ADOLESCENT PATIENT REGISTRATION – GALEN MEDICAL GROUP, PC

Your Child:
Child's Full Name: _____ Name Your Child Goes By: _____
Gender: ❑ Male ❑ Female DOB: _____ Age: _____ SS#: _____
Child's Home Address: _____
City: _____ State: _____ Zip: _____ Phone: _____
Primary Physician: _____

❑ **Mother** ❑ **Stepmother** ❑ **Guardian**
Name: _____ DOB: _____
SS #: _____ Home Phone: _____ Work Phone: _____
Employer: _____ Occupation: _____
Cell Phone(s): _____ E-Mail: _____

❑ **Father** ❑ **Stepfather** ❑ **Guardian**
Name: _____ DOB: _____
SS #: _____ Home Phone: _____ Work Phone: _____
Employer: _____ Occupation: _____
Cell Phone(s): _____ E-Mail: _____

MAY WE LEAVE MESSAGES BY:	EMAIL	TEXT CELL	HOME PHONE	WORK PHONE	CELL PHONE
FOR TEST RESULTS	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
FOR APPOINTMENT REMINDERS	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

PARENTAL MARITAL STATUS: ❑ SINGLE ❑ MARRIED ❑ SEPARATED ❑ DIVORCED ❑ WIDOWED

PREFERRED LANGUAGE: ***Must complete.*** ❑ English ❑ Spanish ❑ Other: _____

PATIENT ETHNICITY: ***Select one.*** ❑ Hispanic or Latino ❑ Non-Hispanic or Non-Latino

PATIENT RACE: ***Select one or more.*** ❑ African American ❑ American Indian or Alaska Native ❑ Asian ❑ Caucasian/White ❑ Native Hawaiian or Other Pacific Islander ❑ Other

INSURANCE INFORMATION:

We require copies of ALL Insurance Cards pertaining to child in order to file your insurance claims.

PRIMARY INSURANCE: _____ INS ID#:_____
RELATIONSHIP TO SUBSCRIBER: _____ SUBSCRIBER NAME: _____
SUBSCRIBER'S ADDRESS: _____
SS #: _____ DOB: _____ PHONE: _____
SECONDARY INSURANCE: _____ INS ID#:_____
RELATIONSHIP TO SUBSCRIBER: _____ SUBSCRIBER NAME: _____
SUBSCRIBER'S ADDRESS: _____
SS #: _____ DOB: _____ PHONE: _____

EMERGENCY CONTACT INFORMATION:

NAME: _____ HOME PHONE: _____ WORK PHONE: _____
RELATIONSHIP TO CHILD: _____

PLEASE COMPLETE THE ADDITIONAL INFORMATION ON THE BACK OF THIS SHEET

CONSENT FOR RELEASE OF MEDICAL INFORMATION:

I, _____, parent/legal guardian of _____, grant permission for the person(s) listed below to have access to any and all of my child's medical information that pertains to his/her care from the physicians of this group. This includes, but is not limited to, appointment times, lab results, his/her physician's plans for health care, etc.

Signature: _____

Name: _____Relationship:_____

Name: _____Relationship:_____

Name: _____Relationship:_____

CONSENT FOR MEDICAL TREATMENT:

I, _____, parent/legal guardian of _____, grant permission for the person(s) listed below to bring my child to Galen Medical Group, PC for medical treatment.

Signature: _____

Name: _____Relationship:_____

Name: _____Relationship:_____

Name: _____Relationship:_____

I AGREE TO NOTIFY GALEN MEDICAL GROUP, IN WRITING, IF THERE ARE ANY CHANGES IN THE PERSON(S) AUTHORIZED.

Please list any siblings who are also patients of ours. Give both first and last names:

_____ _____

_____ _____

_____ _____

_____ _____

ADVANCED DIRECTIVES & AUTHORIZATION:

I authorize Galen Medical Group, PC to release to my insurance company, managed care organization, state agency(ies), federal agency(ies), Health Care Financing Administration, Third Party Administrators, and/or Workers' Compensation or its agents any information needed to process my claim and/or determine benefits payable for related services. I also authorize Galen Medical Group, PC to utilize a fax machine to transmit any or all of the above medical records pertaining to my medical care or insurance reimbursement. I acknowledge that faxing my medical records may increase the risk of accidental disclosure of my medical records. I grant permission to Galen Medical Group, PC to release all or part of my medical record to any consulting entity that may be involved in my medical care. This includes, but is not limited to, testing facilities, consulting physicians, and outpatient facilities.

I understand that I am financially responsible for deductible amounts, co-payments, co-insurance amounts, non-covered charges and any and all balances not covered under a contractual write-off agreement between Galen Medical Group, PC and my third party payer. My carrier's failure to pay does not release me from this responsibility. I also agree that should this account be turned to collection, I will be responsible for all costs associated with debt collection, including attorney fees and court costs.

_____ _____

Signature of Responsible Party / Insured ***Date***

THANK YOU!

Ver. 2017-01

GALEN
MEDICAL GROUP

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 re-scheduled. Galen Medical Group makes it a priority to verify proof of a patient's insurance; however, it is the patient's responsibility to know his/her benefits **including wellness benefits** prior to time of service.

Patient Cost Co-Pays & Co-Insurance
Insurance companies require Galen Medical Group 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.

A $12.00 processing fee will be added for co-pays that are not paid at the time of service.

Outstanding Balances
Patients will be asked to settle any outstanding balances with Galen Medical Group before their appointment. As a patient, you may pay any outstanding balances at any of our Galen Medical Group facilities.

Patients with outstanding balances may be declined treatment or triaged for non-emergency care until the balance is resolved.

Patient balances which 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
Galen Medical Group recognizes that not everyone has insurance coverage. It is difficult to accurately predict what services a patient may ultimately need, but Galen will try to work with the patients to help them anticipate charges and manage their healthcare expenses.

Patients without insurance who pay in full at the time of service may be eligible for a discount.

For patients without insurance or the resources to pay for care, Galen supports the Volunteers In Medicine Clinic, a free primary care clinic located at 5705 Marlin Road in Chattanooga. Residents of Hamilton County who qualify can receive free care from Galen Medical Group physicians and other physicians who volunteer at the clinic.

Billing Insurance

Galen Medical Group 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. If payment is not received within 30 days, 10% interest will be applied to the outstanding balance until the account is paid in full.

No-show and Late cancellation Fee

Patients who cancel appointments with less than 24 hours notice or do not come to scheduled appointments may be subject to a $25.00 fee, not for any service, but for the lost opportunity to see another patient. Patients who cancel appointments with less than 72 hour's notice may be subject to a $200 fee for procedures.

Payments

Galen Medical Group accepts cash, check, Visa, MasterCard or Discover. There is a $30.00 fee for all returned checks.

Payment can be sent to:	**To bring payment in person:**	**To Pay Online:**
Galen Medical Group	Galen Medical Group	www.galenmedical.com
P.O. Box 1030	4976 Alpha Lane	
Chattanooga, TN 37401	Hixson, TN 37343	

To make a payment by phone and/or if you have any questions regarding your statements or our financial policies, please contact our Patient Business Services Representative at **(423) 894-3725**.

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 interest on the balance at 10%, plus all costs associated with such collection activity, including reasonable collection agency fees, attorney fees, and court costs.

_____ _____

Patient Signature Date

_____

Printed Patient Name

4976 Alpha Lane, Hixson, TN 37343
Privacy Officer: Savannah Knuettel **E-mail:** privacy@galenmedical.com
Privacy Office: (423) 308-0280 option 8 **Medical Records:** (423) 899-4413
www.galenmedical.com

Notice of Privacy Practices

Revised effective February 11, 2021

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We keep the health and financial information of our current and former members private as required by law, accreditation standards, and our rules. This notice explains your rights. It also explains our legal duties and privacy practices.

We are required by federal law to give you this notice.

We reserve the right to revise or amend our notice of privacy practices without additional notice to you. Any revision or amendment to this notice will be effective for all of your records our practice has created or maintained in the past, and for any of your records we may create or maintain in the future. Galen Medical Group, P.C. will post a copy of this Notice as amended in a prominent place in our offices and on our web site.

This notice becomes effective September 1, 2013 and amends our previous form of notice. We do not deem any current amendment to constitute a material change notice. No amendment relates to any substantive right of a Galen patient or any duty of Galen. If you have any questions about the Notice of Privacy Practices, please contact our Privacy Officer at 423-308-0280 ext. option 8 or by e-mail at privacy@galenmedical.com.

Treatment. Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing a medical condition, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of Galen Medical Group. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Health Oversight Activities. We may disclose medical information to a health oversight agency, such as the Department of Health and Human Services, for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Family Members. We may release medical information, including mental health information, about you to a family member who is involved in your medical care without consent or authorization if the individual's involvement is related to such information. We may also give medical information, including prescription information or information concerning your appointments to friends who are involved in your care. We may also give such information to someone who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Business Associates. We have contracted with other entities to provide services to Galen Medical Group. When these “associates” require your personal health information in order to accomplish tasks asked of them by Galen Medical Group it will be provided to them. Examples of business associates are: billing service, collection agency, answering service, insurance service, transcription service, and computer software/hardware provider.

Research/Teaching/Training. Your personal health information may be used for the purpose of research, teaching and/or training.

Appointment Reminders. Your health information will be used by our staff to send appointment reminders to you.

Workers Compensation. We may release medical information about you for workers’ compensation or similar programs without consent or authorization. These programs provide benefits for work-related injuries or illnesses. For example, if you are injured on the job, we may release information regarding that specific injury.

Marketing. Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may

interest you. In addition, your name and address may be used to send you a newsletter about our practice and the services we offer. You may contact our Privacy Officer to request that these materials not be sent to you.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Special circumstances requiring your authorization. Most uses and disclosures of psychotherapy notes, health information for marketing purposes, and as part of a sale of protected health information require your authorization. Galen does not maintain psychotherapy notes, nor sell your health information. Your receipt of this notice authorizes Galen to use your health information for marketing purposes. Galen does not receive financial remuneration in exchange for communicating information to you for marketing purposes.

Individual Rights

You have certain rights under the federal privacy standards.

These include:

- The right to request restrictions on the use and disclosure of your protected health information. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
    - If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer and will accommodate this request unless a law requires us to share that information.
- The right to receive confidential communications concerning your medical condition and treatment by alternative means or at alternative locations if you request, your request is reasonable, and you acknowledge that such alternative means or locations could risk the disclosure of all or part of your protected health information
- The right to inspect and copy your protected health information in paper or electronic format. You may obtain a form to request access to your records by contacting the medical records department at (423) 899-4413. We will provide a copy within 10 days of your request. We may charge a reasonable, cost-based fee.
- The right to amend or submit corrections to your protected health information. We may say "no" to this request, but we'll tell you in writing within 60 days.
- The right to receive an accounting of how and to whom your protected health information has been disclosed. We will include all disclosures expect for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make).
    - The right to choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for your before we take any action.
- The right to receive a printed copy of this notice, even if you have an electronic copy
    - The right to file a complaint if you feel your rights are violated. You can complain if you feel we have violated you rights by contacting the Privacy Office using the information on page 1.
        - You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

Galen Medical Group's Duties We are required by law to maintain the privacy of your protected health information, to provide you with this notice of our legal duties and privacy practices regarding protected health information, to notify you of a breach of any unsecured protected health information as defined by applicable regulations, and to abide by the terms of this notice then currently in effect.

Right to Revise Privacy Practices As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit and on our website, unless the revisions are not significant. The revised policies and practices will be applied to all protected health information that we maintain.

Nondiscrimination Galen Medical Group complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Galen Medical Group will make available language assistance services free of charge.

My signature below constitutes my acknowledgement that I have been provided with a copy of the Notice of Health Information Practices. I understand Galen Medical Group, P.C. has the right to change this Notice at any time, subject to Galen's obligation to inform me of material changes.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Print Name of Person Signing Relationship to Patient,*if signed by legal representative*

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MEDICAL GROUP

MOUNTAIN VIEW MEDICINE – SUE GOUGE, D.O.
ADOLESCENT HEALTH HISTORY
(Ages 12-17)

Today's Date: _____
Patient Name: _____ DOB: _____ Age: _____

Previous Doctor: □ None □ Yes (Name of Doctor: _____)

ALLERGIES

Medication, Environmental, and/or Food	Reaction

MEDICATIONS (include vitamins, herbs, supplements, birth control pills, etc)

Name of Medication	Dose (mg, mcg, units)	Times Taken Per Day, Week, Month, or Year

PAST MEDICAL HISTORY

Major Medical Problems: □ None □ Yes (List): _____
Hospitalizations/Operations: □ None □ Yes (List): _____
Broken Bones/Severe Injuries: □ None □ Yes (List): _____

REVIEW OF SYSTEMS (Please check any current problems your child has on the list below)

GENERAL	LUNGS/RESPIRATORY	ALLERGY
□ Fever/Chills/Excessive Sweating	□ Cough/Wheeze	□ Hay Fever/Itchy
□ Unexplained weight loss/gain	□ Chest Pain	**NEUROLOGICAL**
EYES	**GASTROINTESTINAL**	□ Headaches
□ Squinting/Cross Eyes	□ Nausea/Vomiting/Diarrhea	□ Weakness
EAR/NOSE/THROAT	□ Constipation	□ Clumsiness
□ Unusually Loud Voice/Hard of Hearing	□ Blood in Bowel Movement	□ Speech Problems

REVIEW OF SYSTEMS CONTINUED

□ Mouth Breathing/Snoring	**GENITOURINARY**	**PSYCHIATRIC/EMOTIONAL**
□ Bad Breath	□ Bedwetting	□ Anxiety/Stress
□ Frequent Runny Nose	□ Pain with Urination	□ Problems with Sleep/Nightmares
□ Problems with Teeth/Gums	□ Discharge: Penis or Vagina	□ Depression
HEART/VASCULAR	**MUSCULOSKELETAL**	□ Nail Biting/Thumb Sucking
□ Tires Easily with Exercise	□ Muscle/Joint Pain	□ Bad Temper/Breath Holding/Jealousy
□ Shortness of Breath	**SKIN**	**BLOOD/LYMPH**
□ Fainting	□ Rashes	□ Unexplained Lumps
□ Chest Pain with Exercise	□ Unusual Moles	□ Easy Bruising/Bleeding

SOCIAL/SCHOOL HISTORY Current Grade: _____ Name of School _____
Concerns about School Performance? □ No □ Yes (Explain) _____
Concerns about Relationships with Teachers? □ No □ Yes (Explain) _____
Concerns about Relationship with Students? □ No □ Yes (Explain) _____
School Grades: _____ Best Friend? □ No □ Yes Many Friends? □ No □ Yes
Dating? □ No □ Yes Sexually Active? □ No □ Yes
Using Birth Control? □ No □ Yes Would like More Information? □ No □ Yes
Involved in Activities/Sports/Exercise? □ No □ Yes (List): _____

FAMILY HISTORY (Please indicate family members – mother, father, sister, brother, aunt, uncle, grandparent)

High Blood Pressure _____ Heart Attack _____ Stroke _____
High Cholesterol _____ Cancer _____ Diabetes _____
Depression/Suicide _____ Alcoholism _____

In the past year, have there been any changes in your family? (Check all that apply)
□ Marriage □ Separation □ Divorce □ Moved to a New Neighborhood
□ Serious Illness □ Loss of Job □ Death □ Birth
□ Change to New School □ Other Changes/Stress _____

Who Lives at Home with You?

Name	Age	Relationship

Patient Name: _____ ***Date of Birth:*** _____

IMMUNIZATION/INFECTIOUS DISEASE (If you didn't bring your child's immunization record with you today, please provide us with it at your earliest convenience)

Last Flu Shot? _____ Has your child had Chicken Pox? □ No □ Yes
Covid-19 Vaccine? (for anyone over age 16) □ No □ Yes □ Pfizer □ Moderna □ Johnson & Johnson
1st Dose _____ 2nd Dose _____

PREVENTION/SAFETY
What is your Dentist's Name _____ Date of Last Dental Exam: _____
Do you or anyone in your home:
Use Tobacco Products? □ No □ Me □ Household Member Type: _____ Amount: _____
Drink Alcohol? □ No □ Me □ Household Member Type: _____ Amount: _____
Use Illegal Drugs? □ No □ Me □ Household Member Type: _____ Amount: _____
Does your home have smoke detectors? □ No □ Yes
Do you have a gun in your house? □ No □ Yes If yes, is it unloaded and out of reach/locked up? □ No □ Yes
Do you regularly use:
Helmets for bikes/boards/ATVs/motorcycles? □ No □ Yes
Seat belts when riding or driving a car? □ No □ Yes

OTHER CONCERNS (Please review this list and check any concerns you have about the patient)

□ Physical Development	□ Emotional Development	□ Sleep Patterns
□ Weight	□ Diet/Nutrition	□ Amount of Physical Activity
□ Relationship with Parents & Family	□ Choice of Friends	□ Self Image/Self Worth
□ Excessive Moodiness or Rebellion	□ Depression	□ Lying, Stealing, Vandalism
□ Violence/Gangs/Guns/Weapons	□ School Grades/Absences	□ Drug Use
□ Smoking/Chewing Tobacco	□ Alcohol Use	□ Sexual Behavior
□ Sexual Orientation (heterosexual, gay)	□ Pregnancy Risk	□ Sexually Transmitted Diseases (STDs)

What is the greatest challenge(s) for you/your child? _____
_____
What about you/your adolescent makes you proud? _____
_____
Is there anything you would like to discuss in private today? _____
_____

Thank you for your cooperation in providing this information to help us care for you and your family!