The Berry Clinic

731-584-1430

Patient Information

First: _____ **Middle:** _____ **Last:** _____ **Suffix:** _____

SSN: _____-_____-_____ **DOB:** ____/____/____ **Marital Status: (Circle One)** Single/Married/Separated/Divorced/Widowed

Race: (Circle One) Black or African American/White/Other **Language: (Circle One)** English/Spanish/Other _____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: (_____) _____-_____ **Work Phone:** (_____) _____-_____ **Cell Phone:** (_____) _____-_____

Primary Contact: (Circle One) Home/Work/Cell. **Secondary Contact: (Circle One)** Home/Work/ Cell.

E-Mail: _____

***Preferred Pharmacy:** _____ **City/State:** _____

***Drivers License #:** _____ **State:** _____

Primary Insurance *TennCare/Medicaid NOT accepted*

Insurance Company: _____

Subscriber Name: _____ **Birth Date:** _____/_____/_____

Address: _____ **Telephone**: (_____) _____-_____

SSN: ____-___-_____ **Employer:** _____

Employer Address: _____ **Telephone:** (_____) _____-_____

Secondary Insurance *TennCare/Medicaid NOT accepted*

Insurance Company: _____

Subscriber Name: _____ **Birth Date:** _____/_____/_____

Address: _____ **Telephone**: (_____) _____-_____

SSN: ____-___-_____ **Employer:** _____

Employer Address: _____ **Telephone:** (_____) _____-_____

How did you hear about our clinic? Friend/Google/Facebook/Newspaper/PhoneBook/Other _____

THE BERRY CLINIC

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MEDICAL HISTORY FORM

Name: _____ **Birth Date:** ____/____/_____

Chief Complaint_____

Who may we leave information with_____**Telephone**:(____)_____

OR list an emergency contact ONLY? _____**Telephone:** (_____)_____

May we leave information on answering machine? _____ **OR VOICEMAIL**?_____

CURRENT MEDICATION	DOSAGE	HOW OFTEN YOU TAKE IT	Prescriber

Are you allergic to any medications? _____

Are you allergic to IODINE/Betadine? Yes/No

Are you allergic to LATEX/Gloves? Yes/No

Are you allergic to eggs? Yes/No

Are you allergic to X-Ray contrast Dye? Yes/No

List any surgeries, including cosmetic procedures, and year they were performed:

_____

_____

_____

Family Medical History: FATHER Good health? _____ Deceased _____ Has/Had: _____

MOTHER Good health? _____ Deceased _____ Has/Had: _____

Brothers/Sisters Good health? _____ Deceased _____ Has/Had: _____

When did you last get these vaccines? Tetanus_____ Flu _____ Pneumonia _____ Hepatitis _____ HPV _____

THE BERRY CLINIC

Medical History Form 2nd Page

What year did you have any of the following procedures? Colonoscopy_____ Pap Smear_____ Mammogram_____
BMD_____ Prostate Biopsy _____ Stress Test _____ Echocardiogram _____ EGD _____ Chest X-Ray _____ EKG _____

Do you have any of the following medical problems?

	Yes	No		Yes	No
ADD/ADHD	____	____	Depression/Anxiety/Panic Attacks	____	____
Asthma, Bronchitis, or Emphysema	____	____	Schizophrenia/Bipolar	____	____
Anemia	____	____	OCD	____	____
Coronary Heart Disease	____	____	Gout	____	____
COPD	____	____	Insomnia	____	____
Back Pain/DJD/DDD	____	____	Osteoporosis	____	____
Epilepsy/Seizures	____	____	Recurring Cystitis/Incontinence	____	____
High Blood Pressure	____	____	Migraines/Frequent Headaches	____	____
High Cholesterol	____	____	Vision/Hearing Difficulties	____	____
Do you have a Pacemaker	____	____	Dizziness or Faintness	____	____
Heart Attack/Surgery	____	____	Stroke/TIA/ Blood Clot/Emboli	____	____
Infectious Disease	____	____	Thyroid/Goiter/Hypo/Hyperthyroid	____	____
Diabetes	____	____	STD'S	____	____
Cancer/Chemo	____	____	Do you use any illegal drugs	____	____
Arthritis/Swollen Joints	____	____			
Rheumatism/Bursitis	____	____			

Ever been treated for a drug addiction, if so-name drug treated for -yes___ _____

Other illnesses not listed_____
_____

Smoker: Yes_____ No_____ Daily_____ Weekly_____

Alcohol Consumption: Yes_____ No_____ Daily_____ Weekly_____

What else do we need to know about you and your health?_____
_____
_____
_____
_____

The Berry Clinic

Ken D. Berry, MD, FAAFP
731-584-1430

Financial Policy, Assignment of Benefits, and Permission for Treatment

Financial Policy

Your insurance contract is an agreement between you, your insurance company, and in many instances, your employer. All charges incurred by you at The Berry Clinic are your responsibility. Any disputes with the insurance company should be handled by you. You will be expected to pay your portion of the total charges at the time of service. If we do not participate with your insurance provider, you will be expected to pay all charges in full at the time of service. As a courtesy to you, we will file a claim with your insurance company "unassigned" so you will receive payment directly from your insurance company.

1. Payment is due when services are rendered. We accept cash, personal checks, and credit/debit cards. There will be a $35.00 charge assessed for all checks returned by your bank not paid.
2. Payment plans on past due patient balances will be considered on a case-to-case basis, and are the sole discretion of Dr. Berry. This should be discussed and approved by Dr. Berry. Payment plans may be approved if you can make monthly payments and pay off any outstanding balance in a timely fashion.
3. If you are insured with Medicare, Aetna, Blue Cross Blue Shield, Beech Street Network, ChoiceCare, Cigna, First Health, Health Partners, PHCS, Signature, United Healthcare, or USA-MCO we will accept the co-payment or co-insurance, and file the insurance for you at no cost.
4. Concerning minor children, the person bringing the child is responsible for the bill at the visit, regardless of any Parenting Plan from a previous divorce.
5. We consider an account delinquent if it has not been paid within 60 days. If we are unable to collect a bill owed by you, we will be forced to forward your account to the collection company of our choice after 90 days of no payment. You will be responsible for any costs we incur attempting to collect a debt owed by you. Unfortunately, patients and their immediate family members who are referred to a collection company are at risk of being formally discharged from our practice.

By signing below, I agree I have read this information and understand it, and that I am financially responsible for all charges.

Assignment of Benefits

Non-Medicare Patient

I hereby assign to The Berry Clinic, any and all benefits from any insurance plans or any other protection maintained by the Patient and/or on the Patient's behalf or benefit, and authorize and direct such benefits to be paid directly to Ken D. Berry, M.D. d/b/a The Berry Clinic for services provided to the Patient by The Berry Clinic. I certify that the information given by me to The Berry Clinic in applying for payment under my insurance plan or other protection is correct and complete. I authorize release of all records required to act on this release and assignment.

Medicare Patient

I request that payment of authorized Medicare benefits be made to me or on my behalf to The Berry Clinic for any services refurnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. I certify that the information given by me to The Berry Clinic in applying for payment under the Medicare program is correct and complete. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

By signing below, I agree to be financially responsible for all charges. I have read the information and understand it.

I further agree that in the event that my account is placed with a collection agency due to untimely payment, I will be responsible for all additional costs of collection charged by said agency.

I further agree that in the event that my account is placed with an attorney for collection, I will be liable for the reasonable attorney's fees and any court costs incurred in an attempt to settle my account.

Permission for Treatment

I hereby authorize The Berry Clinic, through Dr. Berry and his professional staff, to treat me for conditions requiring their services. I understand that all procedures will be explained to me in the detail that I require to understand the risks and benefits that I have the right to refuse any procedure and/or treatment at any time during my visit.

_____ _____

Date **Authorized Signature (Parent if Patient is a Minor)**

_____

Print Name as Signed Above

The Berry Clinic

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICY

PRIVACY POLICY AVAILABLE UPON REQUEST

I, _____ hereby acknowledge receipt of/or do not want, the Notice of Privacy Practices given to me by The Berry Clinic.

Signed: _____ Date: _____

For Clinical Use Only;

If not signed, document good faith efforts to obtain acknowledgement:

_____

_____

_____

Person seeking acknowledgment: _____ Date: _____

The Berry Clinic

P: 731-584-1430
F: 731-584-1430

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Identification:

Patient Name: _____ Date of Birth: _____

Maiden/Previous Names/Nickname: _____

Social Security Number: _____

Provider (Who is releasing information?):

Provider Name: _____

Phone: _____ _____Fax: _____

Disclose Information to (Where is information to be sent?):

Facility: The Berry Clinic

Address: 30 East Main Street

City/State/Zip: Camden, TN 38320

Phone: 731-584-1430 Fax: 731-584-1439

Service Dates:

Dates of service from (date) _____ to (date) _____

Information to be disclosed:

- ☐ Standard Chart Copy (Includes Demographic Face Sheet, Physician Dictated Reports, All Test Results)
- ☐ Entire Record
- ☐ Other _____
- ☐ History and Physical
- ☐ Discharge Summary
- ☐ Lab
- ☐ X-ray and imaging reports
- ☐ EKG
- ☐ Operative Report
- ☐ Pathology Report

Purpose of Disclosure:

☐ Continued Healthcare ☐ Completion/Payment ☐ Personal ☐Other _____

(Purpose not required for personal requests) A copying fee may be charged on requests for the purposes other than patient care)

Authorization:I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, or treatment for alcohol and drug abuse. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or obtain copies of the information to be used or disclosed, as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Relationship to Patient Signature of Witness

Expiration Date: _____