ETSUHealth

REGISTRATION FORM

SECTION 1: PATIENT INFORMATION			
Full Legal Name (First)	**(Middle)**	**(Last)**	**Preferred Name**
Date of Birth	**Social Security No.**	**Marital Status** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered ☐ Other:_____	
Address (Number and Street, Apt. No.)			
City	**State**	**Zip**	
Home Phone (include area code)		**Cell Phone (include area code)**	
Sex at Birth ☐ Male ☐ Female		**Preferred Pronoun** ☐ Female ☐ Male ☐ Gender Neutral	
Gender Identity w/ Insurance Company ☐ Male ☐ Female			
Ethnicity ☐ Non-Hispanic or Non-Latino ☐ Hispanic or Latino	**Race** ☐ American Indian or Alaska Native ☐ Asian ☐ African American/Black ☐ Caucasian/White ☐ Native Hawaiian or Other Pacific Islander ☐ Other:_____	**Primary Language** ☐ English ☐ Spanish ☐ Other:_____	
Do you need interpreter services? ☐ Yes ☐ No	**Veteran Status** ☐ Veteran ☐ Currently Enlisted ☐ Not applicable		
Agricultural Status ☐ Not applicable ☐ Employed Year-Round ☐ Retired Farmworker ☐ Migrant – A person/dependent whose principle employment has been in agriculture within the last 24 months and has had to establish a temporary home for the purpose of such employment ☐ Seasonal – A person/dependent whose principle employment has been in agriculture on a seasonal basis and has not had to establish a temporary home for the purpose of such employment			
Occupation	**If student, name of school** ☐ Full-time Student ☐ Part-time Student		
Employer Name		**Employer Phone (include area code)**	
Employer Address (Number and Street)			
City	**State**	**Zip**	
Have you executed an Advanced Directive such as a Living Will or Power of Attorney? ☐ Yes ☐ No If yes, please provide a copy.			
Who is your Primary Care Provider?			

SECTION 2: EMERGENCY CONTACT		
Person to Notify in Case of Emergency	**Relationship to Patient**	**Phone Number (include area code)**

Patient Printed Name: _____ Date of Birth: _____

ETSUHealth

SECTION 3: RESPONSIBLE PARTY		
☐ Check here if Patient is also the Responsible Party. Skip to Section 4.		
Full Legal Name (First)	**(Middle)**	**(Last)**
Date of Birth	**Social Security No.**	**Marital Status** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered ☐ Other:_____
Address (Number and Street, Apt No.)		
City	**State**	**Zip**
Home Phone (include area code)	**Cell Phone (include area code)**	
Employer Name	**Employer Phone (include area code)**	
Employer Address (Number and Street)		
City	**State**	**Zip**
Relationship to Patient ☐ Spouse ☐ Parent/Guardian ☐ Child ☐ Other: _____		

SECTION 4: INSURANCE INFORMATION		
Primary Insurance Company Name	**Effective Date**	
Subscriber Name	**Date of Birth of Subscriber**	**Social Security No. of Subscriber**
Relationship to Patient ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Child ☐ Other: _____		
Secondary Insurance Company Name	**Effective Date**	
Subscriber Name	**Date of Birth of Subscriber**	**Social Security No. of Subscriber**
Relationship to Patient ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Child ☐ Other: _____		

I certify that the information provided is true and complete to the best of my knowledge.

_____ _____

Signature of Patient or Legally Authorized Representative Date

If this document is signed by someone other than the Patient, such as a person holding a Durable Power of Attorney for Healthcare, the signer must state his/her relationship to the Patient, describe his/her authority to act on the Patient's behalf, and provide a copy of the Durable Power document:

_____

Please present all insurance cards and information to the receptionist for registration.

Patient Printed Name: _____ Date of Birth: _____

ETSUHealth

Acknowledgment of Corporate Relationship:

ETSU Health is the new outward-facing brand that includes the educational, clinical, and research pursuits of ETSU's thriving Academic Health Sciences Center and the clinical components of ETSU Physicians and Associates and Northeast Tennessee Community Health Centers, Inc. ETSU Health is not a legal entity.

Signature of Patient or Legally Authorized Representative _____ Date _____

Teaching Clinics:

As a patient of East Tennessee State University, Medical Education Assistance Corporation, or the Northeast Tennessee Community Health Centers, Inc. (hereinafter referred to collectively as "ETSU Health"), students (in medical school and health-related studies) and resident physicians (hereinafter referred to collectively as "Trainees") may participate in your care as part of the educational programming. Our mission is a dual one: caring for patients and educating Trainees. As such, faculty supervisors and Trainees work as a team to provide your care. Trainees, depending on their levels of experience, may observe or participate in the care provided to you. We believe this adds to the depth and level of care you receive. Trainees are supervised by faculty supervisors licensed in the State of Tennessee.

Thousands of patients receive medical, behavioral, and mental health treatment at ETSU Health, and enjoy our team-based approach to care. We are grateful for the opportunity to be of service to you and appreciate your willingness to participate in training healthcare providers of the future.

Signature of Patient or Legally Authorized Representative _____ Date _____

Insurance Authorization and Assignment

I hereby authorize East Tennessee State University, Medical Education Assistance Corporation, and the Northeast Tennessee Community Health Centers, Inc. (hereinafter referred to collectively as "ETSU Health") to provide any necessary medical or other information about me or my dependent to my insurance company, and/or its designated representatives, for the purpose of obtaining payment. This authorization is valid as long as I am a patient of any ETSU Health facility.

I hereby assign to the provider all payments for healthcare services, including behavioral and mental health treatment, rendered to myself or my dependent.

I understand that my insurance company may only cover a portion of my total bill, or may cover nothing at all. I understand I am responsible for all bills related to the provision of healthcare services and will be responsible for payment of any charges not covered under this assignment. If for any reason my or my dependent's account becomes delinquent, I agree to pay for any and all charges related to re-billing, cost of collections, reasonable legal fees, and any other charges permitted by law.

Signature of Patient or Legally Authorized Representative _____ Date _____

Medicare

One Time Signature Authorization

I hereby request that payment of authorized Medicare benefits be made on my behalf to East Tennessee State University, Medical Education Assistance Corporation, and the Northeast Tennessee Community Health Centers, Inc. (hereinafter referred to collectively as "ETSU Health") for any healthcare services provided to me or my dependent. I hereby authorize ETSU Health to provide any necessary medical or other information about me or my dependent to the Health Care Financing Administration and its agents as needed to determine these benefits or the benefits payable for related services.

Medigap Assignment Authorization

I request that payment of authorized Medigap benefits be made to ETSU Health for any healthcare services provided to me or my dependent by ETSU Health. I hereby authorize ETSU Health to provide any necessary medical or other information about me or my dependent to the Medigap carrier as needed to determine these benefits or the benefits payable for related services.

Signature of Patient or Legally Authorized Representative _____ Date _____

Patient Printed Name: _____ Date of Birth: _____

ETSUHealth

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

By signing below, I acknowledge that I have received the HIPAA Notice of Privacy Practices of East Tennessee State University, Medical Education Assistance Corporation, and the Northeast Tennessee Community Health Centers, Inc. (hereinafter referred to collectively as "ETSU Health"). I understand that my health information is protected under state and federal law, and that the HIPAA Notice of Privacy Practices describes how my protected health information may be used and shared with others. If I have any questions about the HIPAA Notice of Privacy Practices, I will let staff know.

Signature of Patient or Legally Authorized Representative _____ Date _____

ETSU Health is committed to protecting the privacy and security of your health information. If you wish for us to be able to *discuss* your protected health information with family or close friends, please list those individuals here:

Printed Name: _____ Relationship to Patient: _____

Printed Name: _____ Relationship to Patient: _____

ETSU Health reserves the right to otherwise share your information as permitted or required by law.

Electronic Communication Authorization

As a patient of ETSU Health, you may request that we communicate with you via unencrypted electronic mail ("email"). If you choose to provide ETSU Health with an email address, we may use this email address to communicate with you about your healthcare or payment for your healthcare, to respond to your requests for information, and for other legitimate purposes related to the healthcare services you receive from ETSU Health. Your healthcare is important to us, and we will make every effort to reasonably comply with your request to receive communications via email; however, we reserve the right to deny any request when it is determined that granting such a request would not be in your best interest.

Before providing your email address, please carefully read the risks and limitations associated with email communications:

- Potential Breaches of Privacy and Confidentiality: Do you share a computer with your family? Is your email address or access to your email provided through your employer? Do you access your email over an unsecured connection such as public Wi-Fi? Do you access your email on your mobile device? Emails may be accessed by someone you do not wish to know about your health information. Despite necessary precautions, email may be sent to the wrong email address. Because email is a communication sent over the internet, there is a possibility that an email may be intercepted or altered in transmission by a computer hacker or computer virus.
- Unique Difficulty in Verifying the Sender: Email may be easier to forge than handwritten or signed papers. Providers and staff will only send emails to the email address you provide, but it may be difficult to confirm that you are in fact the person sending the request for information from your email address.
- Delays in Responses: Providers and staff will make every reasonable effort to promptly respond to your requests for information via email. Please note: email communications do not replace the need for telephone and in-person communication about your healthcare. *If you are experiencing an emergency, you should never rely on email communications and should seek immediate medical attention.*

Patient Email Address:

If at any time you change your email address or wish to discontinue email communications altogether, you must provide written notification to a representative of ETSU Health.

By providing your email address and signing below, you acknowledge your understanding of the inherent risks of communicating health information via unencrypted email and hereby request and authorize ETSU Health to communicate with you via email despite those risks. By signing below, you also acknowledge that you have the choice to receive communications via other more secure means such as by telephone, in-person, or through the patient portal instead of via unencrypted email. By signing below, you agree to hold ETSU Health harmless for any unauthorized use or disclosure of your protected health information as a result of an email communication sent to the email address you provide.

Signature of Patient or Legally Authorized Representative _____ Date _____

Patient Printed Name: _____ Date of Birth: _____

ETSUHealth

Integrated Care Consent to Treat

Thank you for choosing East Tennessee State University, Medical Education Assistance Corporation, and the Northeast Tennessee Community Health Centers, Inc. (hereinafter referred to collectively as "ETSU Health") for your care. This consent form provides ETSU Health, its physicians, associates, assistants, affiliates, and other healthcare providers, with your permission to provide medical, behavioral, and mental health treatment. Please read and sign below. If you have any questions, please let our staff know.

General Consent for Care and Treatment

By signing this form, I am requesting that healthcare services be provided to me by ETSU Health. This includes examinations, diagnostic procedures and imaging, laboratory services and testing, medical treatment, behavioral and mental health services, and all other healthcare-related treatment, care, and services ("Healthcare Services") that I may receive. I voluntarily consent to any and all Healthcare Services that providers at ETSU Health consider to be necessary. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees or assurances have been made to me about the results or effectiveness of medical treatment or other Healthcare Services. I intend this general consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. I consent to receiving Healthcare Services at this office or at any other office of the organization. I understand that I may discuss any treatment plan with my provider, including the purpose of any treatment and its potential risks

If you have any concerns regarding any service or treatment recommended by ETSU Health, *we encourage you to ask questions.*

Integrated Healthcare Services

I understand this clinic is a participant of an integrated care organization, which means the clinic may work together with mental health and behavioral health providers when appropriate to give me the best care possible. This organization is also a teaching clinic where students (in medical school and health-related studies) and resident physicians (hereinafter referred to collectively as "Trainees") may participate in my care as part of the educational programming. As such, I understand and agree that Trainees, depending upon their levels of experience, may observe or participate in my care.

Behavioral and Mental Health Treatment

If applicable, I understand and acknowledge there are risks and benefits associated with behavioral and mental health treatment. Additionally, with any clinical treatment, there is no guarantee that these services will help. I acknowledge there may be certain risks associated with medications which could be prescribed as part of behavioral and mental health treatment. I understand the benefits of behavioral and mental health treatment can include feeling less distressed, finding solutions to problems, feeling better physically, and building more positive relationships.

Confidentiality

In general, your health information is protected by law, and your providers will not share this information without your written permission. There may be times, however, in which we are permitted or required under the law to share your health information, and we will do so. Because multiple providers work as a team, they may share information about you with each other that is important for your care. Your treatment may also be discussed in individual and/or group educational consultations between the Trainees and faculty supervisors licensed in the State of Tennessee. All participants in these educational consultations are held to the same professional standards as your provider to ensure your health information is kept confidential. Your care may benefit from this supervision and consultation. If applicable, I understand minor patients may benefit from having a confidential relationship with their behavioral or mental health provider. Health information shared by minors with their behavioral or mental health provider will generally not be discussed with the parent or legal guardian unless the provider, in their professional judgment, feels sharing is necessary.

ETSU Health utilizes a single electronic medical record that can be accessed by all participating practices for purposes such as treatment and payment for your healthcare. This means health information created by one clinic may be viewed by other providers at participating clinics as permitted or required by law for your healthcare.

Patient's Rights and Responsibilities

I understand that I have the right to take part in my medical care and treatment plan.

By signing below, I hereby confirm that I have read and understand this information, and I consent to the treatment and integrated healthcare services to be provided. I understand that, although healthcare services may be discontinued at any time, my consent will remain fully effective until it is revoked in writing and delivered to a representative of ETSU Health.

_____ _____

Signature of Patient or Legally Authorized Representative Date

If this document is signed by someone other than the Patient, such as a person holding a Durable Power of Attorney for Healthcare, the signer must state his/her relationship to the Patient, describe his/her authority to act on the Patient's behalf, and provide a copy of the Durable Power document:

_____

Patient Printed Name: _____ Date of Birth: _____

ETSUHealth
CENTER FOR AUDIOLOGY AND
SPEECH-LANGUAGE PATHOLOGY

PAYMENTS AND BILLING

It is important to us that you are timely notified of the charges associated with your health care. Patients will receive monthly statements via mail. If you anticipate having difficulty paying for your health care, please ask the front desk for information about our sliding fee scale.

ATTENDANCE POLICY

We understand that sometimes things come up unexpectedly and you may need to cancel or reschedule an appointment.

- If you are ill please stay home and contact us to reschedule your appointment.
- We ask that when possible you notify us 24 hours in advance of your missed appointment. Missed appointments interfere with our ability to provide you and others with the care needed. Repeated missed appointments may be grounds for dismissal from our practice.

If you must miss an appointment please contact the Center at: (423) 439-4355

Note to Parents and Legal Guardians:
You are expected to remain on the premises for the duration of the appointment. We are committed to ensuring the patient safe. If the patient becomes sick or needs your assistance, we need to have immediate access to you. Your cooperation is greatly appreciated.

If you have any questions, please let our staff know.

In consideration of receiving services from East Tennessee State University, you confirm you have read and understand the above Center policies and agree to abide by the same.

_____ _____

Signature of Patient or Legally Authorized Representative Date

If this document is signed by someone other than the Patient, such as a person holding a Durable Power of Attorney for Healthcare, the signer must state his/her relationship to the Patient, describe his/her authority to act on the Patient's behalf, and provide a copy of the Durable Power document:

_____

Patient Printed Name: _____ Date of Birth: _____

ETSUHealth
COLLEGE OF CLINICAL AND
REHABILITATIVE HEALTH SCIENCES

1000 Jason Witten Way
Elizabethton, TN 37643
P: 423-439-5070
P: 423-439-4355
F: 423-439-4607

CONSENT TO TELEHEALTH SERVICES

Patient Printed Name: _____	**Date of Birth:** _____
Location of Patient (Originating Site): _____	
SLP Provider: _____	
Location of Provider: _____	

Telehealth involves the use of technology and video conferencing software to enable healthcare providers to connect with patients for assessment, consultation and intervention at distant locations. The software we use will allow you to see and hear your provider in real time. The services you receive will be the same quality you would receive if you visited our clinic in person. Please be aware, there are some conditions we are unable to treat via telehealth. If your provider determines we are unable to treat you via telehealth at any time, we will refer you back to your referring provider. If at any time during the telehealth session *you* decide you would like to stop the session for any reason, you may do so. You must let your provider know you wish to stop.

The ETSU Center for Audiology and Speech-Language Pathology provides speech-language pathology services in a teaching environment where student clinicians may participate in your care as part of the educational programming. As such, student clinicians, depending on their levels of experience, may observe or participate in the care provided to you.

As with any technology, telehealth has its limitations. There is no guarantee, that your telehealth session will eliminate the need for you to see a provider in person.

Expected Benefits:

- Telehealth brings healthcare services to you by connecting you to an SLP Provider at East Tennessee State University without your having to travel.

Potential Risks:

- Your evaluation and treatment may be delayed due to technology or equipment failures.
- Your evaluation and treatment may be delayed if the Provider determines your condition cannot be appropriately treated via telehealth.
- Your health information may be compromised. The electronic systems we use will incorporate security protocols to protect the privacy and security of your health information. In rare instances security protocols could fail resulting in a breach of your health information.

By signing below, you confirm that you have read and understand this form and that you had the opportunity to have it explained to you verbally. You confirm that you have had the opportunity to ask questions and that all your questions have been answered. By signing below, you confirm that you understand you have the right to receive services face-to-face and are freely and voluntarily choosing to receive services via telehealth as described in this form.

_____ _____

Signature of Patient Date

If signed by someone other than the Patient, state your relationship to the Patient and a description of your legal authority to act on the Patient's behalf:

_____

**If signed by someone other than the Patient, proof of legal authority to act on the Patient's behalf must be provided.*

ETSUHealth
COLLEGE OF CLINICAL AND
REHABILITATIVE HEALTH SCIENCES

1000 Jason Witten Way
Elizabethton, TN 37643
P: 423-439-5070
P: 423-439-4355
F: 423-439-4607

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION
UNIVERSITY SCHOOL CONCUSSION SCREENING AND MANAGEMENT

Printed Name of Student _____ Date of Birth _____

Street Address _____ City, State, Zip _____

AUTHORIZES THE RELEASE OF PROTECTED HEALTH INFORMATION:
By signing this Authorization Form, I understand that I am giving my authorization for East Tennessee State University to disclose my protected health information (PHI), as described in detail below, to the following person(s) or organization(s):

University School
68 Martha Culp Ave, Johnson City, TN 37614

I understand that if the person(s) and/or organization(s) listed above are not healthcare providers, health plans or healthcare clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

INFORMATION TO BE RELEASED:
I authorize my entire record created in relation to concussion screening, management and education to be released to the above.

PURPOSE FOR DISCLOSURE: The purpose of this authorization is for the University School and their Athletics Program to obtain a concussion screening to establish a baseline of neurocognitive function for concussion management for student athletes participating in collision and contact sports.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:
I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. In order to inspect or obtain a copy I must contact the ETSU SLP Clinic Site Director. I understand that I do not have to sign this form. If I choose *not* to sign this form, I will *not* be eligible to undergo the concussion screening. I understand that if I agree to sign this authorization, I must be provided with a signed copy of the form.

I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the ETSU SLP Clinic Site Director. I am aware that my revocation will not be effective as to uses and/or disclosures of health information that the person(s) and/or organization(s) listed above already made in reference to this authorization prior to my written cancellation of the same.

EXPIRATION DATE: This authorization shall expire upon Student's graduation date.

I have had an opportunity to review and understand the content of this Authorization Form. By signing below, I am confirming that this form accurately reflects my wishes.

Printed Name of Parent or Legal Guardian _____ Date _____

Signature of Parent or Legal Guardian _____