**Restoring Health Clinic**

**2237 Lowes Dr, W Suite A**

**Clarksville, TN 37040**

**P: 931.272.2446**

**Fax: 855.530.6144**

**Authorization to Release Information**

**I hereby authorize Belinda Caver-Ballard , FNP to (Initial Each One)**

Obtain documents/ information from the records pertaining to services received.

Release documents /information from the records pertaining to services received.

Receive imaging from hospitals, lab, etc. regarding my care.

I understand that my authorization will remain in effect for one year from the date of signature and that the information will be handled confidentially in compliance with all Federal and HIPAA Laws.

I also understand that I may revoke the authorization at any time by written and dated communication if I feel there is something, I don’t want to be sent out by the Belinda Caver-Ballard, FNP.

MEDICAL RECORDS RELEASE

I authorize the release of any pertinent documents to my care to process any claims to the insurance companies by sending a duplicate of the claim.

I also give an authorization of release for information concerning my medical records to the following individual.

Name

Relationship

I have read and understood the above information

Printed Name:

Date:

Signature:

Date:

**Restoring Health Clinic** Pharmacy Phone #

**2237 Lowes Dr, W, Suite A Clarksville, Tn. 37040** Pharmacy Address

**P: 931-272-2446**

**New Patient Registration Form**

TODAY’S DATE

How did you learn about our practice? Physician (PCP)

Relative Friend Website Phone book Newspaper Other

Patient’s Full Name Age

Home Address

City State Zip

Home Phone Number Mobile Phone Number

Emergency Contact Person Emergency Phone Number

Emergency Person DOB Sex M F Relationship to Patient

Patient’s Email Address

Patient’s Date of Birth Social Security Number

Patient’s Employer

If not employed is patient Retired? Student? Homemaker? Unemployed? )

Patient Employer Address

City State Zip

Employer Phone Number Extension Full Time Part Time

**Insurance Information**

**Responsible Party Information (Guarantor)**

Who is Financially Responsible for the Account? The responsible party can never be a child.

Is the Responsible Party the same as the Patient information? Yes No (if no please fill in the information below)

Name

Address City State Zip

Phone Number

Guarantor DOB Social Security Number

Email Address

If patient is a MINOR, fill in responsible parent or guardian:

Patient/Guardian Name

Patient/Guardian Address City State Zip

Patient/Guardian Phone Number

Patient/Guardian Email Address

I acknowledge the above information is correct and I accept financial responsibility

For any services offered for my dependent or myself. Signature Date

Identification Verified: Initials: Method: (For Office Use ONLY)

Primary Insurance Information

Name of Primary Insurance

Primary Insurance Address

City State Zip

Insurance Phone Number

Policy Number Group #

Is the Patient the subscriber for the Primary Insurance? Yes No

(If no, please complete this section.)

Subscriber Relationship to Patient (circle one) SELF SPOUSE CHILD OTHER

Subscriber Name

Subscriber Address

Subscriber City State Zip

Subscriber Date of Birth Sex M F

Subscriber Social Security Number Subscriber Phone

Subscriber Employer

Subscriber Employer Address

City State Zip

Subscriber Employer Phone

**Please present all insurance cards and ID’s**

**IT IS YOUR RESPONSIBILITY TO KEEP UP WITH YOUR MEDICATION REFILLS. IF YOU ARE OUT OF MEDICATIONS, WE DO NOT REFILL MEDICATIONS OVER THE PHONE. YOU MUST MAKE AN APPOINTMENT TO SEE THE DOCTOR FOR REFILLS.**

**Patient Signature: Date:**

If Belinda Caver-Ballard, FNP prescribes you controlled substances, you CAN NOT receive pain medication from any other doctor. If you do, you will be discharged from the practice.

Patient Signature: Date:

Who may be authorized to make/cancel appointments or receive information about your health?

Relationship:

Previous Primary Care Doctor:

Pharmacy: Address:

**Financial Policy**

Payment is required at the time services are provided unless other arrangements have been made in advance. We accept cash, personal checks, and VISA, MasterCard, and Discover credit cards. There is a $35.00 service charge for returned checks

**INSURANCE**

We participate in most managed care plans and will bill your insurance plan as may be necessary. If we do not participate with your managed care plan or you have no insurance, payment in full is required at the time of service. Knowing your insurance benefits – including eligibility, covered benefits, and medically necessary procedures is your responsibility; please contact customer services at your insurance company for questions you may have regarding your coverage. You are responsible for any services not covered by your plan.

Proof of Insurance-- All patients must complete and/or update our Patient Information Form at each office visit. You must furnish valid and up-to-date proof of insurance coverage and a copy of your driver’s license. If you provide false or expired insurance information you will be responsible for the balance of the claim. Please notify us of any changes in insurance coverage prior to the time of service. Insurance denials for termination of coverage will be automatically billed to you.

Co-payments and deductibles--All co-payments, deductibles and co-insurance must be paid at the time of service. Protection of your insurance benefits requires us to charge for, and you to pay for, all required co-payments, coinsurances, deductible and non-covered services.

**Missed Appointments**

Missed appointments--Broken appointments represent not only a cost to us, but also an inability to provide services to others who could have been seen in the time set aside for you. We require 24 hour notice of cancellation to avoid a cancellation fee. The fee for a no show appointment is $65.00. If you miss 3 appointments, or have continuous cancellations, you will be discharged from this practice.

**Assignment of Benefits**

I authorize payments of my medical services to Belinda Caver-Ballard. and any services not covered by insurance company I understand that I am responsible for those charges.

I have read and understood the above information on insurance and missed appointments.

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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Memorandum: Controlled Prescriptions DATE:

I , understand that on being prescribed a controlled drug. I am subject to a urinalysis test at any time that Belinda Caver-Ballard deems necessary. If I fail to provide a specimen at the time of request, I acknowledge that I will not receive the prescription and that I can be immediately discharged. **You also can only use one pharmacy.** If found that you are using more than one you

will be discharged immediately.

Belinda Caver-Ballard, FNP PRINTED NAME

SIGNATURE