Southern Medical Group

6600 Nightingale Lane
Knoxville, TN 37909
Phone (865) 632-5885
Fax (865) 632-5893

Dear patient: _____ **Date:** _____

Welcome to Southern Medical Group. Enclosed in this envelope you will find the required "New Patient forms" used by SMG. The forms are being sent out before your scheduled appointment date to help your initial visit be less time consuming. THESE FORMS NEED TO BE COMPLETED AND SENT BACK TO THE OFFICE BEFORE YOUR SCHEDULED APPOINTMENT TIME IF NOT YOUR APPOINTMENT COULD BE CANCELLED.

1. **The New patient packet includes:**

   a. **Your appointment Card**
   b. **Patient Information form**
   c. **The Electronic Prescription form**
   d. **Authorization for Use or Disclosure of Health Information (Medical Release)**
   e. **Patient Health History form(s) (if required by your Physician)**
   f. **Medical Appointment Cancellation policy**
   g. **Authorization for Release of Information & a Notice of privacy pamphlet**
   h. **Information Regarding Advance Directives**
   i. **Self address envelope to return the packet**

Note: The "Authorization for Use or Disclosure of Health Information form" you will find in the packet needs to be completed, with your previous physicians name and phone number on the line stating "records sent from". Please make sure you sign and date the form on the required line so we can obtain your medical records before the scheduled appointment time.

If you have any questions regarding this information packet, please call the office at 865-632-5885, our office hours are Monday thru Friday between the hours of 8:00 am and 5:00 pm.

PLEASE BRING ALL INSURANCE CARDS AND DRIVERS LICENSE WITH YOU TO EACH OFFICE VISIT.

J. Stephen Alley, M.D. Michael P. Bernard, M.D. Saeed Etezadi, M.D. Sunil John, M.D.
Douglas J. Marlow, M.D. Jeffrey A. Swilley, M.D. Robert G. Thompson, M.D. Jo Ann Bridges, PA-C

Rev. 1/13

SOUTHERN MEDICAL GROUP

6600 NIGHTINGALE LANE
KNOXVILLE, TN 37909
Office: (865) 632-5885
Fax: (865) 632-5893

7564 MOUNTAIN GROVE DRIVE
KNOXVILLE, TN 37920
Office: (865) 632-5885
Fax: (865) 632-5893

Date: _____

PATIENT INFORMATION

Name (Last, First, Middle):			SSN#	Birthdate	Age	Sex
Mailing Address			City, State, Zip			
Home Phone	Cell Phone		Email Address			
Marital Status	Student Status ☐Full-Time ☐Part-Time	Smoker? Yes or No	Veteran (Y/N)?	Ethnicity: Hispanic or Non-Hispanic	Primary Care Physician	
Referring Physician	Referring Physician Contact #	Other Medical Providers				
Race (**Circle Answer**): African American, Alaskan Native, Asian, French, German, Greek, Hawaiian, Hispanic, Indian, Multi-Racial, Native American Indian, Pacific Islander, White				Language		
Emergency Contact Name	Emergency Contact Phone #s Hm:		Cell:			
Employer Name and Address			Work Phone #			

If patient is a minor, please fill out this portion

Parent or Guardian's Name:	Parent or Guardian's Phone #s Hm:	Wk:	Cell:

RESPONSIBLE PARTY INFORMATION (if different from above)

Name (Last, First Middle	SSN#	Birthdate	Sex
Address	City, State, Zip		
Home Phone / Cell Phone / Work Phone	Relationship to patient		

PRIMARY INSURANCE

Name of Insurance Company	Name of Insured	Address of Insured (if different than address above)	
Insured's Birthdate	Insured's SSN #	Insured's Insurance ID #	Relationship to patient

SECONDARY INSURANCE (if applicable)

Name of Insurance Company	Name of Insured	Address of Insured (if different than address above)	
Insured's Birthdate	Insured's SSN#	Insured's Insurance ID #	Relationship to patient

Workers Compensation

Are you here for workers compensation YES____ NO____ Date:

Accident

Auto ☐ Work ☐ Other ☐ Date of Accident:

Do you have any Advanced Directives? (e.g., Living will or Advanced Care Plan) Yes_____ No_____

Do you have a Power of Attorney? Yes_____ No_____

If yes to the above questions please make sure we have a copy for your medical record.

IN CONSIDERATION OF THIS PHYSICIAN PRACTICE (THE "PRACTICE") FURNISHING SERVICES TO THE PATIENT, PATIENT (OR PATIENT'S LEGALLY AUTHORIZED REPRESENTATIVE, ON PATIENT'S BEHALF) AGREES AS FOLLOWS:

I. CONSENT TO MEDICAL TREATMENT AND SERVICES: The below-signed individual hereby authorizes the Practice and its associated professionals to furnish medical treatment and services to the patient and consents to diagnostic and therapeutic medical care, items, services, and procedures furnished by the Practice, its professionals, and their assistants and designees. Such consent includes consent to photographic/video documentation of the patient's medical treatment as the patient's treating professional finds medically necessary. There are potential risks and hazards to any medical treatment or service, and there is no guarantee any particular treatment or service furnished by the Practice or its professionals will be successful. It is the Practice physician's responsibility to provide adequate information concerning a proposed treatment or service and to obtain any additional necessary consent before proceeding except as limited by emergency or other time-sensitive circumstances. The Practice's staff may obtain signature for such consent. The patient has the right to question and refuse treatment; however, if a proposed treatment is refused, the undersigned agrees CMM, the Practice, and their associated professionals and staff shall be released from any and all liability for failure to provide treatment to the patient.

II. CONSENT TO COMMUNICABLE DISEASE TESTING: The below-signed individual consents for the patient to be tested for hepatitis, human immunodeficiency virus infection, or any other blood-borne infectious disease, as well as for any other communicable disease or condition, if and when another patient, a health care practitioner, or other individual furnishing services to patient at the Practice, a Practice employee, or an emergency aid worker has a potential exposure from the patient. If such testing becomes necessary, it will be performed at no charge to the patient.

III. CALCULATION AND PAYMENT OF CHARGES: The patient is liable and individually obligated for payment of the Practice's charges on the patient's account and the undersigned individual understands and agrees to the following: (1) The Practice's charges are set out in a fee schedule, the relevant portions of which may be examined for purposes of verifying the patient's account during regular business hours in our billing office. The Practice reserves the right to change the rates in the fee schedule. Charges on the patient's account are calculated based on fee schedule rates in effect as of the date charges for items or services are accrued. (2) The patient is liable for the uninsured portion of the Practice bill, which is due in full when billed. Any amount not paid in full by insurance, for any reason, is the responsibility of the patient. (3) The Practice has both an uninsured patient discount policy and an indigent care policy. If the patient is uninsured, the patient is automatically entitled to a discount on fee schedule rates in accordance with the Practice's uninsured patient discount policy. In addition, if the patient is uninsured and meets certain criteria set forth in the Practice's indigent care policy (including, without limitation, income criteria), the patient may be entitled to further discounts to fee schedule rates. Please contact the Practice's financial counselors in our office or the CMM billing office at 865-374-5200 for more information. (4) The amount of the patient's Practice charges may differ from amounts other patients are obligated to pay based upon each patient's insurance coverage, Medicare/Medicaid coverage, or lack of insurance coverage. The amount of any discount from charges varies based on the circumstances applicable to each individual under the Practice's policies. (5) After reasonable notice, delinquent accounts may be turned over to a collection agency and/or attorney for collection. The patient agrees to pay the costs of collection, including court costs, reasonable attorney fees, collections charges, and reasonable interest charges, associated with Practice's efforts to collect amounts due.

IV. MEDICARE/MEDICAID PATIENT CERTIFICATION AND ASSIGNMENT OF BENEFITS: The undersigned individual certifies that the information provided in applying for payment or reimbursement under Titles XVIII and XIX of the Social Security Act is true and correct. Further, the undersigned certifies that correct and complete information has been provided regarding the patient's insurance, HMO, health plan, workers' compensation, or other coverage for services and items furnished to the patient by the Practice, and the undersigned consents to the Practice's billing such payers for items and services furnished by the Practice to patient. The undersigned hereby irrevocably assigns to CMM (or, if Practice professionals are not CMM employees, to Practice) all rights, title, and interest in compensation or payments otherwise payable to the patient, or received by or on behalf of the patient, for Practice items or services from any source or payer on file for the patient's account, including Medicare/Medicaid/TennCare, insurance companies, HMOs, and any other third-party payer or financially responsible person, not to exceed charges for services or items rendered. Any person, corporation, or government entity having notice of this assignment is authorized and directed to pay directly to CMM (or, if Practice professionals are not CMM employees, to Practice) all amounts due for health care items and services provided to the patient by the Practice. Except as provided in Section III or by law, the patient is financially responsible to the Practice for the charges not covered by these authorizations. The undersigned understands there are certain items and services for which payers, including Medicare and TRICARE/CHAMPUS/CHAMPVA, do not pay. Any sums not paid by a third-party payer are the patient's obligation. **The patient is responsible for all health insurance or health plan deductibles and co-insurance, as well as noncovered or excluded items or services.** If it is later determined the patient has an HMO or other

health plan primary to Medicare and failed to inform the Practice prior to service of such election, the patient shall be responsible for paying the account. In the case of series services furnished to the patient by Practice, this Agreement shall remain in full force and effect for all such series services until specifically revoked in writing. The undersigned agrees to sign such further documents as may be reasonably requested to confirm and substantiate the Practice's or CMM's rights hereunder. The undersigned further agrees that a copy of this assignment may be used in place of the original copy.

V. RECEIPT OF NOTICE OF PRIVACY PRACTICES; CONSENT TO USE AND DISCLOSE HEALTH INFORMATION: The undersigned acknowledges receipt of the Practice's Notice of Privacy Practices, which is incorporated into this Agreement by reference, and consents to use and disclosure of the patient's protected health information and other patient records (a) consistent with such Notice, including without limitation, for purposes of the treatment, payment, and health care operations functions described in such Notice, whether through electronic health information exchange or otherwise; and (b) as authorized or permitted by federal or state law. Consistent with the above, the undersigned agrees to the Practice's disclosure of all or part of the patient's medical record for treatment purposes and to any person, corporation, or agency that is or may be liable for charges incurred at the Practice or for determining the necessity, appropriateness, amount, or other matter related to such services or charges, including, without limitation, insurance companies, HMOs, PPOs, workers compensation carriers, welfare funds, governmental health plans, the Social Security Administration, the Centers for Medicare & Medicaid Services, or any contractors of the same. The undersigned also consents to release by the patient's health plan or other insurance carrier to the Practice and CMM of any eligibility, utilization, or plan data concerning the patient's coverage that may be required.

VI. PATIENT IDENTIFICATION; PERSONAL VALUABLES: The undersigned consents to photographic documentation of the patient for purposes of identification and registration. Further, the undersigned agrees that Practice is not responsible for loss of or damage to any money, jewelry, eyeglasses, clothing, hearing aids, or other personal property.

VII. HEALTH PLAN NOTIFICATION/AUTHORIZATION; APPOINTMENT: If the patient's health plan, insurer, or other coverage requires notification/authorization as a condition of payment for services, the patient must provide such notification and obtain such authorization. The patient hereby assumes full financial responsibility for charges incurred as a result of failure to comply with prior notification/authorization requirements. Notwithstanding the foregoing, the undersigned hereby appoints Practice as patient's agent for purposes of requesting prior authorization for services Practice professionals order at a Covenant Health hospital (e.g., lab services) and agrees Practice may delegate such appointment to such hospital. The undersigned acknowledges there is no guarantee or assurance authorization will be obtained.

VIII. AMENDMENTS: Revisions to this Agreement are not effective or enforceable unless accepted in writing by a CMM corporate officer.

IX. CONTACTING PATIENT. Patient may be contacted at the following number: _____. In addition, ***please check one of the following***:

☐ Practice may contact or leave messages regarding appointments and lab/test results with the following:

Name:_____Relation to patient:_____Phone:_____
Name:_____Relation to patient:_____Phone:_____

☐ Practice may not leave messages regarding appointments and lab/test results with anyone other than patient.

I HAVE READ AND UNDERSTAND THIS REGISTRATION AGREEMENT AND BY SIGNING BELOW, AGREE TO ITS TERMS. IF THE UNDERSIGNED IS NOT THE PATIENT, SUCH INDIVIDUAL HEREBY CERTIFIES THAT HE/SHE IS THE PATIENT'S AUTHORIZED REPRESENTATIVE AND HAS ALL NECESSARY LEGAL AUTHORITY TO ENTER INTO THIS AGREEMENT ON THE PATIENT'S BEHALF.

SIGNATURE: PATIENT (OR PATIENT"S LEGALLY AUTHORIZED REPRESENTATIVE)

Patient Signed: _____ Printed Name: _____

Relationship to patient: _____ Date: _____ Time: _____ am/pm

A copy of this agreement will be provided on request.

Southern Medical Group
Electronic Prescription System Information

The form listed below is necessary pharmacy information needed for our "Electronic Prescription System". The system allows the physician to send your prescription(s) and/or refills to your pharmacy in a timelier manner.

Your Full Name: _____

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone Number: _____

Pharmacy Fax Number: _____

PATIENT QUESTIONNAIRE

Patient Name _____ Date ____/____/____

FAMILY HISTORY
use ✓ to indicate positive history

	Self	Father	Mother	Sisters	Brothers	Aunts	Uncles	Daughters	Sons
Deceased									
Diabetes									
Hypertension									
Heart disease									
Stroke									
Kidney disease									
Obesity									
Genetic disorder									
Alcoholism									
Liver disease									
Depression or manic Depressive disorder									
Colon or rectal cancer									
Breast cancer									
Other cancer									
Other: _____									

SOCIAL HISTORY

Tobacco use:
Ever used tobacco? ❑ Yes ❑ No If yes: Year started using _____
Still using tobacco? ❑ Yes ❑ No If no: Year quit using _____
Type of tobacco used: (check all that apply) ❑ Cigarettes ❑ Cigars ❑ Pipe ❑ Snuff/Chew

Alcohol use: ❑ Never ❑ Daily ❑ Occasional

Illegal Drug use: ❑ Yes ❑ No If yes, describe._____

OTHER PHYSICIANS AND PROVIDERS OF CARE

Name & specialty/provider type	Type of care	Date of last visit

ADVANCE DIRECTIVE

Do you have a healthcare Power of Attorney? ❑ Yes ❑ No
Do you have a living will? ❑ Yes ❑ No
If yes, please bring a copy to your visit.

Please complete all pages and bring with you to your visit

NAME:_____ DATE:_____

Please list any medical illness you have or have had in the past:

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____

Please list any and all operations you have had in the past:

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____

If you are a NEW PATIENT please list your medications below:

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____

If you are a NEW PATIENT please list any drug allergies:

1._____
2._____
3._____
4._____

Please list the following:

Marital Status:_____

Children: _____
_____
_____
_____

Occupation: _____

Please answer the following questions by circling yes or no:

Have you experienced a lack of interest or pleasure in doing things?
yes no

Do you feel down , depressed or hopeless?
yes no

Do you have trouble falling asleep, staying asleep, or sleeping too much?
yes no

Do you feel tired or have a lack of energy?
yes no

Do you have trouble concentrating on things such as reading or watching television?
yes no

Do you feel fidgety or restless?
yes no

Do you have thoughts of suicide or of harming yourself?
yes no

Name_____ **Date:** _____

PLEASE CHECK THE ITEMS BELOW WHICH APPLY TO YOU

Weight change ____
Fatigue ____
Weakness ____
Sweats ____
Chills ____
Hot flashes ____
Insomnia (can't sleep) ____
Irritability ____
Dizziness or spinning ____
Swollen Glands ____
Memory Loss ____
Headaches ____
Passing out spells ____
Seizures ____
Concussion ____

Skin
Rashes ____
Itching ____
New moles ____
Bruises ____

Extremities
Nail Changes ____
Swelling ____
Pain ____
Ulcers ____

Eyes
Do you wear glasses? ____
Date of Last Exam ____
Glaucoma ____
Pain ____
Redness ____
Operations ____

Ears
Change in hearing ____
Discharge ____
Pain ____
Ringing ____

Skeletal
Dexa Scan (Yr) ____

Resipratory
Frequent colds ____
Sinus trouble ____
Postnasal drip ____
Nosebleeds ____
Snoring ____
Cough ____
Color ____
Any blood ____
Sore Throats ____
Sputum production ____
Shortness of breath ____
Wheezing ____
Pneumonia ____
Chest Disease ____

Breasts
Swelling ____
Lumps ____
Pain ____
Discharge ____
Date of Last Mammogram ____
Do you do self exams? ____

Heart
Chest pain ____
Shortness of breath ____
Palpitations ____
Swelling of legs ____
Murmur ____
High cholesterol ____

Genitalia
Impotence ____
Infertility ____
Tumors ____
Congenital abnormalities ____
Last Pap smear ____

Neurology
Strokes ____
Paralysis ____

Gastrointestinal
Difficulty Swallowing ____
Heartburn ____
Ulcers ____
Nausea ____
Vomiting ____
Stomach Pain ____
Gallstones ____
Change in bowels ____
Blood in bowels ____
Vomiting blood ____
Last Colonoscopy (Yr) ____

Urinary
Pain ____
Do you wake up at night to urinate? ____
Kidney stones ____
Increased urination ____
History of sexually transmitted disease ____
Discharge ____
Blood ____
Incontinence ____

Joints
Pain ____
Weakness ____
Gout ____
Tremor ____
Numbness ____
Back pain ____

Immunizations
Year of last Tetanus ____
Year of Pneumovax ____
Year of last Flu shot ____
History of Zostavax ____

Endocrine
Diabetes ____
Thyroid ____
On steroids (ever) ____

SELF-PAY PATIENT AGREEMENT

I, _____, hereby acknowledge that at this time, my family and I are without medical health insurance coverage and, as such, I hereby agree to be personally responsible for the payment of medical services that are provided to me, my spouse and minor children. I further agree to the following:

1. I will provide my physician with the upfront payment as instructed, to be paid when I (or my spouse and minor children) present to the check in window prior to the appointment with the physician.

2. I am aware that the upfront payment may not pay the balance in full for services provided on the date of service; it is only an upfront payment.

3. Because my family and I are without medical health insurance coverage and I am personally responsible for the payment of medical services rendered to me, my spouse and minor children; I acknowledge that I may be eligible to receive a forty percent (40%) reduction in the charges for medical services rendered to me, my spouse and any minor children.

4. Following any reductions in the charges for medical services provided, I agree if I cannot pay them in full on the date services are rendered, I will pay within thirty (30) days of the date services are rendered or make alternative arrangements for the collection of such debt with the office manager or central billing office of the practice.

5. I acknowledge that failure on my part to adhere to the aforementioned may result in the dismissal of members of my family and myself from being patients of my physician.

_____ _____

Signature Date

*Additional discounts may be applied if a Financial Assistance Application is completed and documentation submitted to Covenant Medical Management which indicates qualification under CMM Indigent Care Policy.

Southern Medical Group

6600 Nightingale Lane
Knoxville, TN 37909
Phone 865-632-5885
Fax 865-632-5893

Notice to Patients about our Prescribing Policy

Dear Patient,

Please be advised that our office does not prescribe controlled medications, except under very limited circumstances. This would include very brief periods for severe pain, terminal diseases, etc. Medication would be written for no more that 5 days.

We do not maintain any supplies or samples of narcotics or other controlled substances in our office.

We will, in most cases, prescribe substitute, non-addicting medications which are usually sufficient. If you feel you require stronger medication, the physician will refer you to an appropriate specialist who can prescribe these medications for you.

Thank you for your understanding and cooperation.

I have reviewed the above information and understand the contents.

_____ _____

Patient Signature Date

Authorization to Release Health Information

I, _____, hereby authorize _____ (the "Provider") to disclose health information regarding the following patient:

Patient Name:_____ Date of Birth: _____

Address:_____ Patient's Phone: _____

_____ Social Security No.:_____

Phone: _____ Date of Death: _____

1. The information is to be disclosed to the following persons or organizations:

Southern Medical Group
6600 Nightingale Lane
Knoxville, TN 37909
Phone: 865-632-5885 Fax: 865-632-5893

2. Purpose. The purpose of the use or disclosure is:

☐ At the request of the patient
☐ Other: _____

_____

_____

If the purpose is for marketing, will the Provider receive direct or indirect compensation or payment in return for using or disclosing the patient's health information? ☐ YES ☐ NO

Will the Provider receive direct or indirect compensation or payment in return for using or disclosing the patient's health information? ☐ YES ☐ NO

3. Information to be Disclosed. The information to be disclosed includes only those items checked below, with respect to services provided on or around _____ *(insert dates)*: **I understand that this information may include, but not limited to, information related to psychiatric or psychological treatment, treatment for drug and/or alcohol use, or information relating to Acquired Immune Deficiency/HIV.**

- Entire medical record, other than psychotherapy notes*; OR
- The following of the medical record

▪ Discharge summary	▪ Progress notes
▪ Lab results	▪ Photographs, videotapes, or other images
▪ History and physical exam	▪ Mental or behavioral health records
▪ Consultation reports	▪ Psychotherapy notes *
▪ X-ray reports	▪ Genetic test results
▪ HIV/AIDS test results and treatment	▪ Admission notes
▪ Treatment plan	▪ Summary of treatment
▪ Alcohol and drug treatment records	

* *If the authorization is for psychotherapy notes, it may not request any other part of the medical record.*

- The following billing and payment information: ____
____

- Other information: ____
____

4. Revocation. I understand that I may revoke this authorization at any time by sending a written notice to the Provider. However, the revocation will not have any effect on any uses or disclosures the Provider may have made before the revocation was received.

5. Expiration. I understand that unless I revoke the authorization earlier, this authorization will automatically expire on the later of the following: (A) one year after the date this authorization is signed or (B) on the occurrence of the following event: ______________________________ (e.g., end of research study; final resolution of specified litigation).

6. Redisclosure. I understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be redisclosed by the receiving party.

7. Refusal to Sign. I understand that I may refuse to sign this Authorization and that the Provider will not condition treatment on whether I sign this Authorization.

8. Certification. I certify that I am *(check whichever applies)*:

☐ the patient, and the identification that I have provided is true and correct.

☐ the patient's authorized representative, and that the identification and proof of authority that I have provided are true and correct. My relationship to the patient is that of: ____________________.

Signed this __________day of ____________________, 20_____.

Signature: ______________________

Print name: ______________________

Address: ______________________

____

Phone No: ______________________

(ONE COPY TO BE RETAINED BY THE PATIENT)

- -

For Provider Use Only:

Date received: ________________ Expiration date: ______________

How was identity verified? ______________________________ Copy made? ☐ Yes ☐ No

How was authority verified?: ______________________________ Copy made? ☐ Yes ☐ No

By: __________________Title: __________________Date: ____________

Southern Medical Group, P.L.L.C.
6600 Nightingale Lane
Knoxville, TN 37909
Phone: (865) 632-5885, Fax (865) 632-5893

INFORMATION REGARDING ADVANCE DIRECTIVES

Federal law requires that we give you information about your right to make advance health care decisions. Right now, you may be able to make your own health care decisions. You may not always be able to make such decisions, however. By giving advance directions, you can tell your health care provider and family about the medical care you would like to receive and whether you want another person to be able to accept or refuse treatment for you.

You can name a person to make medical treatment decisions for you by appointing someone to have a "Durable Power of Attorney for Health Care" for you. This person is allowed to make health care decisions for you, including life support decisions, but only after your health care provider certifies that you are no longer able to make you own health care decisions.

You can also leave advance directions about life support by executing a "Living Will". A Living Will tells your health care provider and family about the types of life support that you want to be provided or withheld in case you are ever kept alive by artificial means and no longer able to make decisions for yourself.

If you already have a Living Will or Durable Power of Attorney for Health Care, please tell your health care provider. We need to put a copy of the document in your medical chart in order to be sure that your wishes are honored. If you want more information on how to name a Durable Power of Attorney for Health Care or how to make a Living Will, please free to ask your health provider, hospital, social worker or your attorney.

It is our policy to honor our patients' health care decisions to the full extent required or allowed by law. You are **NOT** required to give advance health care decisions in order to receive care at this facility.

Please answer the following questions:

DO YOU HAVE A LIVING WILL? **Yes** _____ **No**_____
IF YES, HAVE YOU GIVEN US A COPY? **Yes** _____ **No** _____
IF NO, WILL YOU BRING US A COPY? **Yes** _____ **No** _____

DO YOU HAVE A DURABLE POWER OF ATTORNEY? **Yes**_____ **No**_____
IF YES, HAVE YOU GIVEN US A COPY? **Yes** _____ **No** _____
IF NO, WILL YOU BRING US A COPY? **Yes** _____ **No** _____

_____ _____

Patient Signature **Date**

Tennessee Department of Health
Division of Health Licensure and Regulation
Office of Health Care Facilities
665 Mainstream Drive, Second Floor
Nashville, TN 37243
www.tn.gov/health

ADVANCE CARE PLAN
(Tennessee)

I, _____, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

Agent: I want the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Phone #: (___)_____ Relation: _____
Address: _____

Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Phone #: (___)_____ Relation: _____
Address: _____

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

When Effective (mark one):

☐ I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself.
☐ I do not give such permission (this form applies only when I no longer have capacity).

Quality of Life: By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "**no**" below, I have indicated conditions I would not be willing to live with (that to me would create an **unacceptable** quality of life).

☐ Yes ☐ No	**Permanent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
☐ Yes ☐ No	**Permanent Confusion:** I become unable to remember, understand, or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
☐ Yes ☐ No	**Dependent in all Activities of Daily Living:** I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
☐ Yes ☐ No	**End-Stage Illnesses:** I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is needed most of the time and activities are limited due to the feeling of suffocation.

Treatment: If my quality of life becomes unacceptable to me (as indicated by one or more of the conditions marked "no" above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "**no**" below, I have indicated treatment I **do not want.**

☐ Yes ☐ No	**CPR (Cardiopulmonary Resuscitation):** To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
☐ Yes ☐ No	**Life Support / Other Artificial Support:** Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys, and other organs to continue to work.
☐ Yes ☐ No	**Treatment of New Conditions:** Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
☐ Yes ☐ No	**Tube feeding/IV fluids:** Use of tubes to deliver food and water to a patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.

Please sign on page 2

Other instructions, such as burial arrangements, hospice care, etc.: _____

_____

_____

_____

(Attach additional pages if necessary)

Organ donation: Upon my death, I wish to make the following anatomical gift (mark one):

☐ Any organ/tissue ☐ My entire body ☐ Only the following organs/tissues: _____

_____

☐ No organ/tissue donation

SIGNATURE

Your signature must **either** be witnessed by two competent adults **or** notarized. If witnessed, neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must be someone who is not related to you or entitled to any part of your estate.

Signature: _____ DATE: _____
(Patient)

Witnesses:

1. I am a competent adult who is not named as the agent. I witnessed the patient's signature on this form.

_____
Signature of witness number 1

2. I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

_____
Signature of witness number 2

This document may be notarized instead of witnessed:

STATE OF TENNESSEE

County of _____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient." The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

Notary Public: _____
Signature

My commission expires: _____

WHAT TO DO WITH THIS ADVANCE DIRECTIVE

- Provide a copy to your physician(s)
- Keep a copy in your personal files where it is accessible to others
- Tell your closest relatives and friends what is in the document
- Provide a copy to the person(s) you named as your health care agent

APPOINTMENT OF HEALTH CARE AGENT

(Tennessee)

I, _____, give my agent named below permission to make health care decisions for me if I cannot make decisions for myself, including any health care decision that I could have made for myself if able. If my agent is unavailable or is unable or unwilling to serve, the alternate named below will take the agent's place.

Agent:	Alternate:
_____ Name	_____ Name
_____ Address	_____ Address
_____ City State Zip Code	_____ City State Zip Code
(____) _____ Area Code Home Phone Number	(____) _____ Area Code Home Phone Number
(____) _____ Area Code Work Phone Number	(____) _____ Area Code Work Phone Number
(____) _____ Area Code Mobile Phone Number	(____) _____ Area Code Mobile Phone Number
_____ Patient's name (please print or type) Date	_____ Signature of patient (must be at least 18 or emancipated minor)

To be legally valid, **either** block A **or** block B must be properly completed and signed.

Block A Witnesses (2 witnesses required)

1. I am a competent adult who is not named above. I witnessed the patient's signature on this form.

_____ Signature of witness number 1

2. I am a competent adult who is not named above. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

_____ Signature of witness number 2

Block B Notarization

STATE OF TENNESSEE
COUNTY OF _____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is shown above as the "patient." The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: _____

_____ Signature of Notary Public

Approved by Tennessee Department of Health, Board for Licensing Health Care Facilities, February 3, 2005

Physician Orders for Scope Treatment (POST)
Directions for Health Care Professionals

Completing POST

Must be completed by a health care professional based on patient preferences, patient best interest, and medical indications.

POST must be signed by a physician to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.

Photocopies/faxes of signed POST forms are legal and valid.

Using POST

Any incomplete section of POST implies full treatment for that section.

No defibrillator (including AEDs) should be used on a person who has chosen "Do Not Attempt Resuscitation".

Oral fluids and nutrition must always be offered if medically feasible.

When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only", should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).

IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only".

Treatment of dehydration is a measure which prolongs life. A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment".

A person with capacity, or the surrogate of a person without capacity, can request alternative treatment.

Reviewing POST

This POST should be reviewed if:

(1) The patient is transferred from one care setting or care level to another, or
(2) There is a substantial change in the patient's health status, or
(3) The patient's treatment preferences change.

Draw line through sections A through E and write "VOID" in large letters if POST is replaced or becomes invalid.

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED.

A COPY OF THIS FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

Physician Orders for Scope of Treatment (POST)

This is a Physician Order Sheet based on the medical conditions and wishes of the person identified at right ("patient"). Any section not completed indicates full treatment for that section. When need occurs, first follow these orders, then contact physician.

Patient's Last Name

First Name/Middle Initial

Date of Birth

Section A *Check One Box Only*

CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and/or is not breathing.

☐ **Resuscitate (CPR)** ☐ **Do Not Attempt Resuscitation (DNR / no CPR) (Allow Natural Death)**

When not in cardiopulmonary arrest, follow orders in B, C, and D.

Section B *Check One Box Only*

MEDICAL INTERVENTIONS. Patient has pulse and/or is breathing.

☐ **Comfort Measures.** Treat with dignity and respect. Keep clean, warm, and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. **Do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location.**

☐ **Limited Additional Interventions.** Includes care described above. Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. **Transfer to hospital if indicated. Avoid intensive care.**

☐ **Full Treatment.** Includes care above. Use intubation, advanced airway interventions mechanical ventilation, and cardioversion as indicated. **Transfer to hospital if indicated. Include intensive care.**

Other Instructions: _____

Section C *Check One Box Only*

ANTIBIOTICS – Treatment for new medical conditions:

☐ **No Antibiotics**

☐ **Antibiotics** *Other Instructions:* _____

Section D *Check One Box Only in Each Column*

MEDICALLY ADMINISTERED FLUIDS & NUTRITION. Oral fluids & nutrition must be offered if medically feasible.

☐ **No IV fluids** (provide other measures to assure comfort)
☐ **IV fluids for a defined trial period**
☐ **IV fluids long-term if indicated**

☐ **No feeding tube**
☐ **Feeding tube for a defined trial period**
☐ **Feeding tube long-term**

Other Instructions: _____

Section E *Must be Completed*

Discussed with:
☐ Patient/Resident
☐ Health care agent
☐ Court-appointed guardian
☐ Health care surrogate
☐ Parent of minor
☐ Other: _____ (Specify)

The Basis for These Orders Is: (Must be completed)
☐ Patient's preferences
☐ Patient's best interest (patient lacks capacity or preferences unknown)
☐ Medical indications
☐ (Other) _____

Physician's Name (Print)	**Physician's Signature** (Mandatory)	Date	**Physician's Phone Number** ( )

Signature of Patient, Parent of Minor, or Guardian/Health Care Representative

Preferences have been expressed to a physician /or health care professional. It can be reviewed and updated at any time if your preferences change. If you are unable to make your own health care decisions, the orders should reflect your preferences as best understood by your surrogate.

Name (Print)	Signature	Relationship (write "self" if patient)	
Surrogate	Relationship	Phone Number ( )	
Health Care Professional Preparing Form	Preparer Title	Phone Number ( )	Date Prepared

HIPAA PERMITS DISCLOSURE OF POST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY