

Date: \_\_\_\_\_ Daniel S. Graves, MD  
 Page 1 of 1 120 Administration Road  
 Rev. 1/13 Oak Ridge, TN 37830

Jacob E. Gingerich, DO  
 120 Administration Road  
 Oak Ridge, TN 37830

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 120 Administration Road  
 Oak Ridge, TN 37830

**PATIENT INFORMATION**

Name (Last, First, Middle):		SSN#		Birthdate	Age	Sex
Mailing Address				City, State, Zip		
Home Phone		Cell Phone		Email Address		
Marital Status	Student Status Full-Time Part-Time	Smoker? Yes or No	Veteran (Y/N)?	Ethnicity: Hispanic or Non-Hispanic	Primary Care Physician	
Referring Physician		Referring Physician Contact #	Other Medical Providers			
Race (Circle Answer): African American, Alaskan Native, Asian, French, German, Greek, Hawaiian, Hispanic, Indian, Multi-Racial, Native American Indian, Pacific Islander, White					Language	
Emergency Contact Name			Emergency Contact Phone #s Hm: Cell:			
Employer Name and Address					Work Phone #	
How did you learn about our office? Please circle one.			Billboard Ad	Direct Mail	Hospital Referral	
Insurance	Newspaper Ad	Patient Referral	Physician Referral	Previous Patient		
Internet	Self-Referral	Yellow Pages	Other:			

**If patient is a minor, please fill out this portion**

Parent or Guardian's Name:	Parent or Guardian's Phone #s Hm: Wk: Cell:
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**RESPONSIBLE PARTY INFORMATION (if different from above)**

Name (Last, First Middle)		SSN#		Birthdate	Sex
Address				City, State, Zip	
Home Phone	Cell Phone	Work Phone	Relationship to patient		

**PRIMARY INSURANCE**

Name of Insurance Company	Name of Insured	Address of Insured (if different than address above)			
Insured's Birthdate	Insured's SSN #	Insured's Insurance ID #	Relationship to patient		

**SECONDARY INSURANCE (if applicable)**

Name of Insurance Company	Name of Insured	Address of Insured (if different than address above)			
Insured's Birthdate	Insured's SSN#	Insured's Insurance ID #	Relationship to patient		

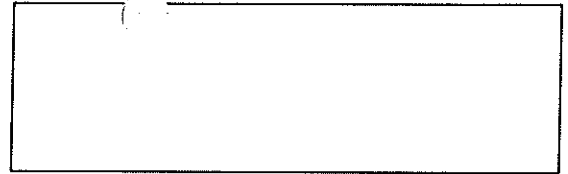
**Workers Compensation**

Are you here for workers compensation YES \_\_\_\_\_ NO \_\_\_\_\_ Date: \_\_\_\_\_

**Accident**

Auto	Work	Other	Date of Accident:
Do you have any Advanced Directives? (e.g., Living will or Advanced Care Plan)			Yes _____ No _____
Do you have a Power of Attorney?			Yes _____ No _____

If yes to the above questions please make sure we have a copy for your medical record.



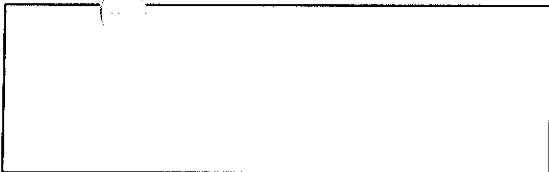
**IN CONSIDERATION OF THIS PHYSICIAN PRACTICE (THE "PRACTICE") FURNISHING SERVICES TO THE PATIENT, PATIENT (OR PATIENT'S LEGALLY AUTHORIZED REPRESENTATIVE, ON PATIENT'S BEHALF) AGREES AS FOLLOWS:**

**I. CONSENT TO MEDICAL TREATMENT AND SERVICES:** The below-signed individual hereby authorizes the Practice and its associated professionals to furnish medical treatment and services to the patient and consents to diagnostic and therapeutic medical care, items, services, and procedures furnished by the Practice, its professionals, and their assistants and designees. Such consent includes consent to photographic/video documentation of the patient's medical treatment as the patient's treating professional finds medically necessary. There are potential risks and hazards to any medical treatment or service, and there is no guarantee any particular treatment or service furnished by the Practice or its professionals will be successful. It is the Practice physician's responsibility to provide adequate information concerning a proposed treatment or service and to obtain any additional necessary consent before proceeding except as limited by emergency or other time-sensitive circumstances. The Practice's staff may obtain signature for such consent. The patient has the right to question and refuse treatment; however, if a proposed treatment is refused, the undersigned agrees CMG, the Practice, and their associated professionals and staff shall be released from any and all liability for failure to provide treatment to the patient.

**II. CONSENT TO COMMUNICABLE DISEASE TESTING:** The below-signed individual consents for the patient to be tested for hepatitis, human immunodeficiency virus infection, or any other blood-borne infectious disease, as well as for any other communicable disease or condition, if and when another patient, a health care practitioner, or other individual furnishing services to patient at the Practice, a Practice employee, or an emergency aid worker has a potential exposure from the patient. If such testing becomes necessary, it will be performed at no charge to the patient.

**III. CALCULATION AND PAYMENT OF CHARGES:** The patient is liable and individually obligated for payment of the Practice's charges on the patient's account and the undersigned individual understands and agrees to the following: (1) The Practice's charges are set out in a chargemaster, the relevant portions of which may be examined for purposes of verifying the patient's account during regular business hours in our billing office. The Practice reserves the right to change the rates in the chargemaster. Charges on the patient's account are calculated based on chargemaster rates in effect as of the date charges for items or services are accrued. (2) The patient is liable for the uninsured portion of the Practice bill, which is due in full when services are rendered. Any amount not paid in full by insurance, for any reason, is the responsibility of the patient. (3) The Practice has both an uninsured patient discount policy and an indigent care policy. If the patient is uninsured, the patient is automatically entitled to a discount on chargemaster rates in accordance with the Practice's uninsured patient discount policy. In addition, if the patient is uninsured and meets certain criteria set forth in the Practice's indigent care policy (including, without limitation, income criteria), the patient may be entitled to further discounts to chargemaster rates. Please contact the Practice's financial counselors in our office or the CMG billing office at 865-374-5200 for more information. (4) The amount of the patient's Practice charges may differ from amounts other patients are obligated to pay based upon each patient's insurance coverage, Medicare/Medicaid coverage, or lack of insurance coverage. The amount of any discount from charges varies based on the circumstances applicable to each individual under the Practice's policies. (5) After reasonable notice, delinquent accounts may be turned over to a collection agency and/or attorney for collection. The patient agrees to pay the costs of collection, including court costs, reasonable attorney fees, collections charges, and reasonable interest charges, associated with Practice's efforts to collect amounts due.

**IV. MEDICARE/MEDICAID PATIENT CERTIFICATION AND ASSIGNMENT OF BENEFITS:** The undersigned individual certifies that the information provided in applying for payment or reimbursement under Titles XVIII and XIX of the Social Security Act is true and correct. Further, the undersigned certifies that correct and complete information has been provided regarding the patient's insurance, HMO, health plan, workers' compensation, or other coverage for services and items furnished to the patient by the Practice, and the undersigned consents to the Practice's billing such payers for items and services furnished by the Practice to patient. The undersigned hereby irrevocably assigns to CMG (or, if Practice professionals are not CMG employees, to Practice) all rights, title, and interest in compensation or payments otherwise payable to the patient, or received by or on behalf of the patient, for Practice items or services from any source or payer on file for the patient's account, including Medicare/Medicaid/TennCare, insurance companies, HMOs, and any other third-party payer or financially responsible person, not to exceed charges for services or items rendered. Any person, corporation, or government entity having notice of this assignment is authorized and directed to pay directly to CMG (or, if Practice professionals are not CMG employees, to Practice) all amounts due for health care items and services provided to the patient by the Practice. Except as provided in Section III or by law, the patient is financially responsible to the Practice for the charges not covered by these authorizations. The undersigned understands there are certain items and services for which payers, including Medicare and TRICARE/CHAMPUS/CHAMPVA, do not pay. Any sums not paid by a third-party payer are the patient's obligation. The patient is responsible for all health insurance or health plan deductibles and co-insurance, as well as noncovered or excluded items or services. If it is later determined the patient has an HMO or other health plan primary to Medicare and failed to inform the Practice prior to service of such election, the patient shall be



responsible for paying the account. In the case of series services furnished to the patient by Practice, this Agreement shall remain in full force and effect for all such series services until specifically revoked in writing. The undersigned agrees to sign such further documents as may be reasonably requested to confirm and substantiate the Practice's or CMG's rights hereunder. The undersigned further agrees that a copy of this assignment may be used in place of the original copy.

**V. RECEIPT OF NOTICE OF PRIVACY PRACTICES; CONSENT TO USE AND DISCLOSE HEALTH INFORMATION:** The undersigned acknowledges receipt of the Practice's Notice of Privacy Practices, which is incorporated into this Agreement by reference, and consents to use and disclosure of the patient's protected health information and other patient records (a) consistent with such Notice, including without limitation, for purposes of the treatment, payment, and health care operations functions described in such Notice, whether through electronic health information exchange or otherwise; and (b) as authorized or permitted by federal or state law. Consistent with the above, the undersigned agrees to the Practice's disclosure of all or part of the patient's medical record for treatment purposes and to any person, corporation, or agency that is or may be liable for charges incurred at the Practice or for determining the necessity, appropriateness, amount, or other matter related to such services or charges, including, without limitation, insurance companies, HMOs, PPOs, workers compensation carriers, welfare funds, governmental health plans, the Social Security Administration, the Centers for Medicare & Medicaid Services, or any contractors of the same. The undersigned also consents to release by the patient's health plan or other insurance carrier to the Practice and CMG of any eligibility, utilization, or plan data concerning the patient's coverage that may be required.

**VI. PATIENT IDENTIFICATION; PERSONAL VALUABLES:** The undersigned consents to photographic documentation of the patient for purposes of identification and registration. Further, the undersigned agrees that Practice is not responsible for loss of or damage to any money, jewelry, eyeglasses, clothing, hearing aids, or other personal property.

**VII. HEALTH PLAN NOTIFICATION/AUTHORIZATION; APPOINTMENT:** If the patient's health plan, insurer, or other coverage requires notification/authorization as a condition of payment for services, the patient must provide such notification and obtain such authorization. The patient hereby assumes full financial responsibility for charges incurred as a result of failure to comply with prior notification/authorization requirements. Notwithstanding the foregoing, the undersigned hereby appoints Practice as patient's agent for purposes of requesting prior authorization for services Practice professionals order at a Covenant Health hospital (e.g., lab services) and agrees Practice may delegate such appointment to such hospital. The undersigned acknowledges there is no guarantee or assurance authorization will be obtained.

**VIII. AMENDMENTS:** Revisions to this Agreement are not effective or enforceable unless accepted in writing by a CMG corporate officer.

**IX. CONTACTING PATIENT.** Patient may be contacted at the following number: \_\_\_\_\_. In addition, please check one of the following:

Practice may contact or leave messages regarding appointments and lab/test results with the following:

Name: \_\_\_\_\_ Relation to patient: \_\_\_\_\_ Phone: \_\_\_\_\_  
Name: \_\_\_\_\_ Relation to patient: \_\_\_\_\_ Phone: \_\_\_\_\_

Practice may not leave messages regarding appointments and lab/test results with anyone other than patient.

**I HAVE READ AND UNDERSTAND THIS REGISTRATION AGREEMENT AND BY SIGNING BELOW, AGREE TO ITS TERMS. IF THE UNDERSIGNED IS NOT THE PATIENT, SUCH INDIVIDUAL HEREBY CERTIFIES THAT HE/SHE IS THE PATIENT'S AUTHORIZED REPRESENTATIVE AND HAS ALL NECESSARY LEGAL AUTHORITY TO ENTER INTO THIS AGREEMENT ON THE PATIENT'S BEHALF.**

**SIGNATURE: PATIENT (OR PATIENT'S LEGALLY AUTHORIZED REPRESENTATIVE)**

SIGNED

PRINTED  
NAME

\_\_\_\_\_

\_\_\_\_\_

PATIENT  
NAME

RELATIONSHIP  
TO PATIENT

\_\_\_\_\_

DATE

TIME

AM/PM

\_\_\_\_\_

*A copy of this agreement will be provided on request.*

## APPOINTMENT CANCELLATION AND NO-SHOW POLICY

Last minute cancellation and same day no-shows make it difficult to serve other patients who are waiting to be scheduled. We ask that you give a twenty four (24) hour notice of cancellation or reschedule prior to your appointment if you will be unable to keep that appointment. We will be happy to reschedule your appointment. Scheduled appointments that you do not show up for, will result in a \$25.00 fee. No show fees are the sole responsibility of the patient and will be billed to the patient.

Patient Printed Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# Health Information

Name \_\_\_\_\_ Date \_\_\_\_\_

Maiden Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Referring Doctor \_\_\_\_\_ Family Physician \_\_\_\_\_

List **all** previous surgeries and their approximate dates:

_____ Appendectomy	_____ Breast	_____ Vascular
_____ Gallbladder	_____ Colon	_____ Hernia
_____ Hysterectomy	_____ Heart	_____ Other
_____ Other	_____ Other	_____ Other

Do you have, or have had problems with:

- |  |   |                                    |                                   |   |  |
|--|---|------------------------------------|-----------------------------------|---|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Bloody Stool   | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV/AIDS         | <input type="checkbox"/> Blood Thinner |
| <input type="checkbox"/> Blood Clots         | <input type="checkbox"/> Lung/Breathing | <input type="checkbox"/> Stroke    | <input type="checkbox"/> TB       | <input type="checkbox"/> IV Dye Allergies | <input type="checkbox"/> Latex Allergy |
| <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Heart          | <input type="checkbox"/> Cancer    | <input type="checkbox"/> Thyroid  | <input type="checkbox"/> Pneumonia        | <input type="checkbox"/> Sleep Apnea   |
| <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Ulcers         | <input type="checkbox"/> Other     | <input type="checkbox"/> Other    | <input type="checkbox"/> Other            |  |

List all medications, dosage, and how often you take them, including aspirin, blood thinner, etc.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Are you allergic to any medications or foods? if so, what: \_\_\_\_\_

Have you had any problems with anesthesia? (explain) \_\_\_\_\_

Have you had any blood transfusions? \_\_\_\_\_

Do you require any special diet? if so, what kind? \_\_\_\_\_

Do you or did you use tobacco? if so, what form? \_\_\_\_\_

How much? \_\_\_\_\_ How often? \_\_\_\_\_ When did you quit? \_\_\_\_\_

Do you drink alcohol? if so, how much? \_\_\_\_\_ How often? \_\_\_\_\_

Do you wear dentures? \_\_\_\_\_ Upper \_\_\_\_\_ Lower \_\_\_\_\_ None \_\_\_\_\_

Last dates and locations for:

Hospitalization \_\_\_\_\_ DATE \_\_\_\_\_ location \_\_\_\_\_

Chest x-ray \_\_\_\_\_ DATE \_\_\_\_\_ location \_\_\_\_\_

EKG \_\_\_\_\_ DATE \_\_\_\_\_ location \_\_\_\_\_

How many pregnancies have you had? \_\_\_\_\_ How many were live births? \_\_\_\_\_ Did you breast feed? \_\_\_\_\_

Occupation \_\_\_\_\_ Hobbies \_\_\_\_\_

Any family history of the following:

- |  |                                  |                                 |                                   |
|--|----------------------------------|---------------------------------|-----------------------------------|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Strokes | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes |
|--|----------------------------------|---------------------------------|-----------------------------------|

Name of your pharmacy \_\_\_\_\_ Telephone Number \_\_\_\_\_

What is the reason for today's visit? \_\_\_\_\_

Do you have a home health agency?  Yes  No

Please give name \_\_\_\_\_ Telephone Number \_\_\_\_\_

**OAK RIDGE SURGEONS, P.C.**

120 ADMINISTRATION RD., OAK RIDGE, TN 37830 865-483-7030