Welcome to Elite Primary Care clinic. We are honored that you have chosen us as your health care provider. Our goal is to provide the highest quality care for all of our patients in a timely and respectful manner. We welcome patients of all ages. Please read about our policies and processes below to become more familiar with our practice as a new patient.

We highly encourage the use of our online patient portal for all patients with internet access. You can submit questions to your provider, request refills, ask billing questions, request appointments…… using the online portal. If we didn't get your picture at the front desk or if you prefer a different profile picture, patients can upload their own picture online. This helps us to always connect a face to the name, not just your medical condition. Elite Primary Care uses Athena Clinicals for electronic medical records. Athena provides text, phone, and email reminders for many things. Some of these messages will be for appointments, statements, need to schedule wellness visits, inclement weather cancellations, etc. An important call to expect is the RESULTS CALL for lab and testing results. Do not just hang up without taking action. The computer will continue to call you until it confirms that you have obtained your results. Please pay close attention to the message and follow the instructions to receive your results. **If you have blood drawn, ask the lab tech for more information on the Results Call process. She has a handout for you.**

We will do our best to provide you with same-day office visits by appointment for all sick visits. Please call as soon as you think you may need to be seen. We appreciate the referral of your friends and family. We will make every attempt to see them same-day for sick visits also. You will need to bring your insurance card and a photo ID with you for each appointment. Please let our staff know if you have had any information changes since your last appointment. You will be asked to fill out new registration forms annually so we may update your information. Please bring all of your prescription and over-the-counter medications with you at each visit, especially any medications which you will request us to refill that you previously obtained from another primary care provider. We will need to know why you take it, how much, and when.

All co-pays and past due balances are expected at time of service, unless a prior agreement has been made with our billing department. Billing questions can also be submitted through the patient portal. Please don't hesitate to ask questions so we can resolve issues ASAP.

We ask that you allow plenty of time to get to the office for your appointment. You may be asked to reschedule your appointment if you are more than 10 minutes late. We will strive to stay on time. From time to time, a patient emergency arises and we may be running late for your visit. You will have the option to re-schedule or stay to be seen and we will keep you informed of how long of a delay you may experience.

Our office policy for a missed appointment is:

- If it is an appointment for a new patient, the appointment will not be rescheduled;
- Two (2) no-show appointments will result in dismissal from the practice.

We understand that appointments sometime need to be changed, so we ask that you call in advance if you cannot keep your scheduled appointment.

Providing the highest quality of professional care to our patients is very important to us. Therefore, the following guidelines for dispensing **medications** in our office have been established:

1. ***Elite Primary Care does not offer chronic pain management and will not dispense chronic pain medication*** (for example, chronic daily narcotics). We will provide you with a referral to a pain management center if you need this specialized form of care after evaluation by our physicians.
2. If you are on a medication that requires refills for a chronic disease (for example, high blood pressure or diabetes), you will be given ample refills for 30 or 90 days at a time during your office visit.
    a. When you are down to a 30 day supply of medication, we ask that you call and schedule your follow-up office visit in order to be evaluated and have your medications adjusted or refilled. We ask that you allow enough time for us to make an appointment so you're not without your medication.
3. For the safety and well-being of our patients,
    a. Requests for new medications (including antibiotics) and medication refills will not be taken over the phone or over the Internet during office hours without an appointment and evaluation by the physician.
    b. We understand that unexpected situations arise, thus a small refill of a chronic medication will be granted for one or two days after office hours on an as-needed basis determined by the on-call physician. This allows patients to be seen and evaluated by the physician during office hours for all their medication refills.

If you need to reach the physician after hours, you can reach our answering service at 931-245-1701. Non-urgent calls will be returned the next business day.

Elite Primary Care is affiliated with Northcrest Medical Center and Gateway Medical Center. We will be directing our patients to use our in-house laboratory collection services by PathGroup Labs unless otherwise requested by the patient. Our in-house x-ray is billed 100% by Elite Primary Care so you will not get an additional bill from a radiology group for x-rays done here.

We must inform you about our non-smoking premises. In addition to the risk to your health and others, smoking is prohibited by our **property management group**. Anyone smoking on property will be fined **$100.00** This is not something we have control of.

Welcome to our practice and thank you for choosing Elite Primary Care for all your health care needs.

Complete this form so that we may obtain your records from your previous doctor, specialists, or hospital.

2690 Madison Street, Suite 130
Clarksville, TN 37043
Phone (931) 245-1701
Fax (931) 245-1720

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(All sections must be completed)

I hereby authorize:

Provider: _____ Provider: _____

Address: _____ Address: _____

Phone: _____ Fax: _____ Phone: _____ Fax: _____

and its physicians employees and agents to release or disclose to the below-named recipient all of my medical records including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, sexually transmitted disease, or HIV/AIDS infection.

Patient Name: _____Date of Birth: _____

I hereby authorize the release of medical records to: __Elite Primary Care_____

Purpose of disclosure: ○Changing PCP ○Moving out of town ○Other: _____

The authorization will expire on: _____

Date or Event may not exceed one year

This request and authorization applies to:

_____ Please send only the **SUMMARY OF CARE** document unless otherwise indicated:

Attn: RELEASING ENTITY Do NOT send entire chart.

_____

_____ Health care information relating to the following treatment, condition, or dates of treatment:

_____

_____

_____ Specific records to be released (eg. Labs, imaging reports, other):

_____

If you DO NOT WANT certain portions of your medical records released, please initial the box for the information you do not want released.

_____Substance abuse _____ Psychological or psychiatric treatment ____HIV/AIDS/STD

I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.

_____

Signature of Patient or Authorized Representative **Date Signed** **Relationship to Patient**

ELITE PRIMARY CARE REGISTRATION FORM Today's Date: _____

Patient's Last Name:	First:	Middle:		
Marital status:	Birth date:	Age:		
Ethnicity: ○ Not Hispanic * ○ Hispanic ○ Latin	Race:	Sex: ○ M ○ F	Driver's License #:	Social Security #:
Address:				
Home phone:	Cell phone:	Email:		
Occupation:	Employer:	Work phone:		

Your Pharmacy/location:
Chose clinic because/referred to clinic by:
Other family members seen here:

INSURANCE INFORMATION *(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)*

Person responsible for bill: *(self or parent)*	Birth date:	Address (if different):	Phone:
Is this person a patient here?	☐ Yes ☐ No	Occupation/Employer:	Work phone:

Please indicate **primary insurance** name:

Subscriber's name:	Subscriber's S.S. #:	Employer:	Birth date:	Relationship to patient:

Name of **secondary insurance** name (if applicable):

Subscriber's name:	Subscriber's S.S. #:	Employer:	Birth date:	Relationship to patient:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone:	Work phone:

MEDICAL INFORMATION DISCLOSURE

May we disclose your appointment information or medical information to members of your family? *circle one:*

Medical info only *Appointment info only* *Both*

Person's Name: Relationship to patient:

To enhance your care, we access your prescription history and pharmacy benefit files that are available electronically based on pharmacy, state, and insurance data. Please indicate here if you wish to deny this access.

* (this does not apply to controlled substances) ○ I elect to OPT-OUT

AUTHORIZATION OF TREATMENT, ASSIGNMENT OF BENEFIT, & FINANCIAL POLICY

I authorize Elite Primary Care to provide medical treatment. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to Elite Primary Care for all medical and surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. I understand that payment for today's visit and future visits are due at the time of treatment. Charges for the collection of delinquent accounts, court costs, and or reasonable attorney's fees will be added to the total balance; including contingent fees to collection agencies of not less than 35%, such contingency fees to be added and collected by the collection agency immediately upon your default and our referral of your account to said collection agency. A photocopy of this authorization shall be considered as effective and valid as the original.

I understand that if my provider, or any person employed by or under the direction and control of my provider, is directly exposed to my body fluids in any manner which may, according to the then current guidelines for the Center for Disease Control, transmit the human immunodeficiency virus (HIV) or hepatitis B or C virus, that I am deemed by law to have consented to testing for infection with HIV or Hepatitis B or C viruses. I further understand by law I will have deemed to have consented to the release of these test results to the person who is exposed to my body fluids.

_____ _____

Patient/Guardian signature **Date**

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

2690 Madison Street, Suite 130
Clarksville, TN 37043
Phone (931) 245-1701
Fax (931) 245-1720

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason: