1231 Tusculum Blvd
Greeneville, TN 37745

PATMOS *EmergiClinic*

423-639-9970

PATIENT'S NAME Please print: ____
(Adult or Minor being treated)

PAYMENT IS EXPECTED AT THE TIME OF SERVICE. A visit typically costs $45 to $75 but can be more or less depending on the severity of your illness, the amount of the physician's time required, whether or not a procedure is performed, and the medicines that you receive. Payment can be made with cash, credit card, debit card, or check.
No checks accepted on the first visit.

We do not accept any third party payment. This enables us to keep our overhead low so as to make primary medical care more affordable to people who have no choice but to pay for it out of their own pockets. If you have commercial insurance and you wish to submit the claim to your insurer for reimbursement, we will be glad to provide the appropriate diagnostic and procedure codes so you can do so. If you would prefer that it be submitted on your behalf, we will forward the appropriate documentation for a $10 surcharge to a professional biller who will then file the claim using a universal claim form (HCFA-1500 or UB-92 form). However, since your insurance company has no contract with us, we cannot guarantee that it will reimburse you. Please note that neither Tenncare nor Medicare can be filed for this visit.

Due to the complexity of the various governments' current healthcare regulations and the immense power it has to enforce these regulations, we feel it best at this time not to see new patients who require a controlled substance on a regular basis.

* ***I understand that I am responsible for paying my bills or those of a dependent today after my visit.***

PAYER'S SIGNATURE: ____ **Date**: ___________________

* * * PATIENT AND PAYER INFORMATION * * *

If the patient is a minor, please fill out this part as the payer and also his/her information below as the minor-child patient

ADULT PATIENT/PAYER'S NAME: __________________________________ Email address: __________________________

Address: ____

City: _________________________________ State: ___________ Zip code: _____________________

Telephone: (home) ___________________________ (cell) ____

Birth Date ________________ Age _________ Social security number: ______________________________

Emergency contact (name & phone number): ____

* If you have insurance, what kind (please circle) – Commercial / Tenncare / Medicare / None
Insurance information is for labs or referrals to other professionals

* If you have commercial insurance, do you want us to provide the codes for the visit so you can file it yourself? Yes /No

* If you have commercial insurance, do you want us to forward the bill to a professional for a $10 surcharge who will file the claim on your behalf? Yes / No

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* * * MINOR-CHILD PATIENT INFORMATION * * *

MINOR-CHILD PATIENT'S NAME: ____

Address (If different from above): ____

City: __________________________ State: ___________ Zip code: ________________

Birth Date: __________________ Age: ______

PARENT/GUARDIAN NAME (please print) ____

INFORMED CONSENT: I am giving consent for Robert S. Berry, M. D. and any other medical professional at PATMOS EmergiClinic to evaluate and treat the MINOR patient named above.

SIGNATURE OF CONSENT: ____ **Date**: ___________________

1. What is your medical problem today?

2. What chronic medical problems do you have (examples – diabetes, hypertension, asthma)?

3. What medicines are you taking now?

4. If the patient is a woman, is she pregnant? Yes / No.
   If not, is it possible that she could become pregnant? Yes / No.
   If not, why not? Bilateral tubal ligation / menopause / hysterectomy / abstinence

5. What surgeries have you had, if any?

6. Are you allergic to any medicines – if so which ones?

7. What pharmacy or pharmacies do you use to fill your prescriptions?

8. How did you find out about PATMOS *EmergiClinic*?