

Sentef Medical Centers, PLLC  
Family & Occupational Medicine

9980 Bradmore Lane #104  
Ooltewah, TN 37363  
(423) 760-4630  
Fax: (423) 760-4631

**Patient Information -- PLEASE COMPLETE ALL INFORMATION**

Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Race: \_\_\_\_\_ Sex: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Marital Status: S / M / W / D

Can we leave appointment reminders/information & lab/test results on voicemail or email? Y N (Circle one)

Email: \_\_\_\_\_ Can e-mail be used for billing purposes? Y N (Circle one)

Employer: \_\_\_\_\_ Employer Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Insurance Information -- WE NEED COPIES OF ALL INSURANCE CARDS**

Primary: \_\_\_\_\_ Member ID#: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Relationship to Policy Holder: \_\_\_\_\_

Secondary: \_\_\_\_\_ Member ID#: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Relationship to Policy Holder: \_\_\_\_\_

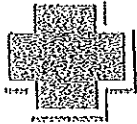
Do you have TennCare/BlueCare? Yes \_\_\_\_\_ No \_\_\_\_\_

By signing this form, I have been made aware that Sentef Medical Centers does not participate with any Tennessee Medicaid Programs. I understand that I will be responsible for any balance after my primary insurance has paid/adjudicated/denied on any medical claims file on my behalf by Sentef Medical Centers. I also agree to notify Sentef Medical Centers of any changes.

Patient/Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_

**Emergency Contact:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_



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### Acknowledgement of Notice of Privacy Practices

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Sentef Medical Centers provides information about how we may use and disclose protected health information about you.

I acknowledge that the Privacy Practices are accessible to me whenever I choose to review them.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Patient Name

\_\_\_\_\_  
Patient's Representative/Guardian

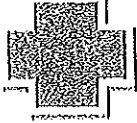
\_\_\_\_\_  
Date

### HIPAA Consent/Emergency Contact Information

I, \_\_\_\_\_ grant permission for the person(s) listed below to have access to any and all of my medical information that pertains to my care from Sentef Medical Centers. Including appointments, lab results, my physician's plan of care, etc.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_



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Financial Policy

Insurance Verification

At each visit, the patient must provide an active insurance card with current, correct information. Without proof of insurance, the patient may be rescheduled. Sentef Medical Centers makes it a priority to verify proof of a patient's insurance, however, it is the patient's responsibility to know his/her benefits for all medical services including wellness benefits prior to time of service.

Patient Cost, Co-Pays & Co-Insurance

Insurance companies require Sentef Medical Centers to collect co-pays, deductibles, or co-insurance amounts at the time of service. A deposit equal to 1/3 of costly procedures or visits is required in advance for services not covered by the patient's insurance.

Outstanding Balances

Patients will be asked to settle any outstanding balances with Sentef Medical Centers before their appointment. As a patient, you may pay any outstanding balances at any of our offices. Patients with outstanding balances may be declined treatment or triaged for non-emergency until the balance is resolved. Patient's balances that are not resolved in a timely manner will be sent to an outside collection agency. If the patient's balance is transferred to an outside agency, the patient will be responsible for paying any additional collection fees associated with the collection of the patient balance.

Self-Pay

Sentef Medical Centers contracts with most insurance companies for patient services. The patient remains financially responsible for all his or her care, but the remaining balance for services rendered to the patient will not be billed to the patient until payment is received from the insurance company(s), the insurance company denies the claim, or the insurance company unreasonably fails to pay in a timely manner. A statement will be sent to the patient or responsible party. *The billed amount on the statement is due when the first statement is received.*

Payments

Sentef Medical Centers accepts cash, checks, Visa, MasterCard, and Discover. Due to COVID-19, we are now offering telehealth visits along with taking payments via the telephone. Patients are responsible for these charges and by signing below you are also consenting to us running your card via telephone authorization and providing us the card numbers, expiration date and the CVV code. If you are uncomfortable paying via telephone, you may send a check in the mail. There is a \$30.00 fee for all returned checks.

Payment can be mailed to:

Sentef Medical Centers  
9380 Bradmore Lane Suite 104  
Ooltewah, TN 37363

To bring payments in person:

Ooltewah Location  
9380 Bradmore Lane Suite 104  
Ooltewah, TN 37363

Note

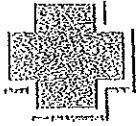
Patient Accounts with outstanding balances and no payment activity will be forwarded to a collection agency at the patient's expense. In addition to any outstanding balances, the patient or the patient's representative who signs below agrees to pay additional collection processing fees of 30% of the original balance plus all cost associated with such collection activity, including reasonable attorney and court fees.

I have read and understand Sentef Medical Centers financial policy and agree to the terms.

\_\_\_\_\_  
Patient/Responsible Party Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Patient Name



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### Patient's Bill of Rights and Responsibilities

Sentef Medical Centers, PLLC and staff are committed to providing quality health care. In accordance with this commitment, we believe that a patient is entitled to the following:

#### Privacy and Respectful Care

Patients have the right to considerate and respectful care, including privacy, security and safety including freedom from all forms of abuse and harassment. The patient has the right to every consideration of his/her privacy, concerning his/her own medical care. Consultation, examination, discussion, and treatment are confidential and should be conducted discreetly. Each patient has the right to know the identity and professional status of all staff members and physicians providing services.

#### Care Decisions/Informed Consent

The patient has the right to be informed about and to participate in decisions related to his/her care. The patient has the right to obtain from the physician complete and current information concerning his/her diagnosis, treatment, and prognosis. In terms the patient can be reasonably expected to understand. When it is not medically advisable to give such information to the patient, the information should be made available to an appropriate person on his/her behalf. The patient has the right to receive from his/her physician information necessary to give informed consent prior to the start of any procedure and/or treatment. Where medically significant alternatives for care or treatment exist, or when the patient requests information concerning medical alternatives, the patient has the right to such information. The patient also has the right to know the name of the person responsible for the procedures and/or treatment.

#### Advance Directives/Ethics Laws

Advance directives for medical care such as Living Wills or the designation of a surrogate decision maker are respected to the extent provided by the law. Each patient can expect to be asked about his/her advance directives and/or given information upon admission or request. Patient or their designated representatives have the right to participate in the consideration of ethical issues that arise in the care of patients.

#### Refusal of Treatment

The patient has the right to refuse treatment to the extent permitted by law, and to be informed of the medical consequences of this action.

#### Confidential Records and Information

The patient has the right to expect that all communication and records pertaining to his/her can be treated confidentially, and that access to one's records will be met within a reasonable period of time.

#### Financial Information

The patient has the right to examine and receive an explanation of his/her bill regardless of source of payment.

#### Request for Services

The patient has the right to expect that within its capacity, Sentef Medical Centers, PLLC, must make reasonable responses to the request of a patient for services. Sentef Medical Centers, PLLC must provide evaluation, service and referral as indicated by the urgency of the patient's condition. When medically permissible a patient may be transferred to another facility only after he/she has received complete information and explanation concerning the needs for and alternatives for such a transfer. The institution to which the patient will be transferred must first have accepted the patient for transfer.

#### Patient Responsibility

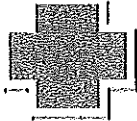
Patient must observe the rules of Sentef Medical Centers, PLLC and give accurate and complete information in order to assist in their diagnosis and treatment. They should report any changes in their condition which may affect their treatment or care. Patients are responsible for the payment to Sentef Medical Centers, PLLC for incurred charges for medical care. Sentef Medical Centers, PLLC, helps in filing claims under any workman's compensation or participating insurance plans. Any balance left unpaid by such plans remains the patient's responsibility. Each patient must consider the rights of other patients and of Sentef Medical Center, PLLC personnel. All share the responsibility for the use of Sentef Medical Center, PLLC property.

#### Resolving Patient Care Complaints/Conflict

Sentef Medical Centers, PLLC, believe patients have the right to voice complaints regarding the care they receive and to have those complaints reviewed and, when possible, resolved. Patient complaints should initially be heard and reviewed by the department providing the patient care. If the problem cannot be resolved at that level, the complaint should be referred to an appropriated manager or director for review.

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Patient Signature



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Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Current Age: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

**Medications** (including dosage and how often taken)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Allergies** (including the reaction)

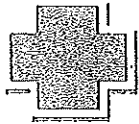
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medical Problems** (check all that apply)

- |                                                |                                               |                                         |
|------------------------------------------------|-----------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Eye Infections        | <input type="checkbox"/> Stomach Ulcer        | <input type="checkbox"/> Seizures       |
| <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Diverticulosis       | <input type="checkbox"/> Arthritis      |
| <input type="checkbox"/> Cataracts             | <input type="checkbox"/> Bowel Trouble        | <input type="checkbox"/> Psoriasis      |
| <input type="checkbox"/> Ear Infections        | <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> Gout           |
| <input type="checkbox"/> Sinus Trouble         | <input type="checkbox"/> Jaundice             | <input type="checkbox"/> Rash           |
| <input type="checkbox"/> Deafness              | <input type="checkbox"/> Liver Trouble        | <input type="checkbox"/> Cancer         |
| <input type="checkbox"/> Thyroid Trouble       | <input type="checkbox"/> Gall Bladder Trouble | <input type="checkbox"/> Anemia         |
| <input type="checkbox"/> Emphysema             | <input type="checkbox"/> Hernia               | <input type="checkbox"/> Bleeding       |
| <input type="checkbox"/> Pneumonia             | <input type="checkbox"/> Hemorrhoids          | <input type="checkbox"/> Diabetes       |
| <input type="checkbox"/> Asthma                | <input type="checkbox"/> GYN Problems         | <input type="checkbox"/> Endocrine      |
| <input type="checkbox"/> Tuberculosis          | <input type="checkbox"/> Breast Problems      | <input type="checkbox"/> Fainting       |
| <input type="checkbox"/> Lung Problems         | <input type="checkbox"/> Venereal Disease     | <input type="checkbox"/> Tumor          |
| <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Varicose Veins       | <input type="checkbox"/> Prostate       |
| <input type="checkbox"/> Heart Attack          | <input type="checkbox"/> Phlebitis            | <input type="checkbox"/> Colitis        |
| <input type="checkbox"/> Hardening of Arteries | <input type="checkbox"/> Mental Problems      | <input type="checkbox"/> Kidney         |
| <input type="checkbox"/> Heart Murmur          | <input type="checkbox"/> Nervousness          | <input type="checkbox"/> Blood in Urine |
| <input type="checkbox"/> Rheumatic Fever       | <input type="checkbox"/> Head Injury          | <input type="checkbox"/> Kidney Stones  |
| <input type="checkbox"/> Heart Condition       | <input type="checkbox"/> Stroke               | <input type="checkbox"/> Headaches      |

Do you smoke? \_\_\_\_\_

Do you drink alcoholic beverages? \_\_\_\_\_



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**Surgical History** (Please list any hospitalizations, operations, and serious injuries within the last year)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

**Preventative Health Screening**

Date of last Physical: \_\_\_\_\_  
Date of last X-ray: \_\_\_\_\_  
Date of last Colonoscopy: \_\_\_\_\_  
Date of last DEXA scan for osteoporosis screening: \_\_\_\_\_  
Date of last Mammogram for breast cancer screening: \_\_\_\_\_  
Date of last Pap Smear: \_\_\_\_\_ Abnormal? Y N  
Date of last Flu vaccination: \_\_\_\_\_  
Date of last Measles vaccination: \_\_\_\_\_  
Date of last Polio vaccination: \_\_\_\_\_  
Date of last Tetanus vaccination: \_\_\_\_\_  
Date of last Mumps vaccination: \_\_\_\_\_

**Family History** (List any medical problems in the following. If you know the age at diagnosis, please include)

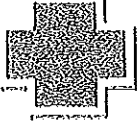
Are you adopted? \_\_\_\_\_

Mother: _____	Father: _____
Brother: _____	Sister: _____
Aunt: _____	Uncle: _____
Paternal Grandmother: _____	Paternal Grandfather: _____
Maternal Grandmother: _____	Maternal Grandfather: _____
Other family member not already mentioned: _____	

Additional info you would like to provide about you?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_



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## Prescription Policy

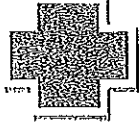
Sentef Medical Centers participates with electronic prescribing directly to your local pharmacy and/or mail order service. Our goal is to assist our patients with prescription requests in an efficient and timely manner. Due to the volume of prescription requests, we have created the following guidelines to help meet these needs.

1. It is the patient's responsibility to notify the office in a timely manner when refills are necessary. Approval of your refill may take up to 72 hours or 4 business days, so do not wait until you are completely out of a medication to call. If you use a mail order pharmacy, please contact us 14 days before your medication is due to run out.
2. Medication refills will only be addressed during regular office hours (Monday-Friday 9:00 A.M.-5:30 P.M.). Please notify our office on the next business day if you find yourself out of medication after hours. NO prescriptions will be filled on Saturday, Sunday or Holidays or by Providers who are on-call to address emergency situations.
3. Prescription refills require close monitoring by our Providers to ensure safety and effectiveness. Your Provider will prescribe the appropriate number of prescription refills to last you until your next scheduled appointment. Generally, when you are down to zero refills, it is time to schedule an appointment. We prefer you request any refills of your medications at the beginning of your office visit. Depending on the type of medication you are prescribed, your Provider may require that you be seen in office every 90 days regardless of your amount of medication.
4. Patients requesting new prescriptions, changes to existing prescriptions or antibiotics, must be seen for an office visit.
5. Refills can only be authorized on medication prescribed by Providers from our office. We will not refill medications prescribed by Providers that are not affiliated with and not part of Sentef Medical Centers group.
6. Some medications require prior authorization. Depending on your insurance, the process may require several steps by your Provider and the Pharmacy. The Providers and Pharmacies are familiar with this process and will handle the prior authorization as quickly as possible. Only the pharmacy is notified of the approval status and neither the Provider nor the Pharmacy can guarantee that your insurance will approve the medication. Please check with your pharmacy or your insurance company for updates.

7. It is important to keep your scheduled appointment for refills when you are due to receive them. We cannot call in medications for refills if you miss your scheduled appointment. Repeated no-shows and cancellations will result in denial of refills.
8. Some medications require patients to do a urine drug screen every 90 days. We cannot refill your medication if you are non-compliant and past your 90 day in-office appointment. As a policy we allow patients to do an office visit and 2 telehealth appointments for refills if it falls within 90 days. We do not allow 2 telehealth appointments for refills that go past 90 days if you are prescribed a controlled substance and require urine drug screens.
9. We reserve the right to require an office visit at any time for refills at the discretion of the Provider and/or Management for the care of the patient, their medication management or other medical reasons.
10. We reserve the right to deny refills and charge an administrative fee if there are multiple requests for prescriptions requested outside of an office visit. The Provider, at their discretion may require a telehealth call or an office visit to do refills if the patient did not address the need for refills on the last appointment.

Patient Signature\_\_\_\_\_Date\_\_\_\_\_





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### Consent to Receive Text Messages and Emails

By signing below, I authorize Sentef Medical Center to contact me via SMS Text Message and/or Email for health related notifications, including appointment reminders, balances and statements.

I understand message/data rates may apply to messages sent by Sentef Medical Center under my cell phone plan.

I know that I am under no obligation to authorize Sentef Medical Center to send me text messages and Emails. I may opt out or receiving these communications at any time.

I understand that Text and Email messages are not substitute for professional or medical attention.

By signing below, I agree to all terms and conditions of use for the text messaging service.

Yes, sign me up for SMS Text Messaging. [ ☐ ]

Phone Number:

(\_\_\_\_\_)\_\_\_\_\_

Yes, sign me up for Email Messaging. [ ☐ ]

Email Address:\_\_\_\_\_

Name:\_\_\_\_\_

Date of Birth :\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Signature:\_\_\_\_\_Date:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_




# PATIENT HEALTH QUESTIONNAIRE (PHQ-9)


NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

add columns  +  + 

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL: 

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	_____
	Somewhat difficult	_____
	Very difficult	_____
	Extremely difficult	_____