



PATIENT DEMOGRAPHICS

NAME: _____ Marital Status: _____

SEX: _____ DATE OF BIRTH: _____ SSN#: _____

EMAIL: _____ (Email needed to access online portal)

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ EMPLOYER: _____

HOME PHONE: _____ CELL PHONE: _____

EMERGENCY CONTACT: _____ PHONE: _____

Can we leave a voicemail/send appointment reminder: Yes No

Responsible Party Information: *If different from patient information*

NAME: _____ DATE OF BIRTH: _____

RELATIONSHIP TO PATIENT: _____ PHONE: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ EMPLOYER: _____

Medication and Medical Release Form

I hereby authorize Heelex LLC/JSPHyMgmt to obtain medications electronically and to disclose any necessary medical records from my visits to my primary care and/or referring physician that I have listed below.

PRIMARY CARE PHYSICIAN: _____

REFERRING PHYSICIAN: _____

ELECTRONIC MEDICATION IMPORT FROM YOUR PHARMACY: YES NO

Insurance Authorization and Assignment:

I hereby authorize Heelex LLC/JSPHyMgmt to furnish any information needed by any insurance carrier to process any claim(s) for services rendered to the above-named patient. I assign benefits payable by the insurance carriers for those services to Heelex LLC/JSPHyMgmt. I agree to be responsible for any amount and/or supplies not covered by insurance or for full amount if the above names patient does not have insurance.

Patient Signature: _____ Date: _____



MEDICAL HISTORY

Date: ____/____/____	
NAME: _____ Birthdate: ____/____/____	
Last First M. I.	
Age: _____ Sex: ☐ F ☐ M	
How did you hear about this clinic? WATE WBIR Fox43	
Friend/Family Social Media Website Doctor Referral: _____	
Briefly describe your symptoms:	
Names of other practitioners you have seen for this problem, other treatments for problem, if any:	
Previous surgeries and dates:	Medications: Can give copy of list to staff
	Are you currently taking Methotrexate? Yes No
Serious medical problems in family members:	Allergies:
	Have you ever had radiation therapy? Yes No

PAST MEDICAL HISTORY

Do you now or have you ever had:

- | | | |
|--|--|--|
| ☐ Diabetes | ☐ Heart murmur | ☐ Crohn's disease |
| ☐ High blood pressure | ☐ Pneumonia | ☐ Colitis |
| ☐ High cholesterol | ☐ Pulmonary embolism | ☐ Anemia |
| ☐ Hypothyroidism | ☐ Asthma | ☐ Jaundice |
| ☐ Goiter | ☐ Emphysema | ☐ Hepatitis |
| ☐ Cancer (type) _____ | ☐ Stroke | ☐ Stomach or peptic ulcer |
| ☐ Leukemia | ☐ Epilepsy (seizures) | ☐ Rheumatic fever |
| ☐ Psoriasis | ☐ Cataracts | ☐ Tuberculosis |
| ☐ Angina | ☐ Kidney disease | ☐ HIV/AIDS |
| ☐ Heart problems | ☐ Kidney stones | ☐ Scleroderma |
| | ☐ Lupus | |

Do you have any Autoimmune disorders?

Patient Signature: _____ Date: _____



Heelex, LLC
6450 Kingston Pike, Suite 2 Knoxville, TN 37919
ph: 865.999.5988 fax: 865.540.6104

No Show & Cancellation Policy

It is necessary for us to make appointments in order to see our patients as efficiently as possible. No-shows take available time slots away from other patients. To help reduce missed appointments, Heelex offers reminders via text, phone call, and/or email to help remind you of your upcoming appointment(s). We understand that situations may arise that keep you from being able to make your appointment. If you are unable to make your appointment, we ask that you call our office within 24 hours of your appointment. If you do not reach a member of staff, please leave a voicemail to ensure you are not charged the no show fee. If you do not call and no show your appointment(s), you will be subject to a \$25.00 fee.

Benefit Estimation

Professional services rendered to you (or a minor for whom you are responsible) by Heelex/JSPHyMgmt LLC are your sole financial responsibility. You further understand that Heelex/JSPHyMgmt LLC will bill your insurance as a courtesy, but you are ultimately responsible for payment. You are financially responsible for any and all allowable balances not paid by your insurance (i.e. deductible, copay, coinsurance, and denied charges). You are expected to pay your estimated personal portion the day of your visit. The estimate reflected on your benefit page can vary depending on your treatment and insurance. Please, speak with your insurance carrier if you have any questions regarding the amount for treatment. Any unpaid balance will be reflected in your monthly billing statement. You can remit payment by mail, portal, or by calling the office to make payment over the phone. Any unpaid charges on an account for 90 days are subject to collection action. If a payment plan is needed, this is your responsibility to set up with our office before the 90 days or within 10 days of receiving the mailed past due letter.

I have read the above information and understand the no show/cancellation policy and benefit estimation.

Patient Signature: _____

Date: _____



P: 865-999-5988 F:865-540-6104

6450 Kingston Pike Ste Knoxville, TN 37919

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

I hereby authorize the use or disclosure of my health information as described below. I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the federal privacy regulations.

Patient Name: _____

DOB: _____ Patient SSN: _____

Requesting Medical Records from: _____

Phone Number: _____ Fax Number: _____

Send Medical Records to: Heelex 6450 Kingston Pike Knoxville, TN 37919 **(F)865-540-6104**

Purpose of the use or disclosure: please circle one

Physician/Staff Request At the request of the individual Changing Physician

☐ All Medical Records at this facility ☐ Specific Date Range: _____

☐ Most recent visit ☐ Other: _____

I understand that I have the right to refuse to sign this form and that my refusal will not result in the physician conditioning the provision of healthcare with the following exceptions:

1. I have the right to withdraw this authorization.
2. I understand that I do not have to sign this authorization to receive treatment.
3. I understand that once my health care information is disclosed as I have authorized, it could be disclosed again by the recipient and is no longer protected by Heelex LLC.
4. I understand that signing this authorization does not cancel any rights I have under other state & federal laws.

Signed By: _____

Signature of Patient or Legal Guardian

Relationship to Patient

Print Name of Patient or Legal Guardian

Date