

# The Frist Clinic

## REGISTRATION INFORMATION

Date: \_\_\_\_\_

Physician: \_\_\_\_\_

<b>Patient's Legal Name:</b>		Middle	Female
Last:	First:	Initial:	Male
Mailing Address:		City:	State: Zip:
Street Address:		City:	State: Zip:
Home Phone <i>(Include Area Code)</i> ( )		Current Marital Status <i>(Circle One)</i> Single Married Divorced Widowed	
Cell Phone Number <i>(Include Area Code)</i> ( )		Living Will? Yes No	
Email Address:			
Patient Date of Birth:	Patient Social Security Number:	Referring Physician:	
Patient Employer:		Patient Work Phone <i>(Include Area Code)</i> ( )	
Spouse's Name:		Spouse's Date of Birth:	
Spouse's Social Security Number <i>(If Insured Through Spouse)</i>			
Emergency Notification <i>(Not Living in Same Household)</i> Name:		Emergency Notification Phone <i>(Include Area Code)</i> ( )	
Name of Responsible Party for Payment <i>(If Different From Patient)</i>			
Last:	First:	Middle Initial:	
Responsible Party Relationship to Patient:		Responsible Party Home Phone <i>(Include Area Code)</i> ( )	
Mailing Address:		City:	State: Zip:
Street Address:		City:	State: Zip:

### POLICYHOLDER INFORMATION

*(Information applies to person whose name the insurance falls under)*

**Primary Insurance Company Name:** \_\_\_\_\_

Insured Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Policy or ID Number: \_\_\_\_\_

Employer: \_\_\_\_\_ Group Number: \_\_\_\_\_

Address for Claims: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### POLICYHOLDER INFORMATION

*(Information applies to person whose name the insurance falls under)*

**Secondary Insurance Company Name:** \_\_\_\_\_

Insured Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Policy or ID Number: \_\_\_\_\_

Employer: \_\_\_\_\_ Group Number: \_\_\_\_\_

Address for Claims: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**PLEASE READ AND SIGN ON BACK**

THE FRIST CLINIC  
**Patient Consent Form**

*(Please Read and Sign)*

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I, the undersigned, hereby consent to the following:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests
- Taking and utilization of cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. **The consent will remain in full force until revoked in writing.**

I understand that The Frist Clinic includes consent at satellite offices under common ownership.

I, the undersigned, acknowledge that The Frist Clinic will use and disclose my information for the purposes of treatment, payment, and healthcare operations.

**Treatment** includes but is not limited to: the administration and performance of all treatments, the administration of any needed anesthetics, the use of prescribed medication; the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient, such as diagnostic procedures, the taking and utilization of cultures and of other medically accepted laboratory tests, all of which the judgment of the attending physician or their assigned designees, may be considered medically necessary or advisable.

**Payment** includes but is not limited to: the authorization of payment directly to The Frist Clinic of benefits otherwise payable to me. I hereby acknowledge the release of my medical records to third party insurers or authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided, such as billing and collection services, insurance payers, auto accident insurers, or for work related injury, to my employer or designee understand that I am financially responsible for charges not covered. I acknowledge that patient records may be stored electronically and made available through computer networks.

**Healthcare Operations** include but are not limited to: release of my medical information to any of my physicians and their offices or insurance companies participating in my care or treatment and the quality of that care.

I fully understand that this is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing. This consent specifically includes the release of medical information concerning drug-related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or infectious diseases including but not limited to blood-borne diseases.

A photocopy of this consent shall be considered as valid as the original.

If there is an exposure, and the patient's test is positive, the attending physician will notify the patient, any person exposed, and the Nashville Metropolitan Public Health Department and appropriate counseling will be offered.

**MEDICARE PATIENTS:** I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to The Frist Clinic.

**I acknowledge that I have been given The Frist Clinic Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official. Patient Initial: \_\_\_\_\_**

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

\_\_\_\_\_  
**Patient (or Responsible Party) Signature**

\_\_\_\_\_  
**Date**