Genesis Neuroscience Clinic

To: _____

RE: New Patient Packet

Appointment Date and Time: _____

Location: 1400 Dowell Springs Blvd, Suite 340, Knoxville, TN 37909

Parking: Parking is available in front of our building free of charge.

Complete the enclosed new patient paperwork. Please bring a complete medication list including prescription, vitamins, and over-the-counter medications and your medication bottles with you to your appointment so we can obtain an accurate medication list. **If you do not complete this paperwork in its entirety, you will be rescheduled.**

If you have any questions or need help completing the forms, please call our office at (865) 888-9494.

You must arrive at least 15 minutes before your scheduled appointment time, or you will be rescheduled.

To complete before the Appointment:

__Patient Consent Form
__Office Policies
__Privacy Practices and Acknowledgement
__Release of Medical Records Authorization
__Patient Contact Information and

To bring on the day of the Appointment:

__Bring ALL prescription, vitamins, and over the counter medications IN THEIR ORIGINAL BOTTLES.
__Bring your insurance cards
__Bring copies of your Healthcare Power of Attorney and Living Will
__If you are visually/hearing impaired, please bring your glasses/hearing aids
__Bring any pertinent medical records and imaging disks

Thank you!

1400 Dowell Springs Blvd, Suite 340 Knoxville, TN 37909
Phone: 865-888-9494 Fax: 865-444-7672

Genesis Neuroscience Clinic

Please note: **All** first appointments are with the Nurse Practitioner. Please allot 2-3 hours for your first appointment.

Directions to our office from I-40

I-40 East: Traveling East on I-40, take exit #383 for Northshore Drive, Papermill Drive. Stay in the right-hand lane. At the light, turn right onto Papermill Drive (west). Turn right at the first light onto Weisgarber Road. Follow Weisgarber to Middlebrook Pike, turn left onto Middlebrook. At the second traffic light turn right onto Dowell Springs Blvd. 1400 will be on the right. Please use the Dowell Springs Blvd entrance, where Knoxville Breast Center is. When you enter the building, take the elevator to the third floor, our office is on the right of the elevator.

I-40 West Traveling West on I-40, take exit #383 for Papermill Drive, Weisgarber Road. Bear left for Weisgarber Road exit. Bear to the right to get in the right-hand lane. Turn right at light onto N. Weisgarber Road. Follow Weisgarber to Middlebrook Pike, turn left onto Middlebrook. At the second traffic light turn right onto Dowell Springs Blvd. 1400 will be on the right. Please use the Dowell Springs Blvd entrance, where Knoxville Breast Center is. When you enter the building, take the elevator to the third floor, our office is on the right of the elevator.

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Genesis Neuroscience Clinic

Patient Information Sheet

Today's Date: _____

Last:	First:	Middle:
Address:		Email:
City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:
Sex: □ Male □ Female	Date of Birth:	Social Security Number:
Ethnicity:	Language Preference:	Race:

Advanced Directives: Please mark if you have any of the following (Please bring copies to first appointment)

□ Healthcare Power of Attorney Name: _____	□ Living Will
□ DNR Form (Do Not Resuscitate)	□ Financial Power of Attorney

Next of Kin Information:

Name:	Relationship:
Address:	Email:
City:	State: Zip:
Home Phone:	Cell Phone:

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Billing Address:

□ Same as patient	□ Same as Next to Kin
□ Other:	
Pharmacy (and Location) and Phone #:	
Primary Care Physician's Name:	
Address: City: State: Zip Code:	
Doctor's Phone Number:	Fax:
Names of Other Physicians:	

I authorize Genesis Neuroscience Clinic to disclose my protected health information to the following family/ non-family member(s): ❑ Patient only

_____ Ph #: _____

_____ Ph #: _____

_____ Ph #: _____

I authorize the practice to disclose only the following protected health information to the individual(s) listed above:

_____ Test results, reports, and general health updates

_____ Appointment information only

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Have you had any of the following brain/head scans: ❑ CT ❑ MRI ❑ PET ❑ N/A

If yes, date and location where it was performed. _____

Primary reason for your visit today:

_____
_____
_____

Family History:

Relative	Living?	Age	Illness/Cause of Death
Mother	□ Y □ N		
Father	□ Y □ N		
Brother	□ Y □ N		
Brother	□ Y □ N		
Sister	□ Y □ N		
Sister	□ Y □ N		

Is there any history of: **If so, who?**

Dementia: □ Y □N _____
Alzheimer's: □ Y □N _____
Memory Problem: □ Y □N _____
Parkinson's: □ Y □N _____

Is there a history of abuse?

Verbal □ Y □N
Sexual □ Y □N
Physical □ Y □N

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Patient's Hospitalizations/Surgeries:

Date	Hospital	Type of Surgery/Reason for Hospitalization

Patient's Medical History: ***Please check all that apply***

□ Heart disease
□ Stroke
□ Parkinson's
□ Depression
□ Loss of Consciousness
□ Other:_____
□ High cholesterol
□ High Blood Pressure
□ Cancer
□ Seizure
□ Concussion
□ Head Trauma
□ HIV
□ Lyme's disease
□ Diabetes

Allergies: □ No known allergies
Please list any known allergies and reactions: _____
_____

Current Medications: Please bring all your prescription and non-prescription medications with you to this appointment **IN THE ORIGINAL BOTTLES.** Include eye drops, pills, nasal sprays, ointments, laxatives, herbals, supplements, vitamins, etc. Separate those that you use regularly from those that you only use as needed. List all medications you use regularly:

Medication Name	Dose/Strength	How Many? How many times per day?

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Social History:

Do you have children? □ Y □ N How Many? _____

Are you or your spouse a veteran? □ Y □ N

Highest grade completed in school: _____

What is your current or former occupation? _____

Native language: _____ Others spoken: _____

Right or Left Handed? □ Right □ Left

Do you currently smoke? □ Y □ N

If *yes*, How long have you been smoking? _____

How many packs a day do you smoke? _____

Did you quit smoking? □ Y □ N

If *yes*, When did you quit? _____

How many years did you smoke prior to quitting? _____

How many packs a day did you smoke? _____

Do you drink alcohol? □ Y □ N

If *yes*, What type, and how much per day? _____

Have you used alcohol in the past? _____

If *yes*, What type, and how much per day? _____

Did you ever use illicit drugs? □ Y □ N

Do you exercise regularly? □ Y □ N

Did you get a flu shot this year? □ Y □ N

Marital status: □ Married □ Single □ Widowed □ Divorced

# of prior marriages_____

Spouse's name: _____

Spouse's health: _____

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Genesis Neuroscience Clinic

Consent to Treat

1. **Consent to Medical Care:** The undersigned hereby authorize Genesis Neuroscience Clinic to perform examinations and administer treatments that are necessary and in his/ her best interest.

2. **Authorization of Release of Medical Information:** The undersigned authorizes Genesis Neuroscience Clinic to furnish medical information, including identity, diagnosis, prognosis, or treatment of any kind to any insurance company that is providing benefits to him/her or to the physician's office and to any professional review organizations with whom the undersigned may have insurance coverage or who may be assisting in payment of his/her medical care expenses. Genesis Neuroscience Clinic will follow terms of our Notice of Privacy Practices.

3. **Transmission of Medical Information:** The undersigned understands that physicians, health care agencies, clinicians, medical and nursing facilities involved in his/her medical care may need medical information quickly for purposes of continuity of care and follow-up. The undersigned hereby authorizes Genesis Neuroscience Clinic to transmit needed medical information to such entities via the most efficient method available in accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and our Notice of Privacy Practices.

4. **Assignment of Insurance Benefits:** In the event that the undersigned is entitled to benefits arising out of any insurance policy, said benefits are hereby assigned to Genesis Neuroscience Clinic for application to his/her bill for services rendered. The undersigned authorizes and directs any insurance company from which payment may be received for his/her care to furnish Genesis Neuroscience Clinic information regarding his/her benefits, status of claim, reasons for non-payment, and other information deemed necessary by Genesis Neuroscience Clinic

5. **Medicare Benefits:** If the patient is covered by Medicare, the undersigned certifies that the information given in applying for payment under Title XVIII of the Social Security Act is correct. The undersigned authorizes any holder of medical or other information about the patient to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. The undersigned assigns the benefits payable for the physician services to the physician or organization furnishing the services.

6. **Financial Agreement:** The undersigned agrees, whether he/she signs as patient, patient's guardian or patient's agent or representative, that in consideration of the services to be rendered to the patient he/she obligates himself or herself to pay the account owed by the patient to Genesis Neuroscience Clinic.

7. **Retirement Communities:** The undersigned agrees that Genesis Neuroscience Clinic has permission to release information to the clinical and social work staff of the retirement community in which he or she lives.

The undersigned understands that he/she retains the right to revoke this consent by notifying Genesis Neuroscience Clinic in writing at any time. Genesis Neuroscience Clinic retains the right to seek payment of services obtained prior to any decision to revoke this consent.

The undersigned certifies that he/she has read and understands the foregoing. The undersigned further certifies that he/she is the patient or is duly authorized by the patient as the patient's general agent or representative to execute the foregoing and accept its terms.

_____ _____

Patient Signature Date

_____ _____ _____

Or Power of Attorney Signature Relationship to Patient Date

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Office Policies

Appointments - All patients must have a referral from their primary care provider and must have ongoing routine care with this provider. Appointments are typically scheduled Monday through Friday from 8:30am – 3:30pm. If you are unable to keep an appointment, please notify the office 48 hours prior to the appointment. New patients **must arrive at least 15 minutes prior** to their appointment time to complete the necessary paperwork. **If you do not arrive at your appointment 15 minutes prior, you will be rescheduled.**

After-Hours Needs - We do not offer after-hours, weekend, or holiday on-call services. If you have emergent or urgent needs after hours, over the weekend, or holidays, you must call 911 or go to the Emergency Department. If you have non-emergent needs, contact your primary care provider.

Co-payments, Deductibles and Non-Covered Services - You will be responsible for paying any claims that are not covered by your insurance. Your insurance plan requires us to collect a copayment that will be requested at the time of service. For your convenience, we accept cash, check and most credit cards. **Note that Medicare does NOT pay for all of your health care costs. When you receive an item or service that is NOT a Medicare benefit, you are responsible to pay for it at check-in.** (If you have questions, please ask for the NEMB form- Notice of Exclusions from Medicare Benefits.)

Prescription Refills - You must contact your pharmacy directly for more expedient prescription refills. Please allow your pharmacy up to 72 hours to process your refill request as the pharmacist may need to check with your physician. **Please note that prescriptions will not be refilled after 2:00pm, on weekends or holidays.** Some prescriptions cannot be refilled if you have not seen your physician within the last 6 months. When you are being seen by your physician, please remind him/her to refill your medications at the time of your visit. If you have mail order prescriptions, please allow 7-10 business days. **Please note that we do not offer pain management services and do not prescribe most controlled substances, including opiate pain medications or benzodiazepines.**

Laboratory and Test Results - Your doctor must review all laboratory and imaging test results before they are released to the patient and filed in the chart. Ordinarily, non-emergent neurological imaging results will be discussed at your next follow-up visit.

Medical Records. Please note that requests for any health information cannot be processed without a signed Medical Record Release from the patient or legal representative. A fee may be charged for this service. Please allow up to 14 business days for your request to be processed.

Patient Signature _____ Date _____

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Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____ Date of Birth:_____

HIPPA – Notice of Privacy Practices

- I have been provided with a copy of Notice of Privacy Practices
- I know that the Notice may be changed at any time.
- I may get a new copy of the notice by writing to the Privacy Official, Genesis Neuroscience, 1400 Dowell Springs, Suite 100, Knoxville, TN 37909

_____

Patient's Signature Date

_____

Signature of Authorized Person Date

For staff use only:

____Patient refused to sign. Patient was informed that signing merely acknowledges that the Notice has been made available to the patient.

_____

Signature of Staff Date

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Genesis Neuroscience Clinic

RELEASE OF MEDICAL RECORDS AUTHORIZATION

Patient's Full Name _____ **Patient's Date of Birth** _____

Address _____ **Patient's Telephone Number** _____

City, State, Zip Code _____

I request the office of Dr. _____ of

Name and Address of Practice _____

Phone Number of Practice _____ Fax Number of Practice _____

To release my most recent **office visit notes, labs, EKG and head imaging results** to:

Dr. Monica Crane // Genesis Neuroscience Clinic
1400 Dowell Spring Blvd, Suite 340
Knoxville, TN 37909

Phone Number: 865-888-9494
Fax Number: 865-444-7672

I may revoke this authorization by notifying Genesis Neuroscience Clinic in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

Signature of Individual (The person about whom the information relates) _____ Date of Signature _____ Date of Birth or Social Security Number _____

OR, if applicable

Signature of Patient's Representative _____ Date of Signature _____ Description of Authority to Act for the Individual _____

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