



Practice of Chet Gentry, MD; Alison Hicks, FNP-C
Chris Klamm, FNP-C; Tiffany Ward, FNP-BC; William Wilson, FNP
3300 Williams Enterprise Drive, Cookeville, TN 38506
o: (931) 528-9222 f: (931) 854-0907

We are happy to welcome you as a new patient to our practice!

As a member of our practice, you and your family will be cared for by a team of dedicated health professionals. We function as a Patient Centered Medical Home. Our goal is to help you be as healthy and fit as possible: mentally, physically, and spiritually. We want to teach you to manage your own health as cost effectively as possible. We will help you keep your full medical history and medical care plan here. No matter what your medical conditions, we will help you develop a medical care plan tailored to your needs. We will assist you in making sure that your medical needs are addressed wherever you are: Home, ER, Hospital, Home Health, Nursing home, or Hospice. We strive to manage your care no matter where you go in the health system.

Office Hours

Monday – Friday 8:00 a.m. – 5:00 p.m. The schedule of individual providers varies.

Same Day Appointments/Work-Ins (for existing patients)

Though you may choose a preferred provider in our practice, there may be times when you will need to be seen by one of the other members of our team. All appointments are to be scheduled in advance to properly accommodate each patient’s needs. However, we understand that health concerns may arise suddenly. Same day appointments or work-ins will be scheduled with an available qualified provider upon approval. Each physician assistant and nurse provider in our practice consults with Dr. Gentry when the need arises.

Nurse Calls

If you have a question about your care, feel free to call and leave a message for one of the nurses. Someone will return your call within 48 hours during the business week. You may also be able to contact the provider team through the patient portal. Please do not leave a message if the issue is urgent or life-threatening.

Medication Refills

Unless you have an appointment scheduled to discuss refills, please call the office for prescription refills at least 72 hours prior to your medication running out. In some instances, you will be required to first make an appointment with a provider.

Lab Studies

All lab studies must be ordered by one of our providers. If you are concerned that you have a condition that requires a lab study (strep test, urinary screening, etc.), you must first make an appointment with the provider.

Same Day Cancellations/No shows

We are committed to providing all of our patients with exceptional care. When a patient does not show up or cancels without giving adequate notice, they prevent another patient from being seen. Please call our office by 3:00 pm on the day prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call us by 3:00 pm on Friday. A patient is considered a no show if they do not come in or if they arrive more than **20 minutes** past their appointment time. **Patients will be billed a \$25 same-day cancellation/no-show fee, which is not billable to insurance.** Patients who arrive late will be seen only at the discretion of the provider. In the case of heavy snow/storms, the fee is waived. Excessive (**3 or more**) no-shows may result in patient discharge from the practice.

Feedback

Please let us know how we are doing by emailing us at info@innovativefamilycare.com or by speaking to a member of our team. We are constantly striving to improve!

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Patient Information:

Name: _____ DOB: __/__/____ Age: _____ Sex: Male Female
 Address: _____ City: _____ State: _____ Zip: _____
 Marital Status: Single Married Divorced Widowed
 Social Security Number: _____ - _____ - _____

Optional:

Race (Check one)
 American Indian/Alaskan Native
 Asian Native Hawaiian or other Pacific Islander
 Black/African American White
Ethnicity (Check one) Of Hispanic Descent Not of Hispanic Descent

Responsible Party or Bill to Information: Check if the same as above

Relationship: _____
Name: _____ **DOB:** __/__/____ **Age:** _____ **Sex:** Male Female
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Social Security Number: _____ - _____ - _____

Contact Information:

Home Phone: (____) _____
Cell Phone: (____) _____
Work Phone: (____) _____

Permission to leave voicemail/send message?

Yes No
 Yes No
 Yes No

Preferred contact number? Home Cell Work

E-mail: _____

Ok to receive appt reminders via email? Yes No

Employer: _____

Emergency contact: Name _____ **Relationship** _____ **Phone (____)** _____

Authorizations

- I understand that I am financially responsible for services rendered by the physician and his/her staff regardless of insurance, including reasonable attorney's fees and costs of collection in the event of default. I authorize my insurance company to pay benefits directly to the physician.
- I understand that any patient under the age of 18 must be accompanied by an adult with authority to make decisions on his/her behalf.
- I understand all of the above and hereby state that the information is correct to the best of my knowledge.
- I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for Innovative Family Care, PLLC.
- These authorizations apply to all occasions until revoked. I give my consent for disclosure of my protected health information for purposes of treatment, payment, daily operations and other disclosures as specifically listed on the Notice of Privacy Practices given to me by Innovative Family Care, PLLC.

Signature of Patient or Authorized Party: _____ Date: _____
 Relationship to the patient: _____

Record Release Authorizations

Patient Name: _____ **DOB:** __/__/____

HIPAA (Health Insurance Portability and Accountability Act of 1996) protects your right to privacy. We cannot provide any information to family (including spouse) and/or friends about you or your health status (for example, test results, x-rays, prescriptions, surgeries, office notes, etc.) unless you give us written permission. We can only provide information to those people listed on this form.

You have the right to revoke this form at any time by calling our Medical Records department.

To whom we may release your medical information:

Name: _____ **Relation:** _____

Name: _____ **Relation:** _____

Name: _____ **Relation:** _____

Name: _____ **Relation:** _____

Name: _____ **Relation:** _____

Name: _____ **Relation:** _____

Patient or Authorized Signature: _____ **Date:** _____

Innovative Family Care, PLLC

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Authorization for Disclosure of Health Information

The purpose of this form is to allow us to communicate effectively with other providers for your care.

Patient Name: _____ DOB: ___/___/___
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: (____) _____ Cell Phone: (____) _____

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following individual or organization is authorized to make the disclosure:

Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: (____) _____ Fax: (____) _____

3. The type and amount of information to be used or disclosed is as follows:

Complete Health Record Lab/Imaging results
 Physical exam Consultation
 Immunization record
 Other (please specify): _____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavior or mental health services and treatment for alcohol and drug abuse.

5. The information may be disclosed to the following organization:

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6. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the medical records department.

7. I understand that the HIPAA Privacy rule permits a provider to release information to my Health Insurance Carrier and to any other health provider for my treatment without my authorization. (45 CFR 164.506)

Patient or Authorized Signature: _____ Date: _____

Patient Portal

Innovative Family Care allows you to access your health information electronically through secure email by use of our Patient Portal. Please complete the following if you wish to have access.

Patient Name: _____ DOB: __/__/____

Email address: _____

Create a username (All lower case letters, no spaces): _____

LOGGING ON TO THE PORTAL:

To access your information, go to our website: www.innovativefamilycare.com.

Select **PATIENT PORTAL** from the sidebar. Click on the link that will pop up. This will take you to the Login Screen. Enter the username you have created above.

Your initial password will be: **Password2#**

You will be asked to change the password when you enter for the first time. The password you create must be at least 8 characters and contain a capital letter, lowercase letter, a number and a symbol. No spaces are allowed.

If you need to reset your password, click the link that says, "If you are a patient and have lost your password". It will ask you for your username and will ask the question that you create below. The system will then email you another temporary password.

Password reset question (example: city of mother's birth): _____

Password reset answer: _____

You will be able to see your lab and x-ray results, visit summaries, and communicate with the providers. When you send messages, please allow 48 hours (2 business days) for a response. When your response arrives, you will be notified by email to check your messages in the portal. DO NOT use the Portal to communicate information of an urgent nature.

Insurance Information

(please include a copy of your card, front and back)

Name of Primary

Insurance: _____

If this is a Medicare Advantage plan, check here _____

Policy #: _____

Group #: _____

Name of Insured: _____

DOB: _____

Employer: _____

Gender: male female

SS#: _____

Relation to Patient: _____

Name of Secondary Insurance: _____

If this is a Medicare Advantage plan, check here _____

Policy #: _____

Group #: _____

Name of Insured: _____

DOB: _____

Employer: _____

Gender: male female

SS#: _____

Relation to Patient: _____