University of Tennessee Graduate School of Medicine
UT Internal Medicine Center
1928 Alcoa Hwy
Bldg B, Suite 127
Knoxville, TN 37920

Welcome and thank you for choosing UT Internal Medicine Center!

We look forward to serving your health care needs. Our office is associated with the University of Tennessee's Graduate School of Medicine and our physicians are Resident Doctors continuing their training in Internal Medicine. Experienced Internal Medicine Physicians who are Faculty of the Graduate School of Medicine directly supervise them.

Please arrive 30 minutes before your scheduled appointment. Bring **all bottles for your current medications** (prescribed, over-the-counter, and supplements/herbals) to the office visit, including pain medications. Pain medications, tranquilizers and sleeping pills will not be refilled at this office. **We are not authorized as a Chronic Pain Clinic and do not write prescriptions for maintenance pain medications. Determination to establish you as a patient in the clinic will be made on your first visit in the Internal Medicine Clinic.**

The office is open Monday through Thursday from 8:00am to 4:30pm. Fridays we are open from 7.00am to 4.00pm. We do see same day or prn appointments for established patients with an acute problem. We expect patients to keep their appointments. Please kindly give a 48-hour notice if you are unable to keep an appointment. Patients who frequently fail to show up for appointments may be dismissed from the practice.

We also have specialty clinics. Dr. Miller is our psychiatrist in the Resident clinics. He sees patients half day everyday and the times vary. Clinic policy also applies to the Psych Clinic.

Due to the pandemic times, we are only allowing ONE visitor in the lobby or the exam rooms & new born babies with Postpartum moms allowed. Patients are expected to wear a mask until further notice.

If you feel you have a health emergency when our office is closed, we urge you to go to the nearest emergency room. For non-emergency problems that cannot wait until business hours, you may contact the physician on call at (865)305-9410.

Please ask your physician to write prescriptions with enough refills to last until your next office visit. If you should run low or run out of medication before your next visit, most pharmacies will fax refill requests to your physician's office on request. However, you may still be required to schedule an appointment in order to receive more medication. **Please allow at least 72 hours for refills on medications. Any phone messages to the nurses after 3.00pm will be addressed on the next business day.**

Our Internal Medicine Resident clinic is now a **Patient Centered Medical Home**. The focus is on coordinating care as a team across the health system, prevent frequent ER visits or hospital readmissions and to be your primary care providers for all your needs. Our practice practices evidence-based medicine as defined by the American Academy of Physicians-Internal Medicine Organization.

Thank you for choosing UT Internal Medicine Center. We are committed to providing you with our best medical service. If you have questions or concerns, please contact our office for assistance at (865)305-9410.
Please visit our website: gsm.utmck.edu/imobgynclinic.cfm for further information or visit our utmck patient portal https://www.utmedicalcenter.org/patients-visitors/patient-portal

UT Internal Medicine Center Staff

UT Internal Medicine and OB/GYN Clinic

Today's Date: _____

PATIENT INFORMATION **MRN #:** _____

Patient's Name: _____
(Last Name) (First Name) (Middle Name) (Preferred)

SS#: _____-_____-_____ **Sex**: Male Female Other **DOB**: ____/_____/_____ **Language**: _____

Race: *(Select all that apply)* ☐White ☐Black or African American ☐American Indian/Alaskan ☐Asian ☐Hispanic ☐Hawaiian or Other Pacific Island ☐Other_____ **Education Level**: _____

Ethnicity: (*Select one*) ○Hispanic/Latino ○ Not Hispanic/Latino **Marital Status:** _____

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Home Phone #: (____) _____ **Cell Phone #**: (____) _____ **Preferred Phone (***Select one)*: ○Home ○Cell

Email Address: _____

INSURANCE INFORMATION ***(Please provide card(s) to receptionist to photocopy at every visit)***

Occupation: _____ (*Select one*): ○ No Insurance ○ SELF PAY

Employment Status: (*Select one*) ○Retired ○Employed ○Student ○Disabled ○Unemployed

Patient's Employer: _____ **Work Phone #:** _____

Name of insurance companies: #1 _____#2_____

Insurance ID number for: #1_____ #2 _____

Name of insured: _____ **DOB**: _____/_____/_____ **SS#**: _____/_____/_____

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

GUARANTOR INFORMATION: (Person Responsible for payment of balance) **SAME AS PATIENT:** ☐

Guarantor: _____ **DOB**: _____/_____/_____ **SS#**: _____-_____-_____

Relationship to Guarantor: *(Select one)* ○ Self ○Spouse ○Child ○Dependent ○Other

Address: _____ **City**: _____ **State**: _____ Zip: _____

Guarantor's employer: _____ **Work Phone #**:

ADDITIONAL INFORMATION

Do you have a Primary Care provider (PCP): ○**Yes** ○**No** **If Yes, Name of PCP:** _____

Are you on the UTMCK Patient Portal: ○**Yes** ○**No** **If No: Do you want to be added to the Portal:** ○**Yes** ○**No**

Referral Source: *(Select one)* ○Physician Referral ○Patient Referral ○Internet Search ○Other_____

Emergency Contact:
Name:_____**Date of Birth:**_____**Phone #:** _____**Relationship:** _____

✖**Signature (Patient or Guardian)**: _____ **Date signed**: _____

Rev 03-21-2022

UT GRADUATE SCHOOL OF MEDICINE
UT Internal Medicine and OB/GYN Center
1928 Alcoa Hwy, Suite 127
Knoxville, TN 37920

Patient Name: _____

Date of Birth: _____
MRN #: _____

CONSENT TO TREAT

Clinical Treatment:

Consent to Treat: I consent to treatments and/or tests provided by UT Internal Medicine and OB/GYN Center. I reserve the right of consent for procedures until after the risks and benefits have been explained to me. This permission includes receipt of medication history through my authorized pharmacy plan.

X Signature: _____ Date: _____

CONSENT TO SHARE MEDICAL & BILLING INFORMATION

How may we contact you? *(Select all that apply)* ☐ Phone Call ☐ Text ☐ Letter ☐ Patient Portal

May we leave messages ? *(Select one)* **Home answering machine**? ○ Yes ○ No **Cell Phone?** ○ Yes ○ No

Who may we speak with about your medical and/or billing information? Please complete below

Name	Relationship	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPPA)

(Available in office UPON REQUEST)

I have been given an opportunity to review, ask questions about and understand UT Internal Medicine and OB/GYN Center's (IMOB) Notice of Privacy Practices for Protected Health Information (Notice). I acknowledge receiving today a copy of the PROVIDER'S notice of privacy policies. I consent to the PROVIDER'S use of protected health information as described in the notice for treatment, payment, or health care operations. I have also seen and read the Notice of privacy policies on this Portal and am able to print the policies if I need a copy.

Signature: _____ Date: _____

Revised 03-21-2022

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Financial Responsibility Consent Form

Patient's Name _____Date of Birth_____ MRN #:_____
(Please Print)

Thank you for choosing UT Internal Medicine & OBGYN Center. The following information is provided regarding your payment for professional services. ***Please sign and date at the bottom of this page.***

Assumption of Responsibility: I agree that in consideration of services to be rendered, I obligate myself, assume financial responsibility and agree to pay upon demand to above named practice all charges for such services and incidentals incurred. Should the account be referred to an attorney for collection, I agree to pay reasonable attorney fees and collection expenses. **I understand that if my account is turned over to an outside agency for collections, I will be dismissed as a patient and given thirty (30) days (from the date of dismissal) of emergency care only.**

Responsibility for Co-pay Amounts: I agree to be fully responsible for paying co-pays of set amounts at the time of services. Further, I understand that if my co-pay is a percentage, I will be responsible for payment immediately after insurance benefits have paid. I understand that any bill received after insurance is paid will be due upon receipt.

Referrals and Prior Authorizations: I understand that if I have insurance coverage, which requires a pre-authorization or referral, it must be received in order to receive the maximum benefits from the insurance company. Our office will attempt to obtain the pre-authorization/referral or reschedule my appointment. I understand that if this office is unable to obtain the pre-authorization/referral that I am fully responsible for payment.

Non-Covered, Out of Network Services, and Self-Pay Patients: I understand that I am responsible for charges for medical services that are considered by my insurance company to be non-covered, out of network, or not medically necessary. I understand that if I do not have group or individual medical insurance, payment is due at the time of visit with a substantial discount. Payment is due before another appointment is scheduled.

Appointment No-Show Procedure: I understand that if I fail to show up for my first appointment I may not be accepted into the practice, or if I fail to show up for 3 appointments, a warning letter will be sent and further you may be terminated from the practice.

Assignment of Insurance Benefits: I hereby assign direct payment of any insurance benefits including Medicare, Medigap, major medical benefits, insurance disability benefits, or injury benefits payable because of liability of a third party or organization, payable to or for the above said patient until account is paid in full.

Concerns of Identity Theft: I understand that an insurance claim may not be accepted without the use of my social security number.

✖ **Signature: _____ Today's Date: _____**
(Signature of patient or guardian)

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General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees (Resident,etc.) as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative	**Date**
Printed Name of Patient or Personal Representative	**Relationship to Patient**

Submit Form