Family Health Center of Ashland City, PLLC, 342 Frey Street, Ashland City, TN 37015, 615-792-1199
RURAL HEALTH CLINIC

PLEASE PRINT CLEARLY

PATIENT INFORMATION

Patient Name: First _____ Middle Initial _____ Last _____

Date of birth: _____ Sex: _____ Marital Status: _____ Social Security #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Best phone #: _____ Alternate #: _____ Race:_____ Ethnicity:_____

Preferred method of appointment reminders (please circle): text email phone Employed? Yes No Retired

Best time to reach you: _____ Email address: _____

***Emergency Contact: _____ Relationship to Patient: _____

***Emergency Contact Phone #: _____

Do you have an advocate (someone other than yourself who manages your healthcare)? Yes No

Name: _____ Relationship to Patient: _____ Ph #: _____

Advance Directives For Health Care (If the patient is over 18) Do you have an Advance Directive, Appointment of Health Care Agent, and/or Physician Orders for Life-Sustaining Treatment? yes no

PEDIATRIC PATIENTS ONLY (under 18 years of age)

Father's Name: _____ Mother's Name: _____

With whom does the child reside? Father / Mother / Both Parents / Other (Specify): _____

Who should we contact with results? _____ Relationship to Patient: _____

RESPONSIBLE PARTY INFORMATION

Name: First _____ Middle Initial _____ Last _____

Date of birth: _____ Sex: _____ Marital Status: _____ Social Security #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Relationship to patient: Self / Spouse / Parent / Other (Specify): _____

Responsible Party Phone # (if different from patient): _____

INSURANCE INFORMATION

Are you covered by health insurance? Yes No (If no, please make payment arrangements with our business office.)

Primary Insurance: _____

Policy #: _____ Group #: _____

Policy Holder Name: _____ Relationship to patient: _____

Policy Holder date of birth: _____ Social Security #: _____

Secondary Insurance: _____

Policy #: _____ Group #: _____Policy Holder Name: _____

Relationship to patient: _____Policy Holder date of birth: _____ SSN: _____

HIPAA-COMPLIANCE

If I cannot be reached my personal health information can be given to: _____ Ph#:_____

I have received the "Notice of Privacy Practices" for FHCAC. yes no

AUTHORIZATIONS & CONSENT FOR PAYMENT: I hereby authorize the Family Health Center of Ashland City PLLC (FHCAC) to obtain medical records from hospitals, specialists, emergency rooms and my previous primary care physician on my behalf. I hereby authorize FHCAC to use and/or disclose pertinent health information to carry out my treatment, payment, and healthcare operations. I hereby authorize my insurance benefits to be paid directly to FHCAC, realizing I am responsible to pay non-covered services. I have listed all health insurance plans from which I may receive benefits. I agree to pay all copayments, coinsurance and deductibles at the time services are rendered. I shall be responsible for reasonable collection agency fees, attorney fees, court costs or any fees incurred in an attempt to collect amounts I may owe, not to exceed 50% of the outstanding charges. If my check is returned for non-sufficient funds, I shall be responsible for a $20.00 NSF fee. If I do not show up for an appointment or cancel my appointment with less than 24 hours' notice I shall be responsible for a $30.00 no-show fee. I understand that while this consent is voluntary, if I refuse to sign this consent, FHCAC can refuse to treat me. I understand this authorization can only be revoked in writing. If I revoke my consent, such revocation will not affect any actions that FHCAC took before receiving my revocation.

Signature of Patient or Patient's Representative: _____ Date: _____