Gallatin Family Practice Center
Subir Guha, M.D. * Noridia Mauras, D.O *
608 Commons Drive Suite A * Gallatin, TN 37066
Telephone (615)452-5901 Fax (615)451-2006

Name: ____ **Social Security#** ____________________

Address: __________________________ **City:** _____________________ **State:** _______ **Zip:**_______

Date of Birth: ____________**Phone:** _______________________**Cell:**__________________________

***Employer:** __________________________________ **Phone:** _________________________________

Marital Status: (circle one) S M D W SEP PARTNER Sex: (circle one) M F

*** Email Address:** ___________________________**Would you like to receive lab results via email? Y or N**

***Primary Insurance:** ________________________________**ID#** ______________________________

Subscriber: _________________________________ **Subscriber Date of Birth:** ____________________

Social Security# _____________________________ **Relationship to Patient:** _____________________

***Secondary Insurance:** _______________________________**ID#** _____________________________

Subscriber: _________________________________ **Subscriber Date of Birth:** ____________________

Social Security# _____________________________ **Relationship to Patient:** _____________________

***Responsible Party:** ____________________________ **Phone:** ________________________________

Address: __________________________ **City:** _____________________ **State:** _______ **Zip:**_______

***Emergency Contact:** ______________________________ **Relationship:** ________________________

Address: __________________________ **City:** _____________________ **State:** _______ **Zip:**_______

Phone: __________________________________ **Cell:** ______________________________________

***Pharmacy:** ______________________________ **Phone:** ____________________________________

I certify that I, and/or my dependent(s) have insurance as indicated above and authorize all insurance benefits payable to Dr. Subir Guha and Associates with Gallatin Family Practice Center. I also understand that I am financially responsible for all charges whether or not paid by the insurance company. I authorize the use of my signature on all insurance submissions.

Signature: ________________________________ **Date:** ____________________________________

Patient Profile

Name: ____ **DOB:** __________________

Family History : Please list any medical problems such as (cancer, heart disease, diabetes, ect)

	Medical Problems	Cause of Death
Father		
Mother		
Brothers/Sisters		
Children		

Please list past medical problems of surgeries:

Please list any current medical problems:

Please list other doctors you currently see:

Please list any allergies to medications:

Please list current medications:

Do you smoke? □ **yes** □ **no**
Have you ever smoked? □ **yes** □ **no**

Gallatin Family Practice
608 Commons Drive Suite A
Gallatin, TN 37066
(615)452-5901 office
(615)451-2006 fax

Request for an Individual's Health Information

Last: ______________________________ First: ____________________ Middle :__________________
Date of Birth:_________________________ Social Security#: __________________________________
Address:_________________________________City:_____________________State:_____Zip:______
Phone: __________________________________Cell: ______________________________________

☐ Most Recent Progress Note ☐ Entire Health Record ☐ Pathology/Lab Reports Other: ________________

☐ I will pick up my records ☐ Fax to number below: ☐ Mail copies to the individual below

Records From:	Records To:
Name:	Name: Gallatin Family Practice
Address:	Address: 608 Commons Drive Suite A
Address 2:	Address 2: Gallatin, TN 37066
Phone:	Phone: (615) 452-5902
Fax:	Fax: (615) 451-2006

I understand:

- I may revoke this authorization at any time, in writing. My revocation will not apply to the information already retained, used, or disclosed in the response to this authorization. Unless revoked, the automatic expiration date will be (1) year from the date of signature.
- **The information authorized for release may include information which may indicate the presence of a communicable disease which may include, but not limited to, diseases such as hepatitis, syphilis, gonorrhea, and human immunodeficiency virus also known as acquired immune deficiency syndrome (AIDS).**
- The information authorization for release also may include protected health information related to mental health.
- All medical information is protected by the Privacy Act of 1974 and the federal or state law or regulations. It will not be given to other persons or organizations unless the law or regulations allow or require us to give out the information, or you allow us to give out that information. If we are permitted to give out the information about your medical/health records, it may not be protected if the person or organization

____ _______________________________
Signature of Patient, Parent, or Legal Representative Date

____ _______________________________
Printed name of Patient, Parent or Legal Representative Date

Gallatin Family Practice

Medical Consent

You agree, in order for us to service our account or to collect any amounts you may owe, our organization's representatives, ancillary providers, HIPAA business associates, vendors, and the representative of our dept collection agency, may contact you by telephone at any telephone number associated with your account, including wireless telephones numbers which could result in charges to you. Our organization's representatives , ancillary providers, HIPAA business associates, vendors and the representatives of our debt collection agency may also contact you by sending text messages or emails, using any e-mail address you provide to us. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I/We have read this disclosure and agree that the Lender/ Creditor, it ancillary providers, HIPAA business associates, vendors, and its debt collection agents may contact me/ us as described above.

______________________________________ ______________________

Borrower/Customer Signature Date

______________________________________ ______________________

Borrower/Customer Signature Date

GALLATIN FAMILY PRACTICE CENTER

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ______________________________

Relationship to Patient: ______________________________

Signature: ______________________________

Date: ______________________________

OFFICE USE ONLY

Attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices acknowledgment, but was unable to do so as documented below:

DATE:	INITIALS:	REASON:

Gallatin Family Practice
Financial Policy

This is an agreement between Gallatin Family Practice and the Patient/Debtor names on this form.

In this policy the words “you’, “your”, and “yours” mean the Patient/Debtor. The word “account” means the account that has been established in your name to which charges are made and payments credited. The words “we”, “us”, and “our” refer Gallatin Family Practice .

Insurance: We participate in most insurance plans, including Medicare. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Proof of Insurance: All patients must complete our demographic form before seeing the doctor. We must obtain a copy of your driver’s license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance card at the time of your appointment, you may have to be self-pay for your appointment.

Coverage Changes: If your insurance changes, please notify us when you check-in for your appointment to help you receive your maximum benefit.

Co-payment, Deductible and Co-Insurance: It is your responsibility to pay any deductible, co-pay, co-insurance or any portion of the charge as specified by your plan. This is your contract with your insurance company. If you do not pay your co-pay upon checking out from your visit, you will have a $25.00 additional fee added to your account. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your portion of the charges at each visit.

Non – Covered Services: Please be aware that some -and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You agree to pay any portion of the charges that is not covered by insurance.

Budget Plans: The business office can set up a budget plan for any outstanding large balance; you will need to leave a credit card on file for our office to run on the specified date each month until your balance is paid off.

Claim Submission: As a courtesy to you, we will submit your claims and assist in any way we reasonably can to help get your claims paid. We will file to both your Primary and Secondary insurance policy only. We do not file to Tertiary plans. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. If your insurance company does not respond within 60 days, you are responsible for the remaining balance. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Non-Payment: If your account is over 60 days past due, you will receive a letter stating that you have 10 days to pay your account in full. Partial payments will not be accepted unless approved us in writing. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from the practice. If this occurs, you will be notified by regular or certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Payments: Unless other arrangements are approved by us in writing, you are responsible to pay your balances within 30 days of services being rendered. Once we send you a statement, the balance on your statement is due and payable upon receipt.

Missed Appointments/No-Show: Our policy is to charge for missed appointments. If you do not show up for an appointment, or do not cancel within 24 hours, there will be a missed appointment fee of $25.00. These charges will be your responsibility and billed directly to you. Please help us serve you better by keeping your regularly scheduled appointment.

Returned Checks: There is a fee (currently $30) for any checks that are returned from the bank. It is our policy to not accept a personal check for future appointments in this situation.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for this account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment cost, it is the authorizing parent's responsibility to collect from the other parent.

Motor Vehicle Accident Claims: Our policy is that we do not get involved with motor vehicle claims. All patients being seen regarding a motor vehicle accident will be self-pay and must file their own paperwork with any 3rd party company.

Workers Compensation Claims: If you are being seen in our office due to a work related injury, you must bring the first report of incident form, which should include the original injury date, your claim number and the claims address that we are to file these claims for you.

ASF (Administrative Service Fees): This may be paid annually at $75 per year to cover all your administrative forms for one year. Or you may choose a "fee per form" status and fees will be assessed at the time the form is completed. These "per form" fees range from $10 to $150. Examples of these forms are:

A: FMLA

Effective Date: Once you have signed this agreement, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.

Please be aware we only verify that you have active insurance and we can file a claim on your behalf. Our office does not verify what your specific plan covers.

Patient/Guardian: ____Patient DOB:_________________

Responsible party (if not the patient):________________________Contact Phone#:______________

Signature: ____Date: ________________________