TRI STAR MEDICAL GROUP
Skyline Neuroscience Associates

PATIENT REGISTRATION FORM

Patient's Name (Last) _____ (First) _____ (Middle) _____

Address _____ City _____ State _____ Zip _____

Primary Phone # _____ Alternate Phone # _____ Work Phone # _____

Date of Birth _____ Social Security # _____ Sex: ☐ Male ☐ Female ☐ Transgender

Email: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Language: ☐ English ☐ Spanish ☐ Other _____

Employment Status: ☐ Employed ☐ Unemployed ☐ Self-Employed ☐ Retired ☐ Active Military ☐ Student

Emergency Contact Name (Last) _____ (First) _____ Relation: _____

Primary Phone # _____ Alternate Phone # _____ Work Phone # _____

Primary Care Physician: _____ Phone #: _____

Pharmacy Name: _____ Location: _____

Have you been to a facility other than *Skyline Neuroscience Associates* since your last visit? Yes ☐ No ☐

PRIMARY Insurance _____ Phone # _____

Name of Insured _____ Patient Relationship To Insured _____

Policy ID # _____ Group # _____ Effective Date _____

SECONDARY Insurance _____ Phone # _____

Name of Insured _____ Patient Relationship To Insured _____

Policy ID # _____ Group # _____ Effective Date _____

How did you hear about us? ☐ Hospital Visit ☐ Online ☐ Newspaper ☐ Mail ☐ Seminar

☐ PCP/Physician _____ ☐ Other: _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

_____ _____

Patient Signature Date

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 or any other satellite office under common ownership. 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 recommend 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 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

Patient Financial Agreement:

Financial Agreement

- I acknowledge, that as a courtesy, Skyline Neuroscience Associates may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand that there is a fee for returned checks.

____ (Patient or Guardian Initials)

Third Party Collection. I acknowledge that Skyline Neuroscience Associates may utilize the services of a third party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

____ (Patient or Guardian Initials)

Assignment of Benefits. I hereby assign to Skyline Neuroscience Associates any insurance or other third-party benefits available for health care services provided to me. I understand Skyline Neuroscience Associates has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Skyline Neuroscience Associates, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

____ (Patient or Guardian Initials)

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to Skyline Neuroscience Associates by the Medicare or Medicaid program.

____ (Patient or Guardian Initials)

Consent to Telephone Calls for Financial Communications. I agree that, in order for Skyline Neuroscience Associates, or EBO Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that Skyline Neuroscience Associates or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or Skyline Neuroscience Associates or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

____ (Patient or Guardian Initials)

A photocopy of this consent shall be considered as valid as the original.

Patient/Patient Representative Signature:

X_____Date_____

If you are not the Patient, please identify your Relationship to the Patient.

(Circle or mark relationship(s) from list below):

Spouse	Guarantor
Parent	Healthcare Power of Attorney
Legal Guardian	Other (please specify) _____

Section A: This section must be completed for all Authorizations			
Patient Name:	**Birth Date:**	**Social Security No. *(optional)*:**	
Provider's Name:	**Recipient's Name:** Skyline Neuroscience Associates P615-860-1040 F615-860-1242		
Provider's Address:	**Address 1:** 3443 Dickerson Pike, Suite 580		
	Address 2:		
	City: Nashville	**State:** TN	**Zip:** 37207

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: **Event:**

Purpose of disclosure: Continuity of care

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	***Date(s):***	***Description:***	***Date(s):***	***Description:***	***Date(s):***
☒ All PHI in medical record		☐ Operative Information		☐ Labor/delivery sum.	
☐ Admission form		☐ Cath lab		☐ OB nursing assess	
☐ Dictation reports		☐ Special test/therapy		☐ Postpartum flow sheet	
☐ Physician orders		☐ Rhythm Strips		☐ Itemized bill:	
☐ Intake/outtake		☐ Nursing Information		☐ UB-92:	
☒ Clinical Test		☐ Transfer forms		☐ Other:	
☐ Medication Sheets		☐ ER Information		☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial)

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing?

If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information?	☐ Yes ☐ No
If yes, describe:	

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient's Representative:	**Date:**
Print Name of Patient's Representative:	**Relationship to Patient:**