THE UNIVERSITY OF TENNESSEE MEDICAL CENTER

Wisdom for Your Life.

To Our New Patients:

We would like to welcome you to our practice. Below is an explanation of what to expect during your initial visit.

In most cases, we will obtain baseline lab studies that DO NOT require fasting. Once the lab results are available, you will be seen by Wahid Hanna, MD preceded by the Nurse Practitioner. The entire medical history and physical examination will then be performed. At the conclusion of the visit, a summary of all findings and recommendation for further evaluation plan or treatment will be discussed with you.

Enclosed you will find patient information forms that **need to be completed** and brought with you to your appointment as this will speed up the check-in process. If your paperwork is not completed at the time of your visit, it may be necessary for us to reschedule your appointment. In addition, you will need to present your insurance card(s). Should your insurance require a referral from your primary care physician, it is your responsibility to obtain this prior to your visit.

We offer two office locations. Directions to both locations are enclosed.

1) University of Tennessee Medical Center Cancer Institute, Building F, 4th floor, Suite 410. There is parking in front of the Cancer Institute; however, it is sometimes challenging to find a Parking space in the CI parking lot so there is additional parking in garage 1 (one). The cost is $3.00
2) Turkey Creek at Parkside Plaza II 11440 Parkside Drive, Suite 202, Knoxville, Tennessee 37934. No cost for parking at this location.

No one under the age of 16 is allowed in the building. In addition, no pets are allowed unless they are a registered service animal. If you need to cancel or reschedule your appointment, contact our office so we can open the time slot up for someone else in need of an appointment.

We hope this letter is helpful; however, should you have additional questions please do not hesitate to contact us. We look forward to seeing you.

Sincerely,

Wahid Hanna

Wahid T. Hanna, M.D., Professor
Hematology/Oncology Division
Department of Medicine

Patient Registration

UT MEDICAL CENTER

Patient Name: _____ DOB: _____ MRN: _____ FIN: _____

PATIENT INFORMATION

Patient Name:		Date of Birth:
SSN:	Birth Gender: ☐ Male ☐ Female	Gender Identity:
Home Address:		
Cell Phone:	Home Phone:	Work Phone:
Employment Status: ☐ Employed ☐ Retired ☐ Student ☐ Unemployed ☐ Disabled ☐ Active Military Duty		
Employer:		Patient Email Address:
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated		
Race: ☐ American Indian / Alaska Native ☐ Asian ☐ Black / African American ☐ Pacific Islander ☐ White ☐ Decline to Answer		
Ethnic Group: ☐ Hispanic / Latino ☐ Not Hispanic / Latino ☐ Decline to Answer		

SPOUSE'S INFORMATION (If Married or Separated)

Spouse's Name:		Date of Birth:
Home Address:		SSN:
Cell Phone:	Home Phone:	Work Phone:
Employment Status: ☐ Employed ☐ Retired ☐ Student ☐ Unemployed ☐ Disabled ☐ Active Military Duty		
Employer:		

RESPONSIBLE PARTY / GUARANTOR OF PAYMENT

Guarantor's Name:		Date of Birth:
Relationship: ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Other:		SSN:
Home Address:		Email:
Cell Phone:	Home Phone:	Work Phone:
Employment Status: ☐ Employed ☐ Retired ☐ Student ☐ Unemployed ☐ Disabled ☐ Active Military Duty		
Employer:		

EMERGENCY CONTACT PERSON (Outside the home)

Contact Name:	Relationship to Patient:
Cell Phone Number:	Home Phone Number:

Patient Registration

UT MEDICAL CENTER

Patient Name: _____ DOB: _____ MRN: _____ FIN: _____

PRIMARY INSURANCE INFORMATION	
Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Other:	
Policy Holder Name:	Date of Birth:
Insurance Provider:	SSN:
Member ID:	Group Number:
Insurance Claims Address:	

SECONDARY INSURANCE INFORMATION	
Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Other:	
Policy Holder Name:	Date of Birth:
Insurance Provider:	SSN:
Member ID:	Group Number:
Insurance Claims Address:	

REFERRING PROVIDER INFORMATION (If applicable)
Referring Provider (Full Name):
Provider Phone Number:

AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS TO PHYSICIAN: I hereby authorized the physician to release any information obtained in the course of my treatment needed to process insurance claims. I also authorize payment directly to the Physician for the surgical and/or medical benefits, if any, otherwise payable to me for his/her services as described, realizing I must pay non-covered charges.

_____ _____

Patient Signature (Parent Signature if Minor) Date/Time

CONDITIONS OF ADMISSION / TREATMENT

UT MEDICAL CENTER

Patient Name: _____ DOB: _____ MRN: _____ FIN: _____

1) MEDICAL AND SURGICAL CONSENT

I consent to the care and treatment, including any X-ray examination, laboratory procedures, anesthesia, medical or surgical treatment and any and all hospital se1vices which my physician(s), their designee(s), or others of the University of Tennessee Medical Center ("UTMC") staff consider to be necessary or appropriate. I understand that my physician(s) or their designee(s) will explain the need for, risk of, and alternatives to blood transfusion when blood may be needed, and my physician(s) or their designees will explain alternative options in treatment when they are available. I understand that the majority of the Medical Staff (physicians) and other practitioners working under their supe1·vision who furnish services to me, including emergency room doctors, radiologists, pathologists, anesthesiologists/anesthetists, physician assistants, advance practice nurses and the like, arc independent contractors and arc not employees or agents of UTMC. I understand and agree that any residents and fellows furnishing medical services to me are not employees or agents of UTMC but are employees or agents of the State of Tennessee.

2) NO GUARANTEE AS TO RESULTS

I understand that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of treatments and examination in UTMC.

3) RELEASE OF INFORMATION

I authorize UTMC and/or physicians to disclose all or any part of my patient record to any person or organization which is or may be liable or responsible for payment of all or part of the hospital charges, including, but not limited to, hospital or medical se1vices companies, insurance companies, workers' compensation carriers, or welfare funds. I further authorize the release of all or any part of my medical record to any physician, hospital, or other health care provider giving me past, present, or future care and treatment.

4) PERSONAL VALUABLES

I acknowledge that I have been asked to send money and valuables home, I understand that UTMC maintains a safe for money and valuables, and that UTMC will not be liable for the loss or damage to any money, jewelry, documents, or any other personal property, including glasses, contact lenses, dentures, hearing aids, or prosthesis, unless deposited with UTMC for safekeeping.

5) ADVANCE DIRECTIVES

I understand that information will be made available explaining my right to prepare an Advance Directive for Health Care, I understand that UTMC cannot honor any such document unless it has been legally executed and made a part of my medical record. I understand that under Tennessee Law, the medical center may refuse to implement an advance directive that conflicts with institutional policy or that is medical inappropriate.

6) HIV/HEPATITIS TESTING

If an employee, sh.1dent, or other health care provider is exposed to my blood or other body fluids, I authorize UTMC to perform confidential blood tests for HIV (the virus that causes AIDS) and hepatitis. I understand that I will not be charged for these tests. I also understand that under Tennessee law this test may be performed without my consent.

7) PHOTOGRAPHY

I understand that UTMC may photograph me, including appropriate portions of my body, for clinical and treatment purposes to be included in my medical record. I authorize UTMC to photograph me or portions of my body for scientific or educational purposes, provided my identity is not revealed by the pictures or any descriptive text accompanying them, I understand that I can withdraw my authorization by sending a written request to: UTMC, Medical Records - Box 110, 1924 Alcoa Highway, Knoxville, TN 37920-6999.

8) EDUCATION AND RESEARCH

I understand that UTMC participates in education and research activities and understand and agree that faculty, residents and students in these programs may be involved in my care. I authorize UTMC to retain, preserve and use for scientific, teaching, educational and research purposes specimens or tissues taken from my body as well as medical information contained in my medical record. I agree that any tissue or specimens may be disposed of by UTMC at its convenience.

The undersigned certifies that he/she has read the foregoing or has had the foregoing read to him/her, and that he/she understands and fully accepts its terms.

_____ _____

Signature of Patient or Patient Representative | Date/Time

_____ _____

Printed Name | Relationship to patient

RELEASE AUTHORIZATION

UT MEDICAL CENTER

Patient Name: _____ DOB: _____ MRN: _____ FIN: _____

1) PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAY REQUEST FOR MEDICARE AND MEDICAID/ TENNCARE BENEFITS

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act and Medicaid/TennCare is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare or Medicaid/TennCare claim. I request that payment of authorized benefits be made on my behalf. This authorization and assignment shall be valid for one year. I request that the payment of authorized Medigap benefits be made on my behalf to University of Tennessee Emergency Group for any services furnished me by that physician/supplier.

2) AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize the University of Tennessee Medical Center (UTMC) and other healthcare providers or suppliers providing service to me during this hospitalization to release information requested by my insurance carrier completed on the attached form. I assign UTMC the insurance benefits herein specified and otherwise payable to me, but not to exceed UTMC's regular charges for this period of hospitalization, and I authorize and direct my insurance carrier to make payment of said benefits directly to UTMC. I understand I am financially responsible to UTMC for charges not covered and paid by reason of this assignment. It is further agreed that any credit balance resulting from payment of the insurance or other sources may be applied on any other account owed UTMC by me or my family.

3) PROMISE TO PAY ACCOUNT

For and in consideration of services rendered and to be rendered by UTMC, I/we jointly and severally promise to pay all charges incurred for the account of the above named patient from admission to discharge. I will be responsible for any court costs, reasonable attorney fees and interest, as allowed by Tennessee law, incurred in the collection of my account. I authorize UTMC or its agents to check my credit and employment history and by this authorization expressly permit sources and employers to provide UTMC with the information requested. If I provide my cell phone number, I authorize UTMC or its agents to call my cell phone either manually or by auto-dialer in order to collect any amount I owe. If I provide my email or text number, I authorize UTMC or its agents to contact me at that email address or text number.

4) UTMC STAFF PHYSICIAN ASSIGNMENT

To facilitate paperless insurance claim processing, I assign my insurance benefits to any physician providing service to me during this hospitalization at UTMC. I understand that I am financially responsible for charges not covered and paid by reason of this assignment. I understand that medical care may be provided by a non-participating facility-based physician (i.e. University Anesthesiology, University Pathology, University Radiology, Team Health Emergency Physician's, etc.), that a separate billing may be received from these physicians for services provided, and that I will be responsible for any court costs, reasonable attorney fees and interest, as allowed by Tennessee law, incurred by such physicians in the collections of my account.

5) DME NOTIFICATION

Your physician may order durable medical equipment (DME), such as wheelchairs, walkers, and crutches, to be used by you following discharge from the hospital. **You have the right to obtain the DME from a supplier or vendor of your choice.** You are financially responsible for the DME you receive. Contact your insurance company if you have any questions about coverage or payment for these supplies.

6) UHS NOTICE OF INFORMATION PRACTICES

I have received a copy of the University Health Systems, Inc. (UHS) Notice of Information Practices. I understand that this Notice describes how my health information may be used or disclosed by UHS and physicians and other providers at UHS and its facilities, and that I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling (865) 305-9118, on the UTMC website at www.utmedicalcenter.org, or by requesting one at a UHS office.

7) PATIENT INSURANCE IDENTIFICATION RESPONSIBILITY

I understand if I have insurance coverage not presented by me at registration/admission, my bill may not be processed timely, and the appropriate authorization may not be obtained from the insurance company. In this circumstance, I agree to be responsible for charges not reimbursed by the insurance plans indicated above or insurance plans I have not divulged.

_____ _____

Signature of Patient or Representative Date/Time

_____ _____

Printed Name Relationship to patient if signing on their behalf

Authorization For Use or Disclosure of Protected Health Information

UT MEDICAL CENTER

Patient Name: _____ DOB: _____ MRN: _____ FIN: _____

I hereby authorize The University of Tennessee Medical Center Cancer Institute to release, use, request, or disclose from the health records of:

Patient Name: _____ Date of Birth: _____

Home Address: _____ Phone Number: _____

Reason for records release/request: ☐ Continuation of Care/Treatment ☐ Other: _____

Information being requested/released:

☐ Abstract (Pertinent) Medical Records	☐ EKG's	☐ Pathology Reports
☐ Complete Medical Record	☐ Immunization Records	☐ Operative Reports
☐ History & Physical	☐ Laboratory Reports	☐ Hospital Orders & Progress Notes
☐ Clinical Notes	☐ Radiology Reports	☐ Hospital Discharge Summary
☐ Billing Information	☐ Radiology Images	☐ Other:

Information / Records to Exclude:

☐ No Exclusions	☐ Behavioral / Mental Health Records	☐ Alcohol Abuse / Treatment
☐ Drug Abuse / Treatment	☐ HIV / AIDS Records and Treatment	☐ Genetics Information
☐ Other:		

Disclosure Statement

You have a right to revoke this authorization by doing so in writing. Such revocation will be effective to the extent that action has not been taken in reliance on the authorization or, if the authorization was obtained as a condition of obtaining insurance coverage, only to the extent that other law provides the insurer with the right to contest a claim under the policy.

I understand that this authorization is voluntary and that I may refuse to sign this authorization, and that my refusal will not affect my eligibility for benefits, payment for coverage of services, or ability to obtain treatment.

I understand the information to be released may include records related to behavior and/or mental health care, alcohol, and drug abuse treatment, HIV/AIDS, and genetics. This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it.

Revocation must be made in writing to the provider/facility releasing the information. The provider will not condition treatment on whether I sign the authorization.

The information used or disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by the regulations that protect individually identifiable health information from use or disclosure by health care providers.

This authorization will expire in 12 months.

_____ _____

Signature of Patient or Representative Date/Time

_____ _____

Printed Name Relationship to patient

Patient Privacy Questionnaire & Notification

UT MEDICAL CENTER

Patient Name: _____ DOB: _____ MRN: _____ FIN: _____

➢ May we leave messages about your healthcare and treatment on your voicemail or answering machine when you are not available?

- ☐ Yes: may leave messages as specified below
- ☐ May leave messages with a call back number only
- ☐ No: Only leave information with me

➢ What is your preferred contact phone number?

☐ Cell Phone: _____ ☐ Home Phone: _____

☐ Work Phone: _____ ☐ Other Phone: _____

May leave messages about appointment schedule & reminders

- ☐ On my voicemail or answering machine
- ☐ With a call back number only
- ☐ Only with me (no message)

May leave messages about lab & test results

- ☐ On my voicemail or answering machine
- ☐ With a call back number only
- ☐ Only with me (no message)

May leave messages about billing & payment information

- ☐ On my voicemail or answering machine
- ☐ With a call back number only
- ☐ Only with me (no message)

May leave messages with questions & general information

- ☐ On my voicemail or answering machine
- ☐ With a call back number only
- ☐ Only with me (no message)

Please list anyone that we may contact to get or disclose personal information about your care on your behalf

Contact Name:	Relationship:	Phone:

- ☐ May leave appointment reminders with the person above
- ☐ May discuss lab / test results with the person above
- ☐ May discuss billing information with the person above
- ☐ May leave questions and information with the person above
- ☐ I prefer that all healthcare messages be given to the person above

Contact Name:	Relationship:	Phone:

- ☐ May leave appointment reminders with the person above
- ☐ May discuss lab / test results with the person above
- ☐ May discuss billing information with the person above
- ☐ May leave questions and information with the person above
- ☐ I prefer that all healthcare messages be given to the person above

If we are not able to reach you by telephone, we will send information through the U.S. Postal Service to your home address. We keep a record of each of your visits to this practice. This record may include your test results, diagnosis, medications, and your response to medications or other therapies. This allows your doctors and other clinical staff to provide proper care to meet your medical needs. The information in your record is called protected health information. We may disclose your protected health information to other healthcare providers or beings involved in your care.

I understand that my protected health information may be used to manage my treatment as stated above. I have been offered a copy of the University Health System, Inc. (UHS) Notice of Information Practices. I understand that this Notice describes how my health information may be used or disclosed by this practice, UHS, UHS Ventures Inc. (UHSV), doctors, and other providers that practice at UHS or UHSV facilities. I should read it carefully. I am aware that the Notice may be changed at any time.

By giving my home phone number, cell phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system. The system will use my contact information, the name of my care provider, and other limited information when needed.

_____ _____

Signature of Patient or Representative Date/Time

_____ _____

Printed Name Relationship to patient

UNIVERSITY OF TENNESSEE MEDICAL CENTER
1934 ALCOA HIGHWAY BLDG D SUITE 170♦ KNOXVILLE, TN 37920
(865) 305-8684

1592

LABEL

Outpatient Home Medication List

Name MR# PHYSICIAN DATE

Allergies: ☐ No Known Drug Allergies

Drug Allergy/Reaction :	Pharmacy :
	Pharmacy Phone:

Any changes need signature, date, & time

Prescription, Over-The-Counter, Herbal, Patches, Inhalers, Total Parenteral Nutrition, etc...

☐ No Current Medications

Drug Name	Dose	Route	Frequency	Indication	Sign/Date/Time

Information source(s): ☐ patient recall ☐ patient medication list ☐ drug container from home ☐ other:

Sign/Date/Time_____ Sign/Date/Time_____ Sign/Date/Time_____

Sign/Date/Time_____ Sign/Date/Time_____ Sign/Date/Time_____

Sign/Date/Time_____ Sign/Date/Time_____ Sign/Date/Time_____

Sign/Date/Time_____ Sign/Date/Time_____ Sign/Date/Time_____

Sign/Date/Time_____ Sign/Date/Time_____ Sign/Date/Time_____

Sign/Date/Time_____ Sign/Date/Time_____ Sign/Date/Time_____

RISK FOR HEREDITARY CANCER

UT MEDICAL CENTER

Patient Name: _____ DOB: _____ MRN: _____ FIN: _____

This form helps us determine whether you may qualify for genetic testing. Some families have a genetic disease that causes cancer in their family. Please let your provider know if you have any questions.

Have you had cancer genetic testing before?	☐ Yes ☐ No
Was the test done AFTER 2013?	☐ Yes ☐ No
What where the results of the genetic test?	
Is there hereditary cancer syndrome in your family?	☐ Yes ☐ No
Type of hereditary cancer syndrome	

The questions below apply to you and your blood relative family members on both your biological father and biological mother's side. If you answer *Yes* to any of the questions below, please list your relationship to the person and their age when they were diagnosed. Include yourself, your parents, brothers, sisters, children, grandparents, aunts, uncles, cousins, nieces, and nephews.

Family Cancer History
Diagnosis of Breast cancer at/or before age 50 ☐ No ☐ Yes - Relationship & age:
Diagnosis of two breast cancers on the same side of the family, with one diagnosed at/before 50 ☐ No ☐ Yes - Relationship & age:
Diagnosis of three or more breast cancers on one side of the family at any age ☐ No ☐ Yes - Relationship & age:
Diagnosis of Ovarian, peritoneal, or fallopian tube cancer at any age ☐ No ☐ Yes - Relationship & age:
Diagnosis of Pancreatic cancer at any age ☐ No ☐ Yes - Relationship & age:
Diagnosis of Prostate cancer that spread to other parts of the body ☐ No ☐ Yes - Relationship & age:
Diagnosis of Uterine cancer before age 50 ☐ No ☐ Yes - Relationship & age:
Diagnosis of Colorectal cancer before age 50 ☐ No ☐ Yes - Relationship & age:
Diagnosis of More than 10 colon polyps during a lifetime ☐ No ☐ Yes - Relationship & age:
Ashkenazi Jewish heritage ☐ No ☐ Yes - Relationship & age:
Other personal or family history of cancer: ☐ No ☐ Yes – Relationship, age, type of cancer:

HANNA CANCER ASSOCIATES

WAHID T. HANNA, M.D.

DIRECTIONS TO UT LOCATION

1926 ALCOA HIGHWAY, MEDICAL BUILDING F, 4TH FLOOR

KNOXVILLE, TN 37920

PHONE (865) 305-9171

From Downtown Knoxville/Morristown Area:

Travel West on I-40 toward Knoxville

Merge onto US 129/Exit 386B toward Airport/Smoky Mtn.

Travel approximately 1 mile to the UT Medical Center/Cherokee Trail Exit.

UT Medical Center Cancer Institute, Building F, 4th Floor

From Lenoir City Area:

Travel North on I-75 to I-40 East to Knoxville

Merge onto US 129/Exit 386B toward Airport/Smoky Mtn.

Travel approximately 1 mile to the UT Medical Center/Cherokee Trail Exit

UT Medical Center Cancer Institute, Building F, 4th Floor

From Maryville/Alcoa Area:

Travel North on US 129 (Alcoa Highway) toward Knoxville

Take the UT Medical Center/Cherokee Trail Exit

UT Medical Center Cancer Institute, Building F, 4th Floor

From Harriman Area:

Travel East on I-40 toward Knoxville

Merge onto US 129/Exit 386B toward Airport/Smoky Mtn.

Take the UT Medical Center/Cherokee Trail Exit

UT Medical Center Cancer Institute, Building F, 4th Floor