PATIENT REGISTRATION

DATE_____ FOR INTERNAL USE ONLY
PATIENT NUMBER_____

PATIENT INFORMATION

SOCIAL SECURITY #_____ HOME ADDRESS_____

FIRST NAME_____ MIDDLE_____

LAST NAME_____ CITY_____ STATE_____ ZIP_____

SEX_____ DATE OF BIRTH_____ EMAIL_____

MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED

HOME PHONE (_____) _____

WORK PHONE (_____) _____

(CHECK ONE)
☐ EMPLOYED ☐ RETIRED

CELL PHONE (_____) _____

☐ FULL TIME STUDENT ☐ OTHER

REFERRING PHYSICIAN_____

EMPLOYER_____ HOW DID YOU HEAR OF US?_____

PRIMARY INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

INSURED / CARD HOLDER'S NAME_____

RELATIONSHIP_____ DOB_____ SOC. SEC. #_____

SECONDARY INSURANCE INFORMATION

INSURED / CARD HOLDER'S NAME_____

RELATIONSHIP_____ DOB_____ SOC. SEC. #_____

EMERGENCY CONTACT

RELATIONSHIP_____ SEX_____

FIRST NAME_____ MIDDLE_____ HOME PHONE (_____) _____

LAST NAME_____ WORK PHONE (_____) _____

SPOUSE / GUARANTOR / RESPONSIBLE PARTY

SOCIAL SECURITY #_____ SEX_____ DATE OF BIRTH_____

RELATIONSHIP_____ DAYTIME PHONE (_____) _____

FIRST NAME_____ MIDDLE_____ EMPLOYER_____

LAST NAME_____ ADDRESS_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

CITY_____ STATE_____ ZIP_____

AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS TO PHYSICIAN: I hereby authorize the physician to release any information acquired in the course of my treatment necessary to process insurance claims. I also authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

_____ _____
SIGNATURE (Patient or Parent if Minor) DATE

UNIVERSITY MEDICAL GROUP

UT Chest Service
1940 Alcoa Highway, Suite E-260
Knoxville, TN 37920
Telephone: 865-305-6955
Fax: 865-305-8238

Dear _____,

You have an appointment with us on _____with Dr. _____of University Heart Surgeons and the UT Chest Service.

In preparation for your visit and to assure we have all information necessary to provide appropriate medical treatment, please complete the enclosed forms and bring with you at the time of your visit.

Please bring your insurance card, drivers' license or some type picture ID, and a *current* medication list. This is important in order to avoid any interactions due to current medications taken, and any medications that may be prescribed to treat your current medical condition.

If you have tests scheduled prior to your visit, it is important that you keep that appointment as well. Bring any films, scans, or disks that may be pertinent to your visit.

If you cannot keep this appointment, please notify us at least 24 hours prior to your appointment at (865)305-6955. Please do not hesitate to call this number if you have questions regarding directions, parking or questions regarding your appointment.

We look forward to welcoming you to our practice.

THE UNIVERSITY OF TENNESSEE MEDICAL CENTER

UNIVERSITY COLON AND RECTAL SURGERY

Patient Privacy Questionnaire

Patient Name:_____

1. May we leave confidential messages with anyone answering the telephone at your home?
   Yes No

2. May we leave confidential messages regarding appointments, return calls for test results, etc. on your home answering machine or voice mail?
   Yes No

3. May we leave confidential messages with anyone answering the telephone regarding appointments, lab results or other healthcare information at numbers other than your home number?
   Yes No
   If yes, please list number(s) ( )_____ - _____; ( )_____-_____

4. If we are unable to reach you by any of the above options, may we leave confidential messages at your place of employment?
   Yes No

5. May we give confidential information to anyone else regarding appointments, lab results or other healthcare information?
   Yes No

   Name:_____DOB_____
   Relationship:_____Phone number_____
   Name:_____DOB_____
   Relationship:_____Phone number_____

If we are unable to reach you by any other means, we will send information through the US Postal Service to your home address.

_____ _____

Signature of patient (or guardian if under age 18) Date

I have received a copy of the University Physician Associations Notice of Information Practices. I understand that this Notice describes how my health information may be used or disclosed by UPA, physicians and other providers practicing at UPA facilities and that I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by call (865) 544-9118, by visiting www.utmedicalcenter.org or by requesting one at a UPA office.

_____ _____

Signature of patient (or guardian if under age 18) Date

- To a correctional institution if you are an inmate.
- For research following strict internal review to ensure protection of information.

All other uses and disclosures not previously described, including psychotherapy notes, may only be done with your signed authorization. You may revoke your authorization at any time.

Your Rights

You have the right to:

- Request that we restrict how we disclose your medical information to a health plan for payment and/or operations when your medical information relates to a health care service or product that you have paid for out of pocket in full.
- Request that we restrict how we use or disclose your medical information (we may not be able to comply with all requests).
- Request that we use a specific telephone number or address to communicate with you.
- Review, inspect and obtain a copy of your medical information in paper or electronic format (fees may apply).[2]
- Request additions or corrections to your medical information. (we may not be able to comply with all requests).[2]
- Receive an accounting of how your medical information was disclosed (excludes disclosures for treatment, payment, healthcare operations and some required disclosures).[2]
- Obtain a paper copy of this notice even if you receive it electronically.

Requests followed by a superscript two [(2)] must be in writing.

To Contact Us

If you would like to exercise your rights, or if you have privacy concerns:
University Health System, Inc
Privacy Officer
Phone: 865-305-9118
Fax: 865-305-6968
Address: 1520 Cherokee Trail, Suite 310
Knoxville, TN 37920

Call the Confidential Reporting line at 1-877-591-6744.

All complaints will be thoroughly investigated, and you will not suffer retaliation for filing a complaint. You may also file a complaint with the Secretary of Health and Human Services in Washington, D.C.

Need more information?

Visit our website at www.utmedicalcenter.org

Call or write the Privacy Officer at the number and address listed.

A part of
UHS
University Health System

University Health System
The University of Tennessee Medical Center

Notice of Information Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

910605 (Rev 11/10)

Patient Privacy

At University Health System (UHS), your privacy is a priority. We follow applicable federal and state guidelines to maintain the confidentiality of your medical information. The federal guidelines with regard to the confidentiality of your medical information may be found in the Code of Federal Regulations at 45 CFR §§ 164.500 et seq.

This is a joint notice covering:

- All UHS employees, volunteers, students, residents, service providers, including clinicians, who have access to health information
- Any health care professional authorized to enter information into your medical record

These persons or entities will share your medical information as necessary to facilitate your care.

Our Responsibilities

UHS is required by law to:

- Maintain the privacy of your medical information.
- Provide this notice of our duties and privacy practices.
- Abide by the terms of the notice currently in effect.

We reserve the right to change privacy practices, and make the new practices effective for all the information we maintain. Revised notices will be available in our facilities, and will be available from your health care provider.

How do we use medical information?

When you visit a UHS facility, we may use your medical information to treat you, to obtain payment for services, and to conduct normal business known as health care operations. Examples of how we use your information include:

Treatment – We keep a record of each visit and/or admission. This record may include your test results, diagnoses, medications, and your response to medications or other therapies. This allows your doctors, nurses and other clinical staff to provide appropriate care to meet your needs.

Payment – We document the services and supplies you receive at each visit or admission and may provide this information as needed so that you, your insurance company or another third party can pay us. We may tell your health plan about upcoming treatment or services that require their prior approval.

Health Care Operations – Medical information is used to improve the services we provide, to train staff and students, for business management, quality improvement, and for customer service

Other services

We may also use information to:

- Recommend treatment alternatives.
- Tell you about health benefits and services.
- Communicate with family or friends involved in your care.
- Communicate with other UHS organizations or associates for treatment, payment, or health care operations. Business associates must follow privacy rules.
- Send appointment reminders.[1]
- Include you on the inpatient list for callers or visitors if you are admitted.[1]
- Let your clergy know if you have been admitted.[1]
- Contact you for UHS fundraising.[1]

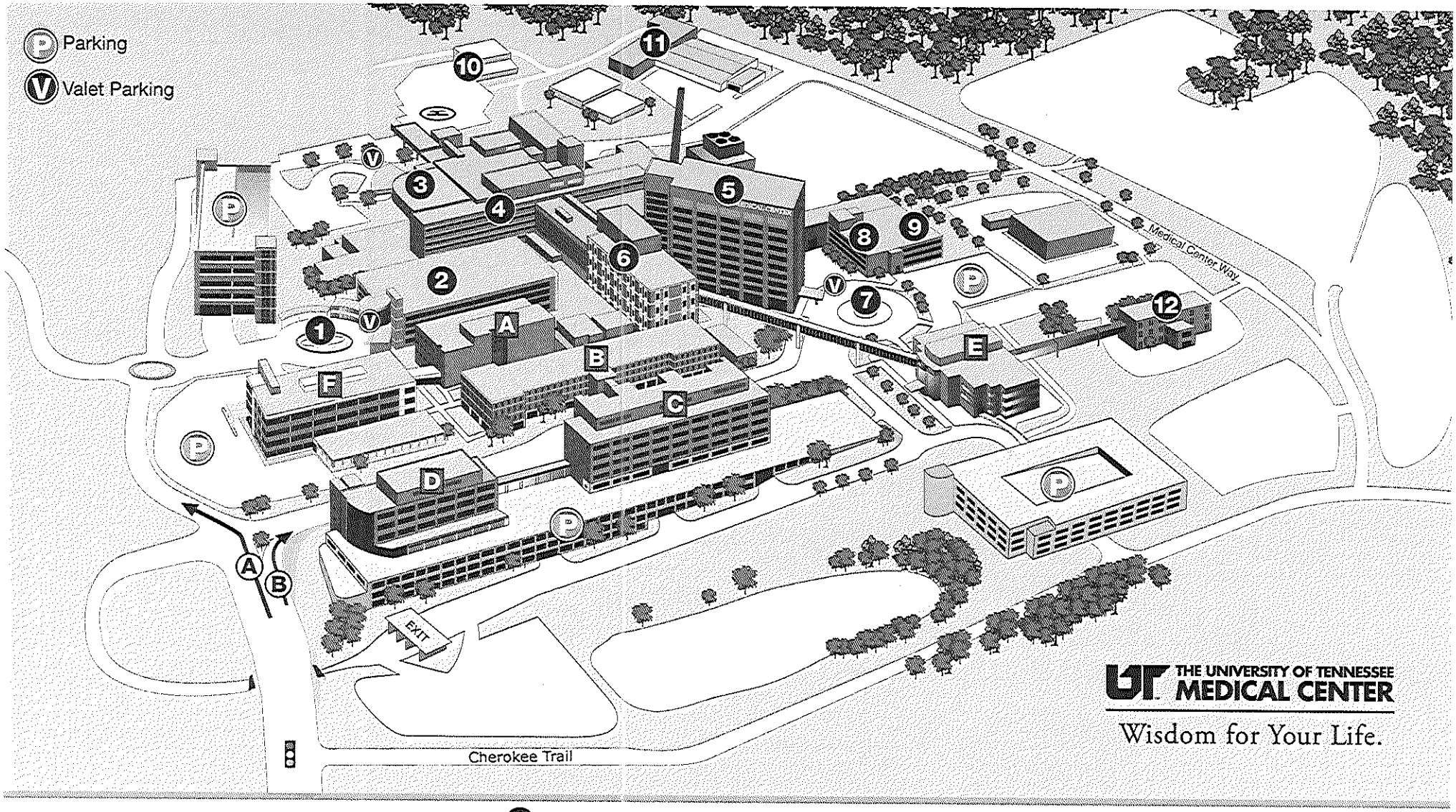
Your choice

Services followed by a superscript one [(1)] are optional. Tell the scheduler, admitting clerk or fundraiser (if contacted) that you do not wish to participate.

Other Permitted Uses and Disclosures of Health Care Information:

There are limited times when we are permitted or required to disclose medical information without your signed permission. These situations are listed below:

- For public health activities such as tracking diseases or medical devices.
- To protect victims of abuse or neglect.
- For federal and state health oversight activities such as fraud investigations.
- For judicial or administrative proceedings.
- If required by law or for law enforcement.
- To coroners, medical examiners and funeral directors.
- For organ donation.
- To avert serious threat to public health or safety.
- For specialized government functions such as military, national security, intelligence and protective service.
- To Workers' Compensation if you are injured at work.



Route A: To Hospital/Main Entrance, Parking Garage, Emergency Dept, MRI, Endoscopy and Cancer Institute

Route B: To Medical Offices and Parking Garage

1. Fountain Circle
2. Heart Hospital, Endoscopy Center, MRI
3. Emergency/Trauma
4. North Tower
5. Boling Patient Pavilion
6. South Pavilion
7. Flag Circle
8. UT Graduate School of Medicine
   University Family Medicine
9. UT College of Pharmacy
10. UT LIFESTAR
11. Human Resources/
    Facilities Planning
12. Cherokee Trail Building

Medical Office Buildings

- A Medical Building A
- B Medical Building B
- C Medical Building C-*Brain and Spine Institute*
- D Medical Building D-*UT Day Surgery*
- E Medical Building E-*Heart Lung Vascular Institute*
- F Medical Building F-*New Cancer Institute*