



To: \_\_\_\_\_

New Patient Paperwork

**Appointment Date and Time:** \_\_\_\_\_

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

**Parking:** Parking is available free of charge. Arrive through the **Upper Entrance**.

Complete the new patient paperwork. Please bring a complete medication list including prescription, vitamins, and over-the-counter medications in their bottles.

All first appointments are always with a Nurse Practitioner. Allow 2 hours for the visit.

If you do not complete this paperwork in its entirety, you will be rescheduled.

**Please arrive at least 15 minutes before your scheduled appointment time, or you will be rescheduled. Pursuant to clinic policy, we are unable to provide physical assistance to patients of any kind including to and from vehicles. Please plan accordingly if mobility support is needed.**

**To complete before the Appointment:**

- Patient Consent Form
- Office Policies
- Privacy Practices & Acknowledgement
- Release of Medical Records Authorization
- Patient Contact Information

**To bring on the day of the Appointment:**

- Prescriptions, vitamins, OTC medications IN THE ORIGINAL BOTTLES.
- Insurance Cards AND a form of ID
- Pacemaker/Implant Cards
- Copy of an Advance Directive/Healthcare Power of Attorney/Living Will
- If you are visually/hearing impaired, bring your glasses/hearing aids



### **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.





**Billing Address:**

<input type="checkbox"/> Same as patient	<input type="checkbox"/> Same as Next to Kin
<input type="checkbox"/> Other:	
<b>Pharmacy (and Location) and Phone #:</b>	
<b>Primary Care Provider's (PCP) Name:</b>	
Address:	
City:	State:                      Zip Code:
PCP Phone Number:	Fax:
<b>Names of Other Physicians:</b>	

I authorize Tennessee Memory Disorders Clinic to disclose my protected health information to the following family/non-family member(s):

Patient only

\_\_\_\_\_ Relationship: \_\_\_\_\_ Ph #: \_\_\_\_\_

\_\_\_\_\_ Relationship: \_\_\_\_\_ Ph #: \_\_\_\_\_

\_\_\_\_\_ Relationship: \_\_\_\_\_ Ph #: \_\_\_\_\_

\_\_\_\_\_ Relationship: \_\_\_\_\_ 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



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

If yes, provide the date and location it was performed. \_\_\_\_\_

Primary reason for your visit today:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Family History:**

Relative	Living?	Age	Illness/Cause of Death
Mother	<input type="checkbox"/> Y <input type="checkbox"/> N		
Father	<input type="checkbox"/> Y <input type="checkbox"/> N		
Brother	<input type="checkbox"/> Y <input type="checkbox"/> N		
Brother	<input type="checkbox"/> Y <input type="checkbox"/> N		
Sister	<input type="checkbox"/> Y <input type="checkbox"/> N		
Sister	<input type="checkbox"/> Y <input type="checkbox"/> N		

**Is there any history of:**

Dementia:  Y  N  
 Alzheimer's Disease:  Y  N  
 Memory Problem:  Y  N  
 Parkinson's Disease:  Y  N

**If so, who?**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Is there a history of abuse?**

Verbal  Y  N  
 Sexual  Y  N  
 Physical  Y  N



**Patient's Hospitalizations/Surgeries:**

Date	Hospital	Type of Surgery/Reason for Hospitalization

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

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Heart Disease                              | <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Head Trauma    |
| <input type="checkbox"/> Stroke                                     | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> HIV            |
| <input type="checkbox"/> Parkinson's                                | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Lyme's disease |
| <input type="checkbox"/> Depression                                 | <input type="checkbox"/> Seizure             | <input type="checkbox"/> Diabetes       |
| <input type="checkbox"/> Loss of Consciousness                      | <input type="checkbox"/> Concussion          | <input type="checkbox"/> Other: _____   |
| <input type="checkbox"/> Pacemaker/Implants (please specify): _____ |  |   |

**Allergies:**  No known allergies

Please list any known allergies and reactions:

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**Current Medications:** Please bring all medications **IN THE ORIGINAL BOTTLES**. Include eye drops, pills, nasal sprays, ointments, laxatives, herbals/supplements, and vitamins. Separate those you use regularly from those you use as needed. List all medications you use regularly:

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



**Social History:**

Marital status:     Married         Single         Widowed         Divorced

# of prior marriages \_\_\_\_\_

Spouse's name: \_\_\_\_\_ Spouse's health: \_\_\_\_\_

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 before 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



**Consent to Medical Care:** This consent should be signed by the patient. However, the patient's parent or legal guardian or another person with the legal authority to act and consent (as described herein) on behalf of the patient may agree to and sign this consent on the patient's behalf. The undersigned patient authorizes Genesis Neuroscience Clinic (GNC), through its individual healthcare providers to perform medical examinations and diagnostics on, and administer medical treatments to, patient, as necessary or advisable and in the patient's best interest. Patient acknowledges that the practice of medicine is not an exact science and that no guarantees have been made regarding the result of any examinations, diagnostics, or treatment.

**Authorization of Release of Medical Information:** Patient authorizes GNC and its individual healthcare providers, employees, and agents to furnish medical information, including identity, diagnosis, prognosis, treatments, billing information, and other related information, to any: (i) insurance company that is providing benefits to patient, (ii) treating physician's office, (iii) professional review organizations with whom the patient may have insurance coverage, and (iv) individual or organization who is assisting in payment of patient's medical expenses. Patient acknowledges receipt and understanding of GNC's Notice of Privacy Practices and consents to GNC's use of patient's medical information as provided therein.

**Transmission of Medical Information:** Patient understands that hospitals, residential care facilities, acute care facilities, health clinics, other healthcare facilities, physicians, practitioners, clinicians, agencies, and other healthcare providers, and emergency medical and transportation services involved in patient's medical care may request medical information for the purposes of coordination and continuity of care, follow-up, and billing. At times, these requests are time sensitive. Patient hereby authorizes GNC to transmit medical information to such individuals and entities by any means that is compliant with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and GNC's Notice of Privacy Practices.

**Assignment of Insurance Benefits:** If the patient is entitled to benefits arising out of any insurance policy for services rendered by GNC or its individual providers, such benefits are hereby assigned to GNC and its providers for application to any amounts owed by patient to them for services rendered. Patient authorizes and directs any insurance company from which payment may be received for patient's care to furnish GNC and its providers with information regarding patient's benefits, status of claims, reasons for non-payment, and other information reasonably requested by GNC and its providers that relates to any services rendered to patient.

**Medicare Benefits:** If the patient is covered by Medicare, patient certifies that the information given in applying for payment under Title XVIII of the Social Security Act, or the Medicare program, is correct. Patient authorizes any holder of medical or other information about him or her to release to the Social Security Administration, its intermediaries, and carriers (collectively, the "SSA") all information requested by SSA to process a Medicare claim. The undersigned assigns any benefits payable by the SSA for services rendered by GNC via its providers to GNC, so that these amounts may be applied to any amounts owed by patient.

**Retirement Communities:** Patient agrees that GNC has permission to release all medical information requested by the retirement community in which patient lives (if any), and its clinical and social work staff, to the requesting person.

**Artificial Intelligence (AI):** Patient consents to the use of AI software programs by GNC providers for the purpose of transcribing the provider's dictated notes of patient visits (i.e., voice-to-text transcription) and/or drafting a summary note of your visit for review by your provider. GNC and its providers DO NOT USE such dictation or transcription software during patient visits. Such software DOES NOT: Record audio of, or otherwise "listen" to, patient's voice nor suggest any diagnoses or medications nor end any communications or messaging directly to patient nor make any decisions or determinations regarding patient's examinations, treatment, or health insurance coverage. Rather, patient's provider furnishes (and retains responsibility for) all clinical decision-making, diagnosis, and treatment planning. All post-visit notes generated by patient's provider using these programs are reviewed, edited as necessary, and authenticated. GNC requires software vendors to comply with HIPAA for the protection of information.

**Financial Agreement:** The undersigned agrees, signing as the patient, or as the patient's parent or legal guardian or other person with legal authority to act and consent (as described above) on patient's behalf, that in consideration of the services to be rendered to the patient, the undersigned obligates himself or herself to pay all amounts owed by the patient to GNC and its providers.

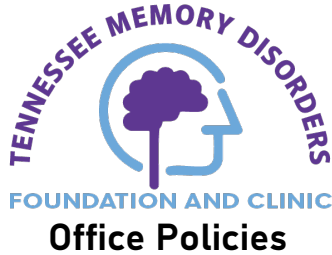
\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Or Power of Attorney Signature

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date



**Appointments:** All patients must have a referral from their primary care provider and must have ongoing routine care with this provider. Appointments are 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. For emergent or urgent needs after hours, over the weekend, or holidays, you must call 911 or go to the nearest Emergency Department. For 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 the collection of a copayment that will be requested at the time of service. We accept only check and most credit/debit cards. **Note that Medicare does NOT pay for all your health care costs. If you receive an item or service that is NOT a Medicare benefit, you are responsible for the balance.** (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 expedient prescription refills. Allow your pharmacy up to 72 hours to process your refill request. **Please note that prescriptions will not be refilled after 2:00 PM, on weekends or holidays.** Some prescriptions cannot be refilled if you have not seen your provider within the last 6 months. When you are being seen by your provider, please remind them to refill your medications at the time of the 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 provider must review all laboratory and imaging test results before they are released to the patient and filed in the chart. Non-emergent imaging results will be discussed at the next follow-up visit.

**Medical Records:** Request 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.

**Artificial Intelligence (AI):** To enhance clinical documentation and ensure timely, accurate medical records, an AI-enabled dictation tool may be used as a transcription aid. It does not participate in clinical decision-making, diagnosis, or treatment planning. All notes generated using this system are reviewed, edited as necessary, and authenticated by the licensed healthcare provider responsible for the patient's care. The use of AI in this context complies with all applicable privacy and security regulations, including the Health Insurance Portability and Accountability Act (HIPAA). Patient information always remains confidential and secure.

**Patient Transport Notice:** We do not provide patient transport or physical assistance to or from vehicles to the office entrance. Patients who require mobility or transfer assistance must arrive with a caregiver or support person to ensure safe entry and exit from the facility.

Patient Signature \_\_\_\_\_

Date: \_\_\_\_\_



## Notice of Privacy Practices

Effective March 29, 2017

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

Your medical record may contain personal information about your health. This information may identify you and relate to your past, present or future physical or mental health condition and related health care services and is called Protected Health Information (PHI). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI. We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or in-person.

### **How we may use and disclose PHI about you:**

**For care or treatment:** Your PHI may be used and disclosed to those involved in your care for the purpose of providing, coordinating, or managing your services. This includes consultation with clinical supervisors or other team members. Your authorization is required to disclose PHI to any other care provider not currently involved in your care. Example: If another provider referred you to us, we may contact that provider to discuss your care or they may contact us.

**For payment:** Your PHI may be used and disclosed to parties involved in payment for care or treatment. If you pay for your care or treatment completely out of pocket with no use of any insurance, you have the right to restrict the disclosure your PHI to your health plan for purposes of payment, and we will honor that request as required by law. Example: Your payer may require copies of your PHI during a medical record request, chart audit, or review.

**For business operations:** We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment, employee review, licensing, and conducting or arranging for other business activities. We may also disclose PHI while providing you appointment reminders or leaving messages on your phone or at your home about questions you asked or test results. Example: We may share your PHI with third parties that

perform various business activities (e.g., Council on Accreditation or other regulatory or licensing bodies) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI.

**Required by law:** Under the law, we must make disclosures of your PHI available to you upon request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule, if so required.

**Without authorization:** Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. Examples of some of the types of uses and disclosures that may be made without your authorization are those that are:

- Required by law, such as the mandatory reporting of abuse/neglect or mandatory government agency audits or investigations (such as the health department)
- Required by court order or subpoena
- Necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.
- If information is disclosed to prevent or lessen the threat, including the target of the threat.

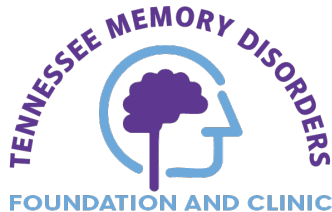
**Verbal permission:** We may use or disclose your information to family members that are directly involved in your receipt of services with your verbal permission.

**With authorization:** All other uses and disclosures not described in this Notice will be made only with your written authorization. You may revoke your authorization in writing at any time. We will obtain your explicit written authorization before using or disclosing psychotherapy notes (except as permitted by law), for marketing purposes, or for the sale of PHI.

**Your rights regarding your PHI:** You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer.

**Right to access and inspect and copy.** You have the right, which may be restricted only in exceptional circumstances or with documents released to us, to inspect and copy PHI that may be used to make decisions about services provided.

**Right to amend.** If you believe the PHI we maintain about you is incorrect or incomplete, you may request an amendment. We may deny your request in certain circumstances but will provide a written explanation.



**Right to accounting of disclosures.** You have the right to request an accounting of the disclosures we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.

**Right to request restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for services, payment, or business operations. We are not required to agree to your request.

**Right to request confidential communication.** You have the right to request that we communicate with you about PHI matters in a specific manner (e.g., telephone, email, postal mail, etc.)

**Right to a copy of this Notice.** You have the right to a copy of this Notice.

**Website Privacy:** Any personal information you provide us with via our website (e.g., email address) will never be sold or rented to a third party without your expressed permission. If you provide us with any personal or contact information to receive anything from us, we may collect and store that personal data. We do not automatically collect your personal email address for visiting our site. In some instances, we may partner with a third party to provide services such as newsletters, surveys to improve services, health or company updates, and in such case, we may need to provide your contact information to said third parties. This information, however, will only be provided to these third-party partners specifically for these communications, and the third party will not use your information for any other reason. While we may track the volume of visitors and download information from specific pages of our website, these numbers are only used in aggregate and without any personal information. This demographic information may be shared with our partners, but it is not linked to any personal information that can identify you or any visitor on our site.

Our site may contain links to outside websites. We do not take responsibility for the privacy policies or practices of these sites and encourage you to verify the privacy practices of all internet sites you use. While we make every effort to ensure that all the information provided on our website is correct and accurate, we make no warranty, expressed or implied, as to the accuracy, completeness or timeliness, of the information available on our site. We are not liable to anyone for any loss, claim or damages caused in whole or in part, by any of the information provided by our site. By using our website, you consent to the collection and use of personal information as detailed herein. Any changes to the Privacy Policy will be made public on this site regarding the collection and use of such information.

**Breaches:** In the event of a breach of unsecured PHI, you will be notified without unreasonable delay and no later than 60 days after discovery of the breach, as required by law.

**Complaints:** If you believe your privacy rights have been violated, you may file a complaint with our Privacy Officer or with the U.S. Department of Health and Human Services Office for Civil Rights.

**You will not be retaliated against for filing a complaint.**

Complaints to HHS may be filed at:

**U.S. Department of Health and Human Services  
Office for Civil Rights  
200 Independence Avenue, S.W.  
Washington, D.C. 20201  
[www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/)**



## 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 at Tennessee Memory Disorders Foundation & Clinic, 1400 Dowell Springs, Suite 340, Knoxville, TN 37909

\_\_\_\_\_  
Patient's Signature Date

\_\_\_\_\_  
*or* 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



## 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 \_\_\_\_\_ 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 K. Crane, MD**

**Amber M. Tayman, FNP-BC, MPH**

**Sarah White, FNP-C**

**Tennessee Memory Disorders Clinic [Genesis]  
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 whom the individual 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