



# TenderCare Clinic

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REGISTRATION FORM

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

(Please Print)

Account Number: \_\_\_\_\_

PATIENT INFORMATION							
Patient's Last Name			First	Middle	<input type="checkbox"/> Mr.	<input type="checkbox"/> Miss	
					<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No		If not, what is your legal name?			Former Name		
Street Address			City	State	ZIP Code		
Mailing Address if different than Physical Address				City	State	ZIP Code	
Home Phone ( )		Cell Phone ( )		Name of Employer		Work Phone ( )	
Birth Date / /		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated			Social Security - -		
Sexual orientation <input type="checkbox"/> Straight or heterosexual <input type="checkbox"/> Lesbian, gay, or homosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Other _____ <input type="checkbox"/> I don't know <input type="checkbox"/> Choose not to disclose			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Gender Queer <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Transgender Female/ Male-to-Female <input type="checkbox"/> Transgender Male/ Female-to-Male <input type="checkbox"/> Other _____				
			Email Address				
ADDITIONAL PATIENT INFORMATION							
Race <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaska Native				Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino			
Language Best Spoken <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____			Homeless <input type="checkbox"/> Yes <input type="checkbox"/> No		Public Housing Patient <input type="checkbox"/> Yes <input type="checkbox"/> No		
Family Size <input type="checkbox"/> _____ <input type="checkbox"/> Choose not to disclose		Income <input type="checkbox"/> \$ _____ <input type="checkbox"/> Choose not to disclose		Veteran <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Choose not to disclose		Student Status <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Not a student	Agricultural Worker <input type="checkbox"/> Yes <input type="checkbox"/> No
RESPONSIBLE PARTY / PARENT / GUARDIAN							
Responsible Party / Guardian / Parent			Relationship to Patient			Birth Date / /	
Street Address		City	State	ZIP Code	Home Phone ( )		
Employer		Employer Address			Employer Phone ( )		
INSURANCE INFORMATION							
Is this patient covered by Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Primary Insurance Name		Subscriber Name	Subscriber DOB	Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____			
Secondary Insurance Name		Subscriber Name	Subscriber DOB	Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____			
EMERGENCY CONTACT (OTHER THAN PARENT, GUARDIAN, RESPONSIBLE PARTY)							
Name of Local Friend or Relative		Relationship to Patient		Home Phone ( )		Cell Phone ( )	
Name of Local Friend or Relative (not living at the same address)		Relationship to Patient		Home Phone ( )		Cell Phone ( )	

ADDITIONAL INFORMATION			
Do you have a preferred pharmacy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Pharmacy Name	Pharmacy Location	Pharmacy Phone (    )
Other Family Members Seen Here:			
Chose Clinic Because / Referred to Clinic By (Please check one box):			
<input type="checkbox"/> Dr. _____	<input type="checkbox"/> Hospital _____	<input type="checkbox"/> Family _____	<input type="checkbox"/> Friend _____
<input type="checkbox"/> Internet	<input type="checkbox"/> Phone Book	<input type="checkbox"/> Other _____	

\_\_\_\_\_ **Initial**    **ASSIGNMENT OF BENEFITS:** I authorize my insurance company to pay directly to TenderCare Clinic the cost allowable and otherwise payable to me under my insurance policy, applicable to the professional services rendered. I agree to pay all charges not covered by insurance payments or, if I receive payment from insurance filed by your company, I will forward the payment to your office within one week of receipt of funds.

\_\_\_\_\_ **Initial**    **CONSENT FOR TREATMENT:** I authorize TenderCare Clinic, and such assistants as they may designate, to carry out diagnostic procedures, if needed, to better diagnose my condition and to administer such treatments and medications, as indicated. I understand that my condition may call for a consultation with another physician. If this situation occurs, I authorize TenderCare Clinic to release medical information that may be needed to better provide for my medical treatment.

\_\_\_\_\_ **Initial**    **PAYMENT AGREEMENT:** The foregoing information is true to the best of my knowledge, and I request TenderCare Clinic to provide me and/or my family with medical care. I acknowledge my responsibility to pay for services according to the policies established by TenderCare Clinic.

**Patient or Guarantor Signature** \_\_\_\_\_

**Patient Account Representative Signature** \_\_\_\_\_



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**PATIENT AUTHORIZATION  
TO RELEASE MEDICAL INFORMATION TO OTHER INDIVIDUALS**

I authorize you to discuss my medical information at any time with the following designated person(s):

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Information that may be discussed is:

\_\_\_\_\_ Any or all information contained in my medical record

Or

Only: \_\_\_\_\_ Medical exams, diagnosis and treatment plans

\_\_\_\_\_ Prescription records

\_\_\_\_\_ Laboratory results

\_\_\_\_\_ Billing and insurance

\_\_\_\_\_ Other

\_\_\_\_\_ The above information can be **discussed in my presence only.**

\_\_\_\_\_ The above information can be discussed **when I am not present.**

This authorization is valid until such date as I change or cancel the authorization to release of my information.

\_\_\_\_\_ Date: \_\_\_\_\_

Patient Name (Print)

\_\_\_\_\_ Witness: \_\_\_\_\_

Signature

**Georgia Registry of Immunization Transactions and Services (GRITS)**

I authorize TCC to share records related specifically to immunizations with the GRITS data base.

\_\_\_\_\_ Date: \_\_\_\_\_

Patient Name (Print)

\_\_\_\_\_ Witness: \_\_\_\_\_

Signature

This authorization is valid until such date as I change or cancel the authorization to release of my information.



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### AUTHORIZATION FOR MESSAGING THROUGH EMAIL, PHONE, AND CELL PHONE

When contacting me with information regarding test results, prescription information or other medical issues, I authorize you to leave messages as follows:

Voice Mail  Anyone at my contact number  Email  Do not leave messages

When contacting me with information regarding appointments I authorize you to leave messages as follows:

Voice Mail  Anyone at my contact number  Email  Do not leave messages

When contacting me with information regarding billing issues I authorize you to leave messages as follows:

Voice Mail  Anyone at my contact number  Email  Do not leave messages

My Email address is: \_\_\_\_\_@\_\_\_\_\_

### Text Messaging

TCC would like to contact you via text messaging using your personal phone regarding appointment reminders and updates. Some limited personal information may be included, however, no medical or test results will be specified. Initial below if you wish to be contacted via text messaging or not.

\_\_\_\_\_Yes, I want TCC to use my cell phone listed below to send text messages for the purposes of appointment reminders/updates.

Cell Number: (    ) \_\_\_\_\_- \_\_\_\_\_

**Please contact our office immediately with any change in your phone number.**

– OR –

\_\_\_\_\_No, I do NOT want TCC to use my cell phone to send text messages for the purposes of appointment reminders/updates.



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**Office Policies**

We would like to thank you for choosing our practice as your medical provider. We have written this policy to keep you informed of our current office policies.

**Office Hours:** All locations are opened Monday through Friday during the hours reflected below:

Office Name	Address	Hours	Phone and Fax #
TenderCare Clinic, Inc. Administrative Offices	803 S. Main St. Greensboro, GA 30642	Mon. – Fri. 8 AM to 5 PM	Phone:(706) 453-1201 Fax: (706) 453-1441
TenderCare Greensboro	803 S. Main St. Greensboro, GA 30642	Mon. – Fri. 8 AM to 6 PM	(706) 453-1201 (706) 454-5114 (706) 454-5199
TenderCare Pharmacy	803 S. Main St. Greensboro, GA 30642	Mon. – Fri. 8 AM to 6 PM <b>(Closed for Lunch:1-2)</b>	(706) 453-1201 (706) 454-5150 (706) 454-5151
TenderCare Dental	803 S. Main St. Greensboro, GA 30642	Mon. 9AM-6PM Tues.-Fri. 8AM-5PM <b>(Closed for Lunch:1-2)</b>	(706) 454-5114 (706) 454-5199
TenderCare Lake Oconee	1041 Park Dr. Greensboro, Ga 30642	Mon. – Fri. 8 AM to 5 PM <b>(Closed for Lunch:12-1)</b>	
TenderCare Wellness	1040 Park Dr. Greensboro, Ga 30642	Mon., Tues., Thurs., Fri., 8 AM to 5 PM Wed, 8 AM to 7 PM <b>(Closed for lunch 12-1)</b>	
TenderCare Milledgeville	111 Fieldstone Dr. Suite 114 Milledgeville, Ga 31061	Mon. – Fri. 8 AM to 5 PM <b>(Closed for Lunch:12-1)</b>	

**Appointments:** We see most patients by appointment. Any patient needing forms completed, please make us aware at the time you make your appointment. All patients scheduled for an appointment will be notified by phone 24-48 hours before the appointment. We ask that each patient arrive at least 15 minutes prior to the appointment to verify and/or update patient information such as telephone numbers, address, and insurance information.

**After Hours and Emergencies:** For a serious emergency, call 911 right away. If you are not sure and call our office, please be sure to tell the person who answers the phone that it is an emergency. After hours you will reach our answering service. They will page the provider on call.

**Cancellations:** Please call within 24 hours if you are unable to keep your scheduled appointment. This allows us to provide that time slot to another patient.

**Complete Physical Exams:** We believe that routine, annual complete physical exams with screening lab tests are very important to the maintenance of good health. However, insurance benefits vary. Some policies cover “wellness” and others cover visits when you have a complaint. Please learn about your benefits prior to your appointment so you will know what is covered by your insurance plan.

**Medications:** Please bring your medications, both prescribed and over-the-counter, to your appointment visits. It is important to us and to you to keep your medications and any allergies updated in your medical records.

### **Prescriptions and Refills:**

- If you need to call for refills, don't wait until you have run out. Most refills require the doctor's approval. If your doctor is out for the afternoon, it may be the next day (or Monday) before it can be authorized.
- Don't go to the pharmacy to wait for your prescription to be called in. Call them first to see if it is ready.
- Refill requests called to us before 2:00 p.m. will be handled by the end of the day. After 2:00 p.m., it may be the next morning before your request can be addressed.
- Some medications have potential side effects that must be monitored. We require check-ups every 3 or 4 months for these medications. Be sure to keep those follow-up appointments.
- Some prescriptions cannot be called in. The prescription must be printed for you to pick up.
- Don't call after hours for prescription refills due to limited access to your chart.
- Narcotic prescriptions and controlled substances will be prescribed and refilled ONLY during regular business hours.

**Laboratory/Radiology Results:** If you have any laboratory or radiology tests performed, please ask your provider at the time of your visit when you will be notified of the results. If you have not received either a written or verbal response within 10 days, please call the office.

**Referrals:** Referrals are handled by our Referral Department. Sometimes this can be done on the same day as your appointment or can take 2-3 days, depending on your insurance and/or the urgency of your situation. Someone will contact you as soon as the referral authorization is obtained.

**Patient Obligation:** Patients play a vital role in the success of their healthcare by actively participating with the physician and staff in their treatment. By following a prescribed treatment plan, the patient increases his or her chances for a successful outcome. The physicians of our practice ask their patients to abide by the following responsibilities:

- Provide your physician with accurate and complete information regarding symptoms, complaints, past illnesses, medication history and hospitalizations relating to your health. Report risks and unexpected changes in your condition and provide feedback relating to the prescribed course of treatment.



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- Ask questions. If you do not understand the treatment plan, please ask for clarification.
- Follow and do not deviate from the course of treatment. Not complying to the treatment plan may result in a less successful outcome.
- Be considerate of the physicians, staff and the policies of the office. These policies have been put in place in order to serve our patients efficiently and effectively.
- Pay financial obligations in a timely manner. Our business office is available to assist you with your financial concerns.

**Dismissal:** If you are “dismissed” from the practice it means you can no longer schedule appointments, get medication refills, or consider us to be your doctor. You have to find a doctor in another practice.

**Dismissal Process:** We will send a letter to your last known address, via certified mail, notifying you that you are being dismissed. If you have a medical emergency within 30 days of the date on this letter, we will see you. After that, you must find another doctor. We will forward a copy of your medical record to your new doctor after you let us know who it is and sign a release form.