Knoxville Rheumatology PLLC

New Patient Registration

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

Date of Birth _____ **Age** ____ **Gender** _____ **Marital Status** _____

Street Address _____

City _____ **State** _____ **Zip Code** _____

Social Security Number _____

Phone (Home) _____ **Phone (Cell)** _____

Can your mobile phone do texting (SMS) and/or video calls (Y/N)? _____

Email Address _____

How do you prefer to be contacted for appointment reminders (Text message, Email or Phone Call)? (list in order of preference) _____

May we leave you detailed messages with health information? _____

Occupation _____ **Employer** _____ **Employer Phone** _____

Pharmacy Name and Address _____

_____

GUARANTOR INFORMATION

Please provide details about person responsible for the bill if this is different from the patient;

Guarantor Name (Last, First, Middle): _____

DOB: _____ SSN _____

Address (if different): _____

Phone (Home) _____ **Phone (Cell)** _____

Employer Name _____ **Employer Phone** _____

Employer Address _____

Address: 2072 Lakeside Center Way, Knoxville, TN 37922 www.knoxrheum.com
Phone: 865-246-6580 Fax: 865-444-6196 Email: info@knoxrheum.com

Knoxville Rheumatology PLLC

EMERGENCY CONTACT

Who is your emergency contact and what is their relationship to you? _____

_____

What is their phone number? _____

INSURANCE INFORMATION

_____ _____

Primary Insurance **Subscriber's Name**

_____ _____

Subscriber SSN **Date of Birth**

_____ _____ _____

Group **Policy** **Co-Payment**

_____

Patient's relationship to subscriber (self, spouse, child)

_____ _____

Secondary Insurance (if applicable) **Subscriber's Name**

_____ _____

Subscriber SSN **Date of Birth**

_____ _____ _____

Group **Policy** **Co-Payment**

_____

Patient's relationship to subscriber (self, spouse, child)

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Knoxville Rheumatology PLLC

Medical History Form

Patient Name: _____ **Date of Birth:** _____

Chief Complaint / Reason for visit: _____

Medication List: (please list all medication including over the counter medications you currently take)

Name	**Dosage**	**Instructions**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergy List: Please list all things you are allergic to and how it affects you.

Name: ex: Penicillin	**Reaction**: ex: Nausea
_____	_____
_____	_____
_____	_____
_____	_____

Past Medical History: Please check if you or your immediate family have a history of any condition below:

	Self	Family Member		Self	Family Member
Alcoholism	□	□ _____	Kidney Disease	□	□ _____
Anemia	□	□ _____	Liver Disease	□	□ _____
Autoimmuue Disorder	□	□ _____	Lupus	□	□ _____
Cancer	□	□ _____	Lung Problems	□	□ _____
Congestive Heart Failure	□	□ _____	Osteoarthritis	□	□ _____
Colitis	□	□ _____	Osteoporosis	□	□ _____
COPD	□	□ _____	Psoriasis	□	□ _____
Crohn's Disease	□	□ _____	Prostate	□	□ _____
Depression	□	□ _____	Rheumatoid Arthritis	□	□ _____
Diabetes	□	□ _____	Scleroderma	□	□ _____
GERD	□	□ _____	Seizures	□	□ _____
Gout	□	□ _____	STD	□	□ _____
Glaucoma	□	□ _____	Stomach Ulcers	□	□ _____
Heart Disease	□	□ _____	Stroke	□	□ _____
High Cholesterol	□	□ _____	Thyroid Disease	□	□ _____
High Blood Pressure	□	□ _____	Tuberculosis	□	□ _____
Hepatitis	□	□ _____	Pulmonary Hypertension	□	□ _____

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Other Major Illnesses:

_____

_____

Surgical History: Please list all past operations with dates.

_____

_____

_____

_____

_____

Social History: Meaningful use of electronic medical records includes the collection of the following demographic information to help identify any health disparities and improve quality of care for all patients.

Gender: (select one) □ Male □Female

Marital Status: (select one) □ Single □ Married □ Divorced □ Widow □ Other: _____

Race: (select one) □ Caucasian □ African American □ Asian □ Native American □ Native Alaskan □ Native Hawaiian □ Pacific Islander □ Declined

Ethnicity: (select one) □ Hispanic □ Non-Hispanic □ Declined

Primary Language: (select one) □ English □ French □ Spanish □ Other:_____

Occupation: _____

Tobacco Use: □Never smoked □Currently smoke every day: Number of packs per day: _____

□ Currently smoke some days □ I have quit smoking: Age when stopped: _____

Alcohol Use: How many days per week do you drink? _____ How drinks per day? _____ Have you ever had a problem with alcohol? □ Yes □No

Illicit / Recreational Drug Use: Do you use drugs? □ Yes □ No How often? _____ Have you ever had a problem with illicit drug use? □ Yes □ No

Exercise: □ Yes: How often? _____ □ No

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Knoxville Rheumatology PLLC

Financial Policy

Thank you for choosing us as your rheumatological care provider. We are committed to providing you with quality and affordable health care. We have developed the following payment policies for our practice. Please read them, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. PAYMENT: Payment is expected at the time of your visit. Just as we make every effort to accommodate you when you need medical care, we expect that you will make every effort to pay your bill promptly. Payment is due at the time services are provided or upon receipt of a statement from our billing office. We will accept cash, check, or credit card. We also accept FSA and HSA card payments. Payment will include any unmet deductible, co-insurance, co-payment amount or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause payment in full is expected at the time of your visit. We do ask for a copy of your current insurance card and driver's license at the time of your visit to ensure we properly file your claim.

2. INSURANCE: We participate with several insurance plans and will file your claims on your behalf. You are expected to present your insurance card at each visit. Insurance claims are filed to participating insurance companies. The patient is responsible for notifying our office of any changes in insurance coverage. Verification of participation with the patient's specific insurance plan is the responsibility of the patient. Patients are encouraged to contact our office at 865-246-6580 or their insurance carrier to ensure participation with the insurance plan prior to arriving for an appointment.

3. SELF-PAY: Payment in fill is expected at the time of service for uninsured patients.

4. RETURNED CHECKS: Checks returned for insufficient funds will incur a service charge currently set at $30, which may vary from time to time as determined by our financial institution. If your check is returned, it may be represented electronically. You authorize service charges and processing fees, as permitted by state law, to be debited from the same account by paper draft or electronically, at our option.

5. PARTIAL REFUNDS: Refunds are issued to patients when a patient overpayment has occurred and there are no outstanding claims to insurance or upcoming appointments scheduled.

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6. COLLECTION ACCOUNTS: All outstanding balances shall be due within 30 days of the date of service. At that time, all past due balances in their entirety must be paid prior to the time of your next visit. Balances that remain outstanding for a period of 120 days or more may be referred to a collection agency and could affect your credit.

7. FORMS FEES: Fees are to be paid when form is completed/picked up. Rates for completion of forms are as follows:

DURING an office visit: No Charge

AFTER an office visit:

- Simple form: $10

Examples of Simple Forms: Handicap tag/sticker, College & Camp Form.

- Complex Forms: $25 (completed within 10 business days)

Examples of Complex Forms: Short Term Disability form, Long Term Disability form, FMLA paperwork.

8. MISSED APPOINTMENTS: If you fail to cancel a previously scheduled appointment **at least 24 hours in advance,** this will count as a missed appointment and you may be charged a fee as outlined below:

• $25 after the second missed appointment.

This charge cannot be billed to the insurance company. Failure to pay a no-show fee will be treated according to our policy on unpaid balances. This charge is not applicable to patients with Medicaid/TennCare insurance coverage. Please refer to the "No Show / Late Show Office Policy" for more information

After 3 no-show appointments in a calendar year, you may be discharged from the practice, at the discretion of the responsible provider and management. Medical care will not be withheld for a medical emergency for thirty days from date of dismissal.

9. FINANCIAL DISMISSAL: Patients who do not make payment arrangements risk being dismissed from the practice. Knoxville Rheumatology PLLC reserves the right to dismiss patients for delinquent financial accounts on personal balances. If dismissed, medical care will not be withheld for a medical emergency for thirty days from date of dismissal.

Knoxville Rheumatology PLLC

QUESTIONS: We accept cash, checks, and credit card for payment. We also accept FSA and HSA card payment. For specific billing inquiries or to pay by phone with a credit or debit card, please call (865) 246-6580 Monday - Thursday 8AM – 5PM or Friday 8AM – 12PM. Payments may also be mailed to Knoxville Rheumatology PLLC, 2072 Lakeside Center Way, Knoxville, TN 37922.

I have read, understand, and agree to the Financial Policy as provided to me. I understand that charges not covered by my insurance company, as well as applicable co-payments, deductibles, and any charges older than 30 days from the date of service are my responsibility.

I authorize Knoxville Rheumatology PLLC to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim. I authorize my insurance benefits be paid directly to Knoxville Rheumatology PLLC. I understand and acknowledge that I am financially responsible for services rendered by Knoxville Rheumatology PLLC and I agree to pay all reasonable attorney fees and court cost in the event of default on my account.

Signature_____ Date _____

Printed Name_____ Date of Birth _____

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Knoxville Rheumatology PLLC

CONSENT FOR MEDICAL CARE AND TREATMENT

I understand that I may have a medical condition that could possibly require examination, diagnosis, and treatment. I do hereby voluntarily consent to such examination, diagnosis and treatment, services, and procedures that may be recommended under the general and specific instructions of the physician of Knoxville Rheumatology PLLC, their assistants, or designees. I acknowledge that the practice of medicine is not an exact science and that the physicians of Knoxville Rheumatology PLLC have made no guarantees to me as to the result of examination, diagnosis, or treatment. Knoxville Rheumatology PLLC recognizes the importance and significance of maintaining confidentiality of information regarding a patient's medical condition.

FINANCIAL RESPONSIBILITY

I hereby authorize payment of medical benefits directly to Knoxville Rheumatology PLLC and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in my medical record as may be necessary to process and complete my insurance claim. I understand that I am financially responsible for the total charges for services rendered which may include services not covered by my insurance companies. I agree that all amounts are due upon request and are payable to Knoxville Rheumatology PLLC. I further understand should my account become delinquent; I shall pay the reasonable attorney fees or collection expenses of Knoxville Rheumatology PLLC, if any. The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before the services are rendered.

PATIENT INFORMED CONSENT FOR TELEMEDICINE SERVICES

Knoxville Rheumatology PLLC has implemented an electronic health record (EHR) in part to meet the U.S. Department Health and Human Services initiative to improve health information technology, toward the goal of improving quality of health care. Our EHR integrates your clinical record with appointments, registration, and billing and makes this information available to the clinicians who are involved in your health care. In connection with its electronic communication systems, Knoxville Rheumatology PLLC has also implemented and has in place privacy and security policies and procedures to minimize risk of inadvertent or unauthorized disclosure, corruption and/or loss or distortion of data, but as with all record keeping systems, whether paper or digital, some risks remain of loss, inadvertent disclosure or errors in the recorded data. I have read and understand the information provided regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of

telemedicine including electronic transfer of medical data to other medical practitioners participating in my medical care. I hereby authorize Knoxville Rheumatology PLLC to use telemedicine in the course of my diagnosis and treatment and consent to the electronic communication of my personal health care information to other entities for treatment, payment, or health care operations.

INFORMED CONSENT FOR PRESCRIPTIONS

Knoxville Rheumatology PLLC continues its position as the network exchange for the flow of vital patient information to physicians and other health care providers. It is essential to improve patient safety and the continuity of care with electronic connectivity between payers, physicians, and pharmacists. Knoxville Rheumatology PLLC's electronic health record (EHR) provides secure access for patients with commercial prescription coverage in the United States. Prescription eligibility, benefit, formulary, and medication history information is provided for consenting patients to authorized physicians at the point of care. Electronic prescriptions are delivered in real-time to pharmacists in the retail and mail order settings. I consent to electronic prescriptions and acknowledge that Knoxville Rheumatology PLLC will use electronic connectivity between payers, physicians, and pharmacists.

_____	_____
Patient's Name	Date of Birth
_____	_____
Signature of Patient or Authorized Representative	Relationship
_____	_____
Witness	Date

Knoxville Rheumatology PLLC

No Show / Late Show Policy

Welcome to Knoxville Rheumatology PLLC. We are happy you decided to trust us with your rheumatologic health needs. The purpose of this page is to explain our practice policies regarding no-shows and late arrivals. These policies are simple and are in place to provide the best and most efficient patient care possible.

1. Please arrive **20 minutes before a new patient appointment** and **10 minutes before a follow up appointment** to ensure timely completion of any relevant forms.

2. Please notify us **at least 24 hours in advance** if you need to cancel or reschedule an appointment. Failure to do so will count as a missed appointment.

3. A $25.00 fee may be incurred after the second missed appointment for not providing the office with prior notice of cancellation at least 24 hours in advance. This charge cannot be billed to the insurance company. Failure to pay a no-show fee will be treated according to our policy on unpaid balances. This charge is not applicable to patients with Medicaid / TennCare insurance coverage.

4. If a new patient no-shows for 2 visits, we will be unable to schedule any future appointments. If an established patient no-shows for 3 visits, we will be unable to schedule any future appointments.

5. Late arrivals of 10 minutes or more will be rescheduled to the next available appointment at the discretion of the provider. Depending on the schedule, the provider may allow a late patient to be seen at a time slot later in the same day if available.

6. We try to provide individualized care to every patient and we may sometimes run behind schedule. Please be assured that we will spend the time necessary to provide you with the best possible care.

We are here to help, so if you have any questions or concerns, please do not hesitate to contact us. Your understanding and cooperation helps us to provide available appointments for patients who urgently need them.

Please sign below as confirmation that you have read, acknowledge, and understand our no show / late show policy as detailed above.

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Knoxville Rheumatology PLLC

_____	_____
Name of Patient	Date of Birth
_____	_____
Signature of Patient or Authorized Representative	Relationship
_____	_____
Witness	Date

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Knoxville Rheumatology PLLC

Controlled Medications Prescription Policy

Dear Patient,

Please be advised that Knoxville Rheumatology PLLC is strictly a non-narcotic practice and our office does **NOT** prescribe controlled medications; occasionally exceptions may be made for brief periods at the discretion of the treating provider.

Knoxville Rheumatology PLLC does **NOT** maintain any samples or supplies of narcotic, benzodiazepine, or other controlled substances in our clinic.

If you feel that you require stronger pain medications for your symptoms then you may be referred to a pain specialist for further relevant management.

Thank you for your understanding and cooperation.

_____	_____
Patient's Name	Date of Birth
_____	_____
Signature of Patient or Authorized Representative	Relationship
_____	_____
Witness	Date

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Knoxville Rheumatology PLLC

NOTICE OF PRIVACY 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.

This Notice is being provided to you in accordance with the requirements of the Standards for Privacy of Individually Identifiable Health Information of the Health Insurance Portability and Accountability Act (the "HIPAA Privacy Rules") and by the amendments to the HIPAA Privacy Rules made by the Health Information Technology for Economic and Clinical Health Act of 2009 (the "HITECH Act") and by the final HIPAA OMNIBUS Rule effective on September 23, 2013.

We are legally required to protect the privacy of your health information. We call this information "protected health information," or "PHI" and it includes information that can be used to identify you that we've created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. PHI also includes "genetic information" as that term is defined in the HIPAA Privacy Rules.

We must provide you with this Notice about our privacy practices that explains how, when, and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this Notice.

We reserve the right to change the terms of this Notice and our privacy policies at any time. Any changes will apply to the PHI we already have. Before we make an important change to our policies, we will promptly change this Notice and post a new Notice in the office. You can also request a copy of this Notice from the office receptionist in the office where your appointment is scheduled and can view a copy of the Notice on our web site at www.knoxrheum.com.

HOW WE MAY USE AND DISCLOSE YOUR PHI:

Uses and Disclosures of Your Protected Health Information That Do Not Require Your Consent

We may use and disclose your Protected Health Information as follows without your permission:

For treatment purposes. We may disclose your PHI to physicians, nurses, medical students, and other health care personnel who provide you with health care services or are involved in your care. For example, if you are being treated for a knee injury, we may disclose your PHI to the physical rehabilitation department in order to coordinate your care.

To obtain payment. We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may provide portions of your PHI to our billing department and your health plan to get paid for the health care services we provided to you. We may also provide your PHI to our business associates, such as billing companies, claims processing companies, and others that process our health care claims

For health care operations. We may disclose your PHI in order to operate our clinical facilities. For example, we may use your PHI in order to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided health care services to you. We may also provide your PHI to our accountants, attorneys, consultants, and others in order to make sure we are complying with the laws that affect us.

Appointment reminders and health-related benefits or services. We may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits we offer.

When required by law. We may be required to disclose your Protected Health Information to law enforcement officers, courts, or government agencies. For example, we may have to report abuse, neglect, or certain physical injuries.

For public health activities. We may be required to report your health information to government agencies to prevent or control disease or injury. We also may have to report work-related illnesses and injuries to your employer so that your workplace may be monitored for safety.

For health oversight activities. We may be required to disclose your health information to government agencies so that they can monitor or license health care providers such as doctors and nurses.

For activities related to death. We may disclose PHI to a coroner or medical examiner for purposes of identifying a deceased person, determining cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose information to funeral directors, as authorized by law, so that they may carry out their duties. Further, we may notify organ procurement organizations to assist them in organ, eye, or tissue donation and transplants.

For research purposes. We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

To avert a threat to health or safety. In order to avoid a serious threat to health or safety, we may disclose health information to law enforcement officers or other persons who might prevent or lessen that threat.

For specific government functions. In certain situations, we may disclose health information of military officers and veterans, to correctional facilities, to government benefit programs, and for national security reasons.

For workers' compensation purposes. We may disclose your health information to government authorities under workers' compensation laws.

For fundraising purposes. We may use certain information (such as demographic information, dates of services, department of service, treating physicians, and outcomes) to send fundraising communications to you. However, you may opt out of receiving any such communications by contacting our Privacy Officer (listed below) and your decision to opt-out will have no impact on your treatment.

Lawsuits and disputes. If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Uses and Disclosures of Your Protected Health Information That Offer You an Opportunity to Object

In the following situations, we may disclose some of your Protected Health Information if we first inform you about the disclosure and you do not object:

In patient directories. Your name, location and general health condition may be listed in our patient directory for disclosure to callers or visitors who ask for you by name.

To your family, friends or others involved in your care. Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Uses and Disclosures of Your Protected Health Information That Require Your Consent

The following uses and disclosures of your Protected Health Information will be made only with your written permission, which you may withdraw at any time:

For marketing purposes. Without your permission, we will not send you mail or call you on the telephone in order to urge you to use a particular product or service, unless such a mailing or call is part of your treatment. Additionally, without your permission we will not sell or otherwise disclose your Protected Health Information to any person or company seeking to market its products or services to you.

Of psychotherapy notes. Without your permission, we will not use or disclose notes in which your doctor describes or analyzes a counseling session in which you participated, unless the use or disclosure is for on-site student training, for disclosure required by a court order, or for the sole use of the doctor who took the notes.

For any other purposes not described in this Notice. Without your permission, we will not use or disclose your health information under any circumstances that are not described in this Notice.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have the following rights related to your Protected Health Information:

To inspect and request a copy of your Protected Health Information. You may look at and obtain a copy of your Protected Health Information in most cases. You may not view or copy psychotherapy notes, information collected for use in a legal or government action, and information which you cannot access by law. If we use or maintain the requested information electronically, you may request that information in electronic format.

To request that we correct your Protected Health Information. If you think that there is a mistake or a gap in our file of your health information, you may ask us in writing to correct the file. We may deny your request if we find that the file is correct and complete, not created by us, or not allowed to be disclosed. If we deny your request, we will explain our reasons for the denial and your rights to have the request and denial and your written response added to your file. If we approve your request, we will change the file, report that change to you.

To request a restriction on the use or disclosure of your Protected Health Information. You may ask us to limit how we use or disclose your information, but we generally do not have to agree to your request. An exception is that we must agree to a request not to send Protected Health Information to a health plan for purposes of payment or health care operations if you have paid in full for the related product or service. If we agree to all or part of your request, we will put our agreement in writing and obey it except in emergency situations. We cannot limit uses or disclosures that are required by law.

To request confidential communication methods. You may ask that we contact you at a certain address or in a certain way. We must agree to your request as long as it is reasonably easy for us to do so.

To find out what disclosures have been made. You may get a list describing when, to whom, why, and what of your Protected Health Information has been disclosed during the past six years. We must respond to your request within sixty days of receiving it. We will only charge you for the list if you request more than one list per year. The list will not include disclosures

made to you or for purposes of treatment, payment, health care operations if we do not use electronic health records, our patient directory, national security, law enforcement, and certain health oversight activities.

To receive notice if your records have been breached. UWM will notify you if there has been an acquisition, access, use or disclosure of your Protected Health Information in a manner not allowed under the law and which we are required by law to report to you., We will review any suspected breach to determine the appropriate response under the circumstances.

To obtain a paper copy of this Notice. Upon your request, we will give you a paper copy of this Notice.

HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the following person/persons. We will take no retaliatory action against you if you file a complaint about our privacy practices.

Knoxville Rheumatology PLLC Privacy Officer:
Amna Mishal
2072 Lakeside Center Way
Knoxville, TN 37922
865-246-6580

Secretary of the U.S. Department of Health and Human Services
200 Independence Avenue SW,
Washington, D.C. 20201
1-877-696-6775.

Effective Date
This Notice went into effect on August 20th, 2020

Knoxville Rheumatology PLLC

Acknowledgement of Receipt of Notice of Privacy Practices

Privacy Officer: Amna Mishal

I hereby acknowledge that I received a copy of the Notice of Privacy Practices for above medical practice (i.e. Knoxville Rheumatology PLLC). I further acknowledge that any amended Notice of Privacy Practices will be made available at my next appointment upon request.

Print Name: _____

Signed: _____

Date: _____

Telephone: _____

If note signed by patient, please indicate relationship to patient:

__ Parent or Guardian of minor patient

__ Guardian or conservator of an incompetent patient

__ Beneficiary or personal representative of deceased person

Name of Patient: _____

TO BE COMPLETED IF THE PATIENT REFUSES TO SIGN THE ACNKLOWLEDGEMENT

Reason for Refusal: _____

Employee Name: _____

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Knoxville Rheumatology PLLC

Patient's Rights and Responsibilities

At Knoxville Rheumatology we have a team approach to providing high quality medical care. This involves a partnership between the practice and the patient. Please review, understand, and acknowledge the Rights and Responsibilities you have as a patient and a partner in our quest to provide you with high quality medical care.

Patient's Rights

You have the right to:

1. Receive health care that respects your cultural, psychosocial, and personal values and beliefs without being subjected to discrimination or reprisal.

2. Obtain a copy of any rules or regulations that relate to the conduct of patients

3. Know that your records and communications are confidential to the extent provided by law.

4. Expect privacy during medical treatment and care, within the capacity of our clinic.

5. Receive care in a safe setting free of all forms of abuse and harassment.

6. Participate in any consideration of ethical issues that arise in your care, such as resolving conflict, withholding resuscitation, forgoing, or withdrawing life-sustaining treatment, or taking part in research studies.

7. Right to make suggestions and exercise rights without being subjected to reprisal or discrimination.

8. Have all reasonable requests responded to promptly and adequately within the capacity of the clinic.

9. Expect reasonable access and continuity of care.

10. Be an active participant in the development of your plan of care. Patients will receive sufficient information to give an informed consent to treatment, to the extent provided by law, including an explanation of their condition, proposed treatments, and alternative therapies, with their expected outcome, respective benefits, and risks.

11. Make informed decisions regarding your health care, including the decision to refuse or discontinue treatment to the extent permitted by law.

12. Bring an interpreter or other assistance as needed and available, when there is a language, communication, or hearing barrier.

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13. Inspect your medical record and receive a copy of it. If you would like a copy you may be charged a fee.

14. Receive a copy of an itemized list of charges submitted by us to your insurer or another third party regarding your care, the amounts covered by the third-party payer.

15. To know services available such as provisions for after-hours or emergency care, educational material available and policies concerning payment policies and fee for services.

16.Register complaints or grievances and seek solutions to problems with Practice Administrator.

Patient Responsibilities

By taking an active role in your health care you can help your caregivers meet your needs as a patient or family member. That is why we ask that you and your family share with us certain responsibilities.

1. We ask that you Provide, to the best of your ability, accurate and complete information about your present condition, past illnesses, hospitalizations, medications, over the counter products, dietary supplements, allergies, sensitivities and other matters related to your health including information about home, and work that may impact your ability to follow the proposed treatment.

2. We ask that you follow the treatment plan developed with your provider. You should express any concerns about your ability to comply with a proposed course of treatment. You are responsible for the outcome if you refuse treatment or do not follow your care provider's instructions.

3. We ask that you keep appointments or call us when you are unable to do so at least 24 hours before your appointment.

4. We ask that you be considerate of other patients and our facility staff and their property. Abusive, threatening, or inappropriate language or behavior will not be tolerated and may lead to discharge or transfer of care.

5. We ask that you make known to your attending Physician, Nurse or other healthcare personnel of any concerns or complaints you may have.

6. We ask that you make sure you understand all information regarding the implications of your symptoms, or procedure (if applicable) and any risks related to having or declining such treatment / procedure, the expected outcome of the plan of care outlined by your Physician, and his responsibilities with regard to that plan of care, or sustaining treatment.

Knoxville Rheumatology PLLC

I have read this form, or had it read to me, and I certify that I fully understand and accept its contents.

_____	_____
Patient's Name	Date of Birth
_____	_____
Signature of Patient or Authorized Representative	Relationship
_____	_____
Witness	Date

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