯ Yes ◯ No**

**CONSENT TO TREAT**

**Clinical Treatment:**

**Consent to Treat:** I consent to treatments and/or tests provided by UT Internal Medicine and OB/GYN Center. I reserve the right of consent for procedures until after the risks and benefits have been explained to me. This permission includes receipt of medication history through my authorized pharmacy plan.

**X Signature: _____ Date: _____**

**CONSENT TO SHARE MEDICAL & BILLING INFORMATION**

**How may we contact you**? *(Select all that apply)* ◯ Phone Call ◯ Text ◯ Letter ◯ Patient Portal

**May we leave messages ?** *(Select one)* **Home answering machine**? ◯ Yes ◯ No **Cell Phone?** ◯ Yes ◯ No

**Who may we speak with about your medical and/or billing information?** Please complete below

| Name | Relationship | Phone |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

***Our office may send patient satisfaction surveys to you, answering the survey will help us improve our clinic**

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPPA)**

(Available in office UPON REQUEST)

I have been given an opportunity to review, ask questions about and understand UT Internal Medicine and OB/GYN Center's (IMOB) Notice of Privacy Practices for Protected Health Information (Notice). I acknowledge receiving today a copy of the PROVIDER'S notice of privacy policies. I consent to the PROVIDER'S use of protected health information as described in the notice for treatment, payment, or health care operations. I have also seen and read the Notice of privacy policies on this Portal and am able to print the policies if I need a copy.

**Signature: _____ Date: _____**

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## Financial Responsibility Consent Form

**Patient's Name _____Date of Birth_____ MRN #:_____**
(Please Print)

Thank you for choosing UT Internal Medicine & OBGYN Center. The following information is provided regarding your payment for professional services. ***Please sign and date at the bottom of this page.***

**Assumption of Responsibility:** I agree that in consideration of services to be rendered, I obligate myself, assume financial responsibility and agree to pay upon demand to above named practice all charges for such services and incidentals incurred. Should the account be referred to an attorney for collection, I agree to pay reasonable attorney fees and collection expenses. **I understand that if my account is turned over to an outside agency for collections, I will be dismissed as a patient and given thirty (30) days (from the date of dismissal) of emergency care only.**

**Responsibility for Co-pay Amounts:** I agree to be fully responsible for paying co-pays of set amounts at the time of services. Further, I understand that if my co-pay is a percentage, I will be responsible for payment immediately after insurance benefits have paid. I understand that any bill received after insurance is paid will be due upon receipt.

**Referrals and Prior Authorizations:** I understand that if I have insurance coverage, which requires a pre-authorization or referral, it must be received in order to receive the maximum benefits from the insurance company. Our office will attempt to obtain the pre-authorization/referral or reschedule my appointment. I understand that if this office is unable to obtain the pre-authorization/referral that I am fully responsible for payment.

**Non-Covered, Out of Network Services, and Self-Pay Patients:** I understand that I am responsible for charges for medical services that are considered by my insurance company to be non-covered, out of network, or not medically necessary. I understand that if I do not have group or individual medical insurance, payment is due at the time of visit with a substantial discount. Payment is due before another appointment is scheduled.

**Appointment No-Show Procedure:** I understand that if I fail to show up for my first appointment I may not be accepted into the practice, or if I fail to show up for 3 appointments, a warning letter will be sent and further you may be terminated from the practice.

**Assignment of Insurance Benefits:** I hereby assign direct payment of any insurance benefits including Medicare, Medigap, major medical benefits, insurance disability benefits, or injury benefits payable because of liability of a third party or organization, payable to or for the above said patient until account is paid in full.

**Concerns of Identity Theft:** I understand that an insurance claim may not be accepted without the use of my social security number.

✖ **Signature: _____ Today's Date: _____**
*(Signature of patient or guardian)*

Rev 03/20/2024

## General Consent for Care and Treatment Consent

***TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).***

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees (Resident,etc.) as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

| | |
|---|---|
| **Signature of Patient or Personal Representative** | **Date** |
| **Printed** Name of Patient or Personal Representative | **Relationship to Patient** |

Submit Form