Patient Registration Form PLEASE PRINT

PATIENT INFORMATION

Last Name: _____ First Name: _____ M. Initial: _____

DOB: _____ Sex: ☐ Female ☐ Male Social Security Number: _____-_____-_____

Marital Status: _____ email: _____

Race: _____ Ethnicity: _____ Language: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

PHARMACY NAME & PHONE NUMBER: _____

PARENT OR GUARDIAN INFORMATION *(Only fill out if the patient is under the age of 18)*

Last Name: _____ First Name: _____ M. Initial: _____

Address: _____

City: _____ State: _____ Zip: _____

DOB: _____ Social Security Number: _____-_____-_____

Home Phone: _____ Cell Phone: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

EMPLOYER: _____

PRIMARY & SECONDARY INSURANCE INFORMATION *(ALL insurance)*

Insurance Plan Name: _____

POLICY HOLDER NAME *(if other than patient)*: _____

DOB: _____ Sex: ☐ Female ☐ Male Relationship to Patient: _____

HOW MAY WE CONTACT YOU REGARDING YOUR PROTECTED HEALTH INFORMATION (PHI)?

☐ No ☐ Yes: I may be contacted by e-mail at: _____

☐ No ☐ Yes: I may be contacted by phone at: _____

☐ No ☐ Yes: May we leave a message with your PHI at the number you have provided? ***(MUST BE ANSWERED)***

Would you like to receive text messages regarding your appointment, lab results, etc.?

☐ No ☐ Yes: What number? _____

DO YOU WANT ANYONE TO HAVE ACCESS TO YOUR PHI? IF SO, WHO? NAME: _____

Signature: _____ **Date:** _____

Relationship to Patient: _____

HARTGROVE**MEDICAL**

651 East Fourth Street, Suite 150, Chattanooga, TN 37403 ▪ 423.633.1625 ▪ www.HartgroveMedical.com

Notice Of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

Patient Name or Legal Guardian: _____

Signature: _____

Date: _____

PRACTICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date: _____ Initials:_____

Reason: _____

_____

General Consent For Treatment

As the patient, you have the right to be informed about your conditions and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify appropriate treatment and/or procedure for any identified condition(s).

I request and authorize medical care as my provider, his assistant or designees (collectively called "the providers") may deem necessary or advisable. This care may include, but is not limited to, routine diagnostics, radiology and laboratory procedures, administration of routine drugs, biological and other therapeutics, and routine medical and nursing care. I authorize my provider(s) to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my (the patient) care is directed by my provider(s) and that other personnel render care and services to me (the patient) according to the provider(s) instructions.

I understand that I have the right and the opportunity to discuss alternative plans of treatment with my provider and to ask and have answered to my satisfaction any questions or concerns.

In the event that a healthcare worker is exposed to my blood or bodily fluid in a way which may transmit HIV (human immunodeficiency virus), hepatitis B virus or hepatitis C, I consent to the testing of my blood and/or bodily fluids for these infections and the reporting of my test results to the healthcare worker who has been exposed. _____ **(initial)**

I HAVE READ OR HAD READ TO ME AND FULLY UNDERSTAND THIS CONSENT; I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS AND HAD THESE QUESTIONS ADDRESSED.

Name of Patient: _____

Signature of Patient: _____ Date: _____

☐ Consent of Legal Guardian, Patient Advocate or Nearest Relative **if patient is unable to sign**

☐ Consent Caregiver **if patient is unable to sign**

Name of Legal Guardian, Patient Advocate, Nearest Relative or Other: _____

Relationship: _____ Telephone: _____

Address: _____

Signature of the above: _____ Date: _____ Time: _____

Signature of Witness: _____ Date: _____

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Concierge Medicine Patient Agreement

THIS CONCIERGE MEDICINE PATIENT AGREEMENT (this **"Agreement"**) is entered into as of _____, 20____ by and between **AdvancedHEALTH d/b/a Hartgrove Medical (the "Practice") and**

_____ **(the "Patient").**

In exchange for certain fees paid by the Patient, the Practice, through Nathan Hartgrove, DO (the **"Physician"**) and its clinical and administrative staff, agrees to provide Patient with certain medical and/or nonmedical services set forth in **Exhibit A**, which such services may be amended from time to time in the Practice's sole discretion (the **"Services"**), pursuant to the terms and conditions set forth in this Agreement.

1. **INSURANCE / OTHER MEDICAL COVERAGE. The practice does not accept health insurance, including medicare, and will not bill or submit any claim for any services or excluded services, as such term is defined herein. The fees paid under this agreement are not covered by any health insurance or health plan that the patient may carry. This agreement is not an insurance plan and is not intended to replace any health insurance or health plan that the patient may carry. This agreement does not cover hospital services, or any services not personally provided by the practice. The patient acknowledges and agrees that the practice has advised the patient to obtain or keep in full force such health insurance policies or plans that will cover the patient for general healthcare costs and needs that are not provided pursuant to this agreement.**

2. **Term.** The term of this Agreement shall commence upon the date of the latest to occur of the following: (a) execution of this Agreement, and (b) Patient's payment of the first full annual Fee, as such term is defined herein (the **"Effective Date"**). Unless otherwise terminated as provided herein, this Agreement shall continue for an initial term of one (1) year from the Effective Date and shall automatically renew for additional one (1) year terms upon payment of the Fee within thirty (30) days prior to the expiration of the current term (the initial term and any succeeding term(s) may be collectively referred to herein as the "Term"); provided, however, that the Practice may require the Patient to execute a new agreement prior to the beginning of any new Term, and failure to execute such agreement prior to the expiration of the current Term will result in termination of the membership at the expiration of the current Term. Additionally, if the annual fee for any upcoming Term is not paid within thirty (30) days prior to the expiration of the current Term, this Agreement shall terminate at the end of the current Term.

3. **Fees.** The Patient shall pay the Practice the following annual fee for the Services (the **"Fee"**), which such Fee may be paid by check, credit card, or debit card (*select one*):

   ☐ Two payments of Nine Hundred Dollars and No/100 ($900.00)

   ☐ Single discounted (-10%) payment of One Thousand, Six Hundred Twenty Dollars and No/100 ($1,620.00)

   Credit/debit card payments will be set up to auto-draft on the date the payment is due. If this Agreement is terminated by the Practice, the Practice shall refund the Patient's pro-rated share of the Fee for the number of days remaining in the Term for which the most recent Fee was paid. If this Agreement is terminated by the Patient, the Fee is nonrefundable and shall not be returned to the Patient for any reason.

4. **Statement of Services Rendered Issued Upon Request.** Upon request by the Patient, the Practice will provide the Patient with a statement of services that reflects the portion of the Fee attributable to services rendered to the Patient by the Practice.

5. **Preventative Visits**. The Practice recommends that the Patient attend an office visit for preventative care and maintenance purposes at least one time during each six-month period of the Term, and the Patient agrees to make an effort to schedule and attend such visits a minimum of every six months.

6. **Termination.** This Agreement may be canceled by the Practice or the Patient for any reason upon giving thirty (30) days' prior written or verbal notice to the other party. Upon termination of this Agreement and the Patient's request, the Practice and/or the Physician will assist the Patient in the transfer of the Patient's care to another provider of the Patient's choosing.

7. **Medical Records Release.** The Patient acknowledges and agrees that his or her medical records from other treatment providers and/or facilities may be useful to the Practice in providing the Services to the Patient, and that the Patient may be asked by the Practice or the Physician to execute a Medical Records Release (a **"Release")** or take other action to enable the Practice to receive the Patient's medical records from other treatment providers and/or facilities, including treatment providers and/or facilities formerly associated with the Physician. The Patient understands that the Practice will be unable to obtain from other treatment providers and/or facilities any of the Patient's medical records that are not covered by a Release executed by the Patient.

8. **Laboratory Testing.** For the Patient's convenience, the Practice will coordinate laboratory testing services at the Practice's Location through a third-party laboratory. If the Patient requires laboratory testing, the Patient may utilize the on-site laboratory service, or must notify the Provider that they elect to have laboratory testing handled by another off-site laboratory. Laboratory services are not included as part of the Services provided under this Agreement, and thus are not covered by the Fee paid by the Patient. The Patient acknowledges and agrees that whether the on-site laboratory or another laboratory of the Patient's choosing is used for laboratory testing for the Patient, the Patient will be billed directly by the laboratory and will be fully responsible for the cost of all laboratory services. If the Patient wishes to have the laboratory file a claim with the Patient's insurance provider, it is the Patient's responsibility to coordinate with that laboratory to do so.

9. **Excluded Services.** From time to time the Practice may, in the Practice's sole discretion, make services available to the Patient that are not included in the Services or covered by the Fee (the **"Excluded Services"**). The Patient acknowledges and agrees that any Excluded Services provided to the Patient will be charged to and paid by the Patient separately from and in addition to the Fee.

10. **Severability.** If for any reason any provision of this Agreement shall be deemed by a court of competent jurisdiction to be legally invalid or unenforceable in any jurisdiction to which it applies, the validity of the remainder of this Agreement shall not be affected, and that provision deemed invalid or unenforceable shall be modified to the minimum extent necessary to make that provision valid and enforceable under applicable law.

11. **Reimbursement for Services Rendered.** If this Agreement is held to be invalid for any reason, and if the Practice is therefore required to refund all or any portion of the Fee paid by Patient, Patient agrees to pay the Practice an amount equal to the reasonable value of the Services actually rendered to Patient during the period of time for which the refunded Fee was paid.

12. **Amendment.** Except with regard to the Services set forth on **Exhibit A**, which may be amended from time to time by the Practice without the Patient's consent, this Agreement may not be amended or modified except by written agreement signed by the parties hereto. Notwithstanding the foregoing, the Practice may unilaterally amend this Agreement to the extent required by federal, state, or local law or regulation by sending the Patient thirty (30) days prior written notice of any such change. Any such changes are established by the Practice and/or the Physician. Moreover, if federal, state, or local law requires this Agreement to contain provisions that are not expressly set forth in this Agreement, then, to the extent necessary, such provisions shall be incorporated by reference into this Agreement and shall be deemed part of this Agreement as though they had been expressly set forth herein.

13. **Assignment.** This Agreement and any rights the Patient may have under it may not be assigned or transferred by the Patient.

14. **Entire Agreement.** This Agreement contains the entire agreement between the parties with respect to its subject matter and supersedes all prior oral or written understandings and/or agreements between the parties regarding such subject matter.

15. **Choice of Law.** This Agreement shall be governed by and construed according to the laws of the State of Tennessee.

16. **Legal Significance.** The Patient acknowledges and understands that this is a legal document that creates certain legal rights and responsibilities. The Patient understands that he or she has the right and has had a reasonable time to seek legal counsel of the Patient's choosing regarding the Agreement and has either done so or has chosen not to do so.

17. **Dispute.** The substantially prevailing party in any dispute relative to this Agreement shall be entitled to collect from the other party reasonable costs associated with such dispute, including, but not limited to, attorney fees and legal costs.

18. **Miscellaneous.** This Agreement shall be construed without regard to any presumptions of rules requiring construction against the party causing the instrument to be drafted. Captions in this Agreement are for convenience only and shall not limit, broaden, or qualify the text.

IN WITNESS WHEREOF, the parties have executed this Lease to be effective as of the day and year first above written.

PRACTICE

AdvancedHEALTH d/b/a
Hartgrove Medical

Name: **Nathan Hartgrove**

Title: **D.O. (Doctor of Osteopathy)**

PATIENT

_____

Signature

_____

Print Name

Exhibit A

THE SERVICES

- Unlimited office visits are included with annual fee.
- Zero to minimal wait times. Your time is *your* time.
- Same-day or next-day appointments.
- Telehealth appointment availability.
- Weekend availability, if needed for emergencies.
- Dr. Hartgrove's work email for questions needing research or patient care updates.
- Limited patient pool to allow for more meaningful interactions.
- Wellness-focused practice.
- Individualized medical plan tailored for you, including dietary review, fitness goals, and wellness targets.
- Encouragement and prayer from a biblical-based mindset.

Authorization For Release Of Protected Health Information (PHI)

SECTION A: This section must be completed for all Authorizations for Release or Right to Access

Patient Name: _____ DOB: _____ SSN: _____

Requestor's Name / Address / Phone No. (Who is receiving PHI):

_____

_____

_____

Recipient's Name / Address / Phone No. (Who receives this form)

_____

_____

_____

Patient Address: _____

This authorization will expire on the following Date: _____/_____/_____

Purpose of Disclosure: _____

SECTION B: DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED

Is this request for psychotherapy notes? ☐ **YES**, then this is the only item you may request on this authorization.

YOU MUST SUBMIT another authorization for other items below. ☐ **NO, then you may check as many items below as you need.**

DESCRIPTION	DATE(S)	DESCRIPTION	DATE(S)	DESCRIPTION	DATE(S)
☐ All PHI in Psychotherapy Medical Record		☐ Laboratory		☐ Demographics	
☐ All PHI in Medical Record		☐ Imaging/Radiology		☐ Itemized Bill	
☐ History & Physical		☐ Pathology		☐ Claim Form	
☐ All Progress Notes		☐ Operative Notes		☐ Other:	
☐ Discharge Summary					

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV or AIDS results, testing or information. _____ (Initial)

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary
2. If I do not sign this form, my health care and the payment for my health care will not be affected
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it
6. I will receive a copy of this form after I sign it

SECTION C: SIGNATURES

I have read the above and authorize the disclosure of the protected health information as stated

_____ _____

Signature of Patient/Guardian/Patient Representative DATE:

_____ _____

Print Name of Patient's Guardian/Representative Relationship to the Patient

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