Turkey Creek Office
11440 Parkside Drive
Suite 302
Knoxville, TN 37934
Ph. (865) 218-9220
Fx. (865) 218-3331

Cherokee Mills Office
2250 Sutherland Avenue
Suite 121
Knoxville, TN 37919
Ph. (865) 218-9220
Fx. (865)218-3330

Welcome _________________________

Your Appointment is ____________________________ Location ________________________
(Date and Time)

Thank you for choosing our practice for your medical care. The staff of Faculty Internal Medicine wants to make your experience with our office pleasurable.

For your convenience, below is a check list of what you need to bring to your first appointment:

__ **Patient History Record (included in this packet)**
__ **Complete medication list**
__ **Photo ID**
__ **Insurance Card/s**
    __ **Policy holders address and date of birth for each**
__ **Co Pay and/or coinsurance**
__ **Names and phone numbers of anyone allowed to have access to your medical and/or financial records**
__ **Names and phone numbers of all emergency contacts**
__ **Living Will**

We do ask that you arrive **30 minutes** prior to your appointment. This will allow time for you to input this information into our electronic check-in system. This system is an electronic tablet where information is gathered from the patient and electronically transmitted into your medical record, eliminating the need for paper.

We ask that you present this packet fully completed at your time of arrival. Failure to have this packet filled out completely may result in your appointment being rescheduled.

We ask that you come to your New Patient appointment **fasting** in case the physician orders lab work:
AM appointments: Nothing to eat or drink after midnight. You may have water or black coffee.
PM appointments: You may have a light non-fat breakfast 8 hours prior to your scheduled appointment. You may have water or black coffee.

Faculty Internal Medicine staff can not assist your from your vehicle into our suite or from our suite to your vehicle. We do have wheelchairs in our suite that you may utilize at your visit. If you need assistance with navigation, please have a caregiver accompany you to your scheduled appointments.

We want to make your experiences in our office positive ones. Please alert us to any special needs, questions or concerns. If there is ever anything we can do to improve your experience in our office, please let us know.

Thank you for allowing us to serve you! We look forward to seeing you soon.

Sincerely,
Faculty Internal Medicine

Faculty Internal Medicine, PLLC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Faculty Internal Medicine

Patient Information Sheet

After-hours EMERGENCIES:

- In case of a major emergency, call 911 or proceed to the nearest emergency room. If necessary, the emergency room will contact the physician.
- For other after-hours problems that require a doctor (weekends, holidays or week days 4:00 PM – 8:00 AM) our telephone number is 865-218-9220. The physician or his representative will return your call.
- All after hours phone calls are subject to a $25.00 fee. Most insurance companies will not cover this fee therefore; we will not file with your insurance company. You will be responsible to pay this fee.
- Prescription refills are handled only during office hours to maintain quality of care and reduce prescribing errors.

What to bring to the office each visit:

- Current health insurance card
- Means of paying for services or co-payments
- Photo identification
- Any change of address, phone number, employment
- List of all medication including occasional medication, 'over the counter' medication or supplements (vitamins, herbs, etc.). Please include dosages, and how often taken.

Appointments:

- When you schedule your appointment, please provide the complete list of reasons for your appointment so that we can schedule an appropriate amount of time for your appointment. If you are coming for an annual/physical exam, but have other medical issues for the doctor to review, please inform us when scheduling the appointment. To keep your waiting time to a minimum, we need to know how much time to schedule for whatever issues you may need to discuss with the doctor.
- Please provide at least 24 hours notice if it becomes necessary for you to cancel or reschedule an appointment.
- Faculty Internal Medicine staff can not assist you from your vehicle into our suite or from our suite to your vehicle. We do have wheelchairs in our suite that you may utilize at your visit. If you need assistance with navigation, please have a caregiver accompany you to your scheduled appointments.

Phone calls during business hours:

- While the physicians or the nurses are seeing patients, a "triage nurse" is on duty to handle medical calls. However, if the triage nurse is assisting another patient at the time of your call, you may be asked to leave a message on the voicemail and the nurse will return your call as soon as possible.
- It is our office policy that if the patient is ill enough to require a prescription for an antibiotic, he/she will need to schedule an appointment for an office visit within a reasonable time period. Antibiotics will not be prescribed over the phone without an office visit being scheduled within a day or two.
- When leaving a message please state the reason for your call, your name, your date of birth and your phone number. Please also spell your last name and repeat your phone number slowly. This will allow a nurse to accurately document your problem for better quality of care.
- If your message is not clear and understandable on the voicemail, we will not be able to respond to your requests.
- Routine Calls – expect a return phone call by the end of the same business day, but on occasion there may be a delay until the following business day.
- Urgent Medical Calls – will be returned as promptly as possible and may require phone triage as we handle hundreds of messages each day. If you cannot wait for a return call, urgent care clinics or various emergency rooms are available.

Prescription Refills:

- Please call your pharmacy at least THREE (3) business days before you need your refill. The pharmacist will notify our office for approval of refills. To provide the best patient care, our office may limit or not authorize refills if we have not seen you in the office in an appropriate time period.
- If you need a prescription for your mail-order pharmacy, please notify us at the time of your appointment.

Your Insurance:

- Please be familiar with your insurance benefits. If you expect insurance to pay for your services, please be sure that our office is a provider on your insurance plan. Also, please notify the office whether your plan covers preventive medicine or wellness care (physicals), and what the limitations of this coverage are. Also, if you want to have multiple procedures done on the same visit, please check with your insurance company to see if they will cover multiple procedures on the same day. Many insurance companies

Patient Registration

Please have this information available to input in our electronic check-in system.

Patient information:

NAME (last, first, middle): ______________________________ TITLE: __________________

HOME ADDRESS:____

PREFERRED NAME:________________________ SS# ______-______-______ DOB: ______ /______ /______

HOME PHONE:__________________________ CELL PHONE:________________________ SEX: M____F_____

EMPLOYER/ADDRESS: ____

WORK PHONE: ______________________________

WHOM MAY WE THANK FOR THIS REFERRAL? ____

PRIMARY Insurance: ____

(Please present your insurance card to our front office staff to be copied)

Policyholder Name:______________________________ Relationship to Patient: __________________

Policyholder Address: ____

Employer:____ DOB:________/________/__________

SECONDARY Insurance: ____

(Please present your insurance card to our front office staff to be copied)

Policyholder Name:______________________________ Relationship to Patient: __________________

Policyholder Address: ____

Employer:____ DOB:________/________/__________

Emergency Contact Information:

Name: __________________________ Relationship to Patient: __________ Phone #: __________________

You will be required to sign our Financial Policy on the electronic check-in system.

Financial Policy

Please note that all insurance providers have different coverage and benefit levels depending on what you have chosen to purchase or what your employer has chosen for you. Some plans require that you pay a deductible for labs and diagnostic testing in addition to your visit copay. You should check with your insurance provider to see what your plan covers and what you will be responsible to pay for labs, x-rays and other diagnostic tests. We use outside reference labs (Labcorp, Quest, Millennium) for labs that we do not perform in our office. They are participating on most plans, however, you may be billed by them for any balance not covered by your insurance.

We participate with most insurance plans. If you are an HMO patient, you must choose one of our physicians for your primary care physician. This can be done by calling your insurance company and having them list our physician as the PCP. You will be responsible for the visit if we are not listed as the PCP with your plan.

As a courtesy, we will submit your claim for all services to your insurance company. Please remember your individual health insurance policy is a contract between you and your insurance company and we are not a party to that contract. Be aware that some of your services may not be covered by your insurance policy. By presenting for care, you agree that you are responsible for all services and charges regardless of your insurance status. Should any provided services not be covered by your insurance, we will not alter your claim, change your diagnosis, or report a different service than what was performed in order that your insurance will cover the charge. You will be responsible for the balance.

All balances including deductibles and copays are due at the time of service. We file your insurance and then any balances that are due by you must be paid within 30 days unless prior arrangements are made with the billing office. If you have a billing or insurance question, please contact our billing office (865) 288-1100 and they will be happy to assist you. We ask patients to refrain from discussing billing questions with the physicians as they devote their time and expertise to your health care and cannot answer billing questions.

Additional Practice Related Fees:

- $25.00 Fee = Request to complete Life, Disability, FMLA, & various other types of independent health forms.
- $30.00 Fee = Returned checks for non-sufficient funds will have a processing fee that will be charged back to the patient. We will be unable to accept any personal checks after the first occurrence.
- $25.00 Fee = After hour phone calls to the physician may be charged a fee.
- $25.00 Fee = Charge for missed appointments or appointments canceled with less than 24 hour notice with the Physician or Nurse Practitioner.
- $50.00 Fee = Charge for missed appointments or appointments canceled with less than 24 hour notice on any testing (i.e.: ultrasounds, cardiac testing, etc.)

MEDICATION LIST

Name: ________________________ Date of Birth: ________________ Date: ______

Active Medications (including non prescription)	**Dose**	**Prescribing Physician**
1. ______________________________	__________	________________
2. ______________________________	__________	________________
3. ______________________________	__________	________________
4. ______________________________	__________	________________
5. ______________________________	__________	________________
6. ______________________________	__________	________________
7. ______________________________	__________	________________
8. ______________________________	__________	________________
9. ______________________________	__________	________________
10. _____________________________	__________	________________
11. _____________________________	__________	________________
12. _____________________________	__________	________________
13. _____________________________	__________	________________
14. _____________________________	__________	________________

Medication Allergies

1. _________________________________ 4. _________________________________

2. _________________________________ 5. _________________________________

3. _________________________________ 6. _________________________________

Pharmacy Name: ________________________________ Phone: ______________________________

Updated:

Date: _________ Signature: ______________________________________

Date: _________ Signature: ______________________________________

Date: _________ Signature: ______________________________________

Date: _________ Signature: ______________________________________

PATIENT PRIVACY QUESTIONNAIRE

Please have this information available to input in our electronic check-in system.

CONTACT RECORD

Patient Name: ____ Date of Birth: ______________

Please contact me as follows: (in order of preference)

1. (____) ______-_________ Home, Work, Cell Phone, Other (circle one)
2. (____) ______-_________ Home, Work, Cell Phone, Other (circle one)
3. (____) ______-_________ Home, Work, Cell Phone, Other (circle one)

- ☐ Okay to leave messages with healthcare information
- ☐ Leave message with call back number only
- ☐ Do **NOT** leave messages
- ☐ No restrictions – speak with whomever necessary on my behalf

List the names and phone numbers of individuals you authorize us to speak with regarding your healthcare:

- ☐ None
- ☐ Spouse ______________________________ Phone Number____________________________
- ☐ Child ______________________________ Phone Number____________________________
- ☐ Parent ______________________________ Phone Number____________________________
- ☐ Other ______________________________ Phone Number____________________________

Note: If we are unable to reach you by another means, we will send information through the U.S. Postal Service to your home address.

I have received a copy of Faculty Internal Medicine's Notice of Information Practices. I understand this Notice describes how my health information may be used or disclosed by FIM physicians and other providers at Faculty Internal Medicine. It is our policy that patient medical records will be given only to the patient unless specified otherwise above. This authorization does not expire unless revoked or terminated by the patient or the patient's personal representative. You may revoke or terminate this authorization by submitting a written revocation to Faculty Internal Medicine. I am aware the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling (865) 218-9220 or on the web site at www.facultyinternalmedicine.com or by requesting one at the Faculty Internal Medicine office. Information that is disclosed under this au-thorization may be disclosed again by the person or organization to which it is sent. It may not be possible to ensure your right to the protection of the privacy of this information once Faculty Internal Medicine discloses it to a party listed above. You may inspect or copy information used or disclosed under this authorization.

PATIENT HISTORY RECORD
FACULTY INTERNAL MEDICINE

Date of Appt: ____/____/____

Name: ____Date of Birth: _____/____/______
Last First Middle

The information you provide today is very important in regards to your healthcare. Please answer the following questions carefully and thoroughly to the best of your ability.

Reason for today's visit (list in order of importance to you): ____

____

____

Other physicians you are currently seeing:

____

____

Do you see a Chiropractor, Massage therapist, Therapist, Faith healer, Practitioner of homeopathy and/or others?
Please list: ____

____

Allergies:____

____

PAST MEDICAL HISTORY:

Do you have or have you ever had?

High blood pressure	Colonoscopy (Date __/__/__)	Seizures
Heart disease	Anemia (low blood)	Cancer
Heart attack	Blood transfusions	Breast masses
High cholesterol	Bleeding disorder	Prostate disease
Stroke	Blood clots	HIV screening (Date__/__/__)
Diabetes	Splendectomy	AIDS/HIV
Thyroid disease	Asthma/allergy	DEXA (Date__/__/__)
Rheumatic fever	Emphysema/COPD	Arthritis
Colon disease	Pneumonia or TB	Depression
Stomach disease	Glaucoma	Other _________________
Liver disease/hepatitis	Nervous/anxiety problems	_________________

Patient Name: ___________________

Hospitalizations:

Please list hospitalizations and dates for medical and surgical problems including childbirth:

__________________________________ __________________________________
__________________________________ __________________________________
__________________________________ __________________________________
__________________________________ __________________________________
__________________________________ __________________________________
__________________________________ __________________________________

Vaccinations:

When did you have last tetanus shot? ________________________

Do you get a yearly flu shot?	____Yes	___ No	Yr. ______
Have you had the pneumonia vaccine?	___ Yes	___ No	Yr. ______
If yes, which type:	___ Pneumococcal 23		___ Prevnar 13
Any exposure to TB?	___ Yes	___ No	
TB Skin test results:	___ Positive	___ Negative	Yr. ______
If born after 1956, have you received a second MMR vaccine?	___ Yes	___ No	Yr. ______
Hepatitis A vaccine (series of 2)	___ Yes	___ No	Yr. ______
Hepatitis B vaccine (series of 3)	___ Yes	___ No	Yr. ______
Chickenpox or vaccine	___ Yes	___ No	Yr. ______
Shingles vaccine	___ Yes	___ No	Yr. ______
HPV (Gardisil) vaccine	___ Yes	___ No	Yr. ______

Social History:

Occupation _______________________ Employer__________________________________
Education (Highest level completed) ___________ Marital status __(M)___(W)__(D)__(S)
Spouse Name__________________________ His/Her employer ____________________
Religious preference if any____

Smoking:

Do you currently smoke? __Yes __No
Age started____ Age stopped____
Interested in stopping? __Yes __No

Have you ever smoked? __Yes __No
How many packs per day? ____
Dip/Snuff/Chew? __Yes __ No

Alcohol:

Do you drink alcohol? __Yes __No How many drinks/week?____
Do you think you have a drinking problem? __ Yes __ No
Do you feel the need to cut down? __Yes __No

Drugs:

Do you presently use drugs? __Yes __No
Have you ever used drugs (eg: cocaine, marijuana, heroin)? __Yes __No

Wellness practices:

Do you examine your skin? __Yes __No Do you use sun protection? __Yes __No

Do you use a seat belt? __Yes __No Do you currently exercise? __Yes __No

Type of exercise_____________________ Frequency and duration of exercise _________________

Hobbies/recreation: ____

Have you been hurt or threatened by someone? ___ Yes ___ No

If yes, please explain:____ ______

Family history:

Father: Current age (if living) ____ Illnesses ________________________

Age at death ___________ Cause of death __________________

Mother: Current age (if living) ____ Illnesses ________________________

Age of death ___________ Cause of death ___________________

Siblings: No. Brothers____ No. Sisters _____ Age range _______________________

Illnesses____

Age at death _____________________ Cause of death_________________________

Do you have children? __Yes __No Age(s):_____________ Any health problems?_________________

Have any other relatives had any of the following (include grandparents, aunts, uncles, but exclude relatives by marriage)

Diabetes	Colon cancer	Stroke (prior to age 60)
Heart attack (prior to age 60)	Kidney disease	Other cancer _____________
Prostate cancer	Ovarian cancer	Other ___________________
Breast disease	Thyroid disease	

REVIEW OF SYSTEMS:

Have you had any of the following symptoms in the past four months?

Weight Loss/gain
Fever
Night Sweats
Loss of consciousness
Headache
Dizziness
Change in eyesight
Hoarseness
Ears ringing/hearing loss
Shortness of breath
Swelling of ankles
Nasal congestion/drainage
Cough
Coughing up blood
Wheezing
Backache

Joint swelling or pain
Chest pain/pressure/heaviness
Stomach/abdominal pain
Loss of appetite
Nausea/vomiting
Diarrhea
Constipation
Black or bloody bowel
Heartburn/indigestion
Difficulty swallowing/food sticking
Yellow eyes/skin
Frequent urination
Difficulty urinating/incontinent
Blood in urine
Excessive tiredness

Sleep problems
Face pain
Loss of strength or speech
Difficulty concentrating
Anxiety
Depression/tearfulness
Hot flashes
Hair loss
Extra heart beats or racing heart
Unusual bruising or bleeding
Nose bleeds
Sexual difficulties
Leg cramps
Changes in wart/mole/skin growth
Other ______________________

Date and location of your most recent hospital admission: ___________________________________

Date and location of your most recent ER visit: ____

Date and location of your most recent doctor office visit: _____________________________________

Special ambulatory needs or limitations: cane, walker, wheelchair, other:______________________

Physical disabilities-please list: ____

Hearing impairment? __Yes __No   If yes, please describe: ________________________________

Vision impairment? __Yes __ No   If yes, please describe: ________________________________

Last complete eye exam (date and provider): ____

Do you have trouble chewing or swallowing? __Yes __No   Explain: ___________________________

Dentures (including partials)? __Yes __No

How many meals a day do you eat on average? ____

Do you need assistance with meals? __Yes __No If yes, please describe: _____________________

Patient Name: ___________________

Sex assigned at birth? __Male __Female __Intersex

Legal Sex (based on Govt. ID) __ Male __Female __ Non binary

Gender Identity? (Check all that apply) __ Male __ Female __ Non binary __ Transgender
__ Other: ___________________________

Sexual orientation? ___________________________________

Have you ever had an abnormal pap smear? ___ If yes, when? __________ Date of last period _________

Date of last pap smear? ____/___/____

Do you have irregular menstrual bleeding? ___ Do you have painful periods? ____

Do you have vaginal discharge? ___ Have you bled after menopause? ___

Number of pregnancies ___ Number of live births___ Number of living children___

Hysterectomy? _____ If yes, When? _______________ Why? ____

Are ovaries still present? ___ Do you perform monthly self-breast exams? __

Date of last mammogram? ___/___/____

Do you have breast lumps/nipple discharge? ____________

Sexual History

Do you have known risks for HIV or other Sexually Transmitted Infection? ____________________________________

Are you sexually active?: __ Yes __ No If so, with: (circle all that apply) Men Women Both

Have you had multiple sexual partners in the last 6 months? __ Yes __ No

Have you been treated for a Sexually Transmitted Infection in the past year: __ Yes __ No

Do you use condoms? __ Yes __ No Do you use a Birth Control Method? _____

****

________________________________ ______________________ ____________
Signature of patient or responsible party Relationship Date

Name of caregiver and phone number:____

_____________________________ ____________
Reviewed by Date

Faculty Internal Medicine, PLLC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex

Cancellation, Rescheduling and No Show Policy

We understand situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel or reschedule your appointment that you provide 24 hour notice. This will enable another person who is waiting for an appointment to be scheduled in that appointment slot.

Office appointments which are cancelled or rescheduled with less than 24 hour notification may be subject to a **$25.00** fee. Any test/procedures cancelled or rescheduled with less than 24 hour notification may be subject to a **$50.00** fee.

Patients who do not show up for their appointment without a call to cancel an office appointment or test/procedure appointment will be considered as NO SHOW. Patients who no call/no show two or more times in a 12 month period may be dismissed from the practice. Patients may also be subject to a **$25.00** fee for an office appointment no call/no show or a **$50.00** fee for a test/procedure no call/no show. Patients who show up *after* their scheduled appointment time are considered no call/no show and may not be seen.

The above fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that special unavoidable circumstances may cause you to cancel or reschedule within 24 hours. Fees in this instance may be waived with management approval.

Our practice firmly believes that good physician/patient relationships are based upon understanding and good communication.

Please sign that you have read, understand and agree to this Cancellation, Rescheduling and No Show Policy.

_______________________________________ _______________

Patient Name (Print) Date of Birth

____ ________________

Signature of Patient or Patient Representative Date

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10/19