Sentef Medical Center
Family & Occupational Medicine

9380 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: _____

Email and Cell Phone number will be used for billing purposes. We do not send paper statements.

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 or through our Patient Pay Portal. 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. We send statements electronically through email and cell phone messages that will direct patients to the E-portal to make payments. 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 pay through the E-portal. There is a $30.00 fee for all returned checks.

Payment can be mailed to:	To bring payments in person:
Sentef Medical Centers	Ooltewah Location
9380 Bradmore Lane Suite 104	9830 Bradmore Lane Suite 104
Ooltewah, TN 37363	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 Center 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 reasonable 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 Center, must make reasonable responses to the request of a patient for services. Sentef Medical Center 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 Center 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 for incurred charges for medical care. Sentef Medical Center 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 personnel. All share the responsibility for the use of Sentef Medical Center property.

Resolving Patient Care Complaints/Conflict

Sentef Medical Center believes 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 heart and reviewed by the department providing the patient care. If the problem cannot be resolved at that level, the complaint should be refer to an appropriated manager or director for review.

_____

Patient Signature

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Patient Consent for Use of Artificial Intelligence (AI)-Assisted Clinical Documentation

At Sentef Medical Center, we use an Artificial Intelligence (AI)-assisted documentation tool to help our healthcare providers create accurate and efficient medical records. This technology may be used during your visit to assist with capturing and organizing information discussed during your appointment.

The AI tool may process audio from the visit for the purpose of generating clinical documentation, such as visit notes and summaries. The information generated by the AI tool is reviewed and finalized by your healthcare provider before becoming part of your medical record.

The AI tool is used only to assist with documentation. It does not diagnose conditions, make treatment decisions, or replace the judgment of your healthcare provider.

Your health information will continue to be handled according to applicable privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA). The AI documentation system used by Sentef Medical Center is configured to support the protection and confidentiality of your health information.

You have the right to ask questions about the use of AI-assisted documentation and may decline the use of this technology during your visit. If you choose not to participate, your provider will document your visit using traditional methods.

By signing below, you acknowledge that:

☐ You have been informed that Sentef Medical Center may use AI-assisted documentation tools during your healthcare visits.

☐ You understand that the AI tool may capture and process information discussed during your appointment for the purpose of assisting with medical record documentation.

☐ You understand that your provider reviews and approves the documentation before it is included in your medical record.

☐ You consent to the use of AI-assisted documentation during your visits.

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Date of Birth: _____

Patient Signature: _____

Date: _____

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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)

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

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 figety 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		+	+	
TOTAL:				

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

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 _____

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Authorization for Release of Medical Records Patient Information

Name:_____ Date of Birth:_____

Address: _____City:_____

City: _____ST:_____ Zip:_____

Phone: _____

Request Information to be released from:	**Request information to be released to**
Name:	Sentef Medical Center
Address:	9380 Bradmore Lane Ste. 104
City: ST: Zip:	Ooltewah, TN 37363
Phone:	Phone: 423-760-4630
Fax:	Fax: 423-760-4631

I, _____authorize_____

To release my medical records to_____

For the following purpose _____

Signature of patient: _____

Relationship to patient (if not patient): _____

Date:_____

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Patient Consent for Email and Text Communications

Patient Name: _____

At Sentef Medical Center, we strive to provide convenient communication regarding your healthcare. By signing below, you authorize us to contact you using the email address and/or mobile phone number you provide.

I understand that Sentef Medical Center may contact me by **email and/or text message** regarding:

- Appointment reminders and confirmations
- Billing statements and payment reminders
- Requests to update insurance or demographic information
- Notifications regarding forms, referrals, or test results when appropriate
- General practice announcements and other healthcare-related communications

I understand and acknowledge that:

- Standard text messaging and data rates from my mobile carrier may apply.
- Email and text messaging are convenient but may not always be secure methods of communication. While reasonable safeguards are used, there is a risk that messages could be intercepted or viewed by someone with access to my email account or mobile device.
- I am responsible for notifying Sentef Medical Center if my email address or mobile phone number changes.
- I may withdraw my consent to receive email and/or text communications at any time by notifying the office in writing or by contacting our staff.
- This consent does not authorize communication for emergency medical situations. If I am experiencing a medical emergency, I will call 911 or go to the nearest emergency department.

Preferred Communication

Email Address: _____

Mobile Phone Number: _____

Please indicate how you would like to receive communications:

☐ Email Only

☐ Text Message Only

☐ Both Email and Text Message

I have read and understand the information above and voluntarily consent to receive communications from Sentef Medical Center by the method(s) selected above.

Patient Signature: _____

Date: _____