Medina Family Medical Clinic

Mechelle Perry, CFNP Darren Perry, CFNP
209 Grace Cove | Po Box 100 | Medina, TN
Phone: 731-783-0400 Fax: 731-783-0402
www.medinafamilymedical.com

Patient Information (Please Print)

Last Name _____ First Name_____ MI_____ Date_____

Date of Birth ___/___/___ Social Security Number _____ - _____ - _____ **Gender** ○ Male ○ Female

Marital Status: ○Married ○Single ○Divorced ○Life Partner ○Separated ○Widowed **Language (if not English)** _____

Race: ○ Black (non-Hispanic) ○ American Indian/Alaskan Native ○ Hispanic ○ Asian/Pacific Islander ○ White (non-Hispanic)

Home Address _____ Apt/Lot#_____ City_____ State_____

Zip_____ Home Phone _____ Cell Phone _____

Email Address _____

Employment Status: □ full-time □part-time □unemployed □retired □disabled.

Employer: _____ Employer Phone: _____

If A Student: What school do you attend? _____ Highest Education Level _____

Emergency Contacts

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Pharmacy Information

Name: _____ Address: _____ Phone: _____

Responsible Party Information

(Person responsible for <u>any</u> charges not covered by insurance)

If you are the responsible party, mark "self".

Patient's relationship to responsible party : □ Self □ Spouse □ Child □ Other: _____

Guarantor Information

(If patient is a child, which PARENT is the insurance subscriber?)

Are you covered by health insurance? □ Yes □ No If YES, name insurance plan name: _____

Last Name _____ First Name _____ MI _____ DOB _____

Address _____ SSN _____ - _____- _____

Home / Cell Number _____ Employer _____

_____ _____

Patient / Guardian Signature **Date**

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Clinic Policies

- Proof of insurance must be provided at the time of appointment
- A valid photo ID must be provided
- Copay(s) must be paid at the time of your appointment
- If you have a deductible that has not been met for the year, a fee of $110 for new patients and $85 for existing patients will be collected at the time of your appointment and applied to that day's visit
- If you have a past due account balance in excess of $200, you will be asked to set up a payment plan with a minimum payment of $50 per month
- Balances under $200 will not be required to set up a payment plan but will require that the balance be paid down within a timely manner
- Patients who arrive late by 15 minutes or more will be rescheduled and/or worked into the schedule at a different time with a different provider
- If you do not show up for your scheduled appointment time, or within the 15 minute grace period, you will be marked as a NO SHOW. After 2 no shows you will get a warning and after 3 we will no longer be able to schedule you.
- A fee of $30 will be applied to your account for any returned checks.
- Our providers are not required to continue controlled substances prescribed by other providers. We will review those medications at the time of your visit.

_____ _____ _____

Patient Name **Signature** **Date**

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Consent to Treat / Financial Policy / Advance Directive

Patient: _____ DOB: _____ SSN: _____

1. I consent to treatment necessary for the care of the above patient named.
2. I authorize the release of all medical records to my insurance company, if applicable.
3. I authorize the release of all medical records to referring and/or family physicians, if applicable.
4. A allow fax transmittal of my medical records, as necessary.
5. I understand that payment of copays, deductible, coinsurance, and charges incurred are due at the time of service.
6. In the event the charges incurred are not paid in full when services are provided and collection action is instituted by a collection agency, attorney, or both; I understand and agree to be responsible for the outstanding balance and any additional charges incurred during the collection process. Cost for the collection process is included but not limited to reasonable collection agency, attorney fees, and court costs.
7. I authorize insurance payments to be made directly to the provider at Medina Family Medical Clinic.
8. I have read and fully understand the consent for treatment, financial responsibility, and release of medical information.
9. I acknowledge full financial responsibility for services rendered by Medina Family Medical Clinic.

_____ _____

Patient or Guardian Signature **Date**

Advance Directives:

1. Do you have a living will, advance directive, or durable power of attorney? □ Yes □ No
2. If you answered yes above, please identify location:

_____ _____

Name/Locations Phone Number

3. Would you like a packet of information on advance directives? □ Yes □ No

_____ _____

Patient or Guardian Signature **Date**

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Authorization to Release Protected Health Information to Person(s) Other Than the Patient

Patient Name _____
Date of Birth _____ **Social Security Number** _____

I, _____ have been encouraged and have been given the opportunity to allow family members or other designated person to be involved in my personal health care, and to be given certain information concerning my care.

I **AGREE** to allow the following individuals to be involved in my PERSONAL HEALTHCARE, and to be given certain information access concerning my health care. This information includes **MEDICAL INFORMATION, SCHEDULING** and **BILLING INFORMATION**.

Name(s) of Authorized Person(s):

1. **Name** _____ **Relationship** _____
2. **Name** _____ **Relationship** _____
3. **Name** _____ **Relationship** _____

I HAVE RECEIVED, OR BEEN OFFERED, A COPY OF THE NOTICES OF PRIVACY PRACTICE.

Signature of Patient: _____ **Date:** _____

Signature of Witness: _____ **Date:**_____

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CONSENT FOR TREATMENT OF A MINOR WHEN PARENTS/GUARDIANS

ARE TEMPORARILY UNAVAILABLE

(Only complete this form for children under the age of 18!)

Patient Name: _____ Date Of Birth: _____

I give permission to the Providers and nurses of Medina Family Medical Clinic to treat my child in my absence. I authorize any medical treatment which may be necessary in an emergency, and in my absence, for the well-being of the above-mentioned minor.

It is understood that this consent is given in advance of any specific diagnosis or treatment and allows the provider to diagnose and treat the child even when the parent or guardian is not present.

1. **Person(s) who may consent to treatment (please print):**
   Name:_____ Relationship to Child:_____ Phone:_____
   Name:_____ Relationship to Child:_____ Phone:_____
   Name:_____ Relationship to Child:_____ Phone:_____

2. **Medical issues/concerns: _____**
3. **Known allergies:_____**
4. **Current Medications:_____**

Name of Parent or Legal Guardian* _____Relationship to Child:_____

Contact Number(s):_____

Address:_____ City, State, Zip:_____

Signature:_____ Date:_____

*If Power of Attorney is required to show legal guardianship, you will be required to show Power of Attorney paperwork.

This Consent is effective until withdrawn in writing by the child's parent or guardian or until child turns 18 years of age.

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Patient Health History Form

Name: _____ **Date:** _____
SSN: _____ **DOB:** _____
Chief Complaint: What is the reason for your visit today? _____
_____
_____
_____

Past Medical History: Please check all that apply to you!

□ Arthritis	□ Epilepsy/Seizures	□ Psychiatric disease
□ Cancer	□ Heart problems	□ Stroke
□ Depression	□ Heart surgery	□ Thyroid
□ Diabetes	□ High blood pressure	□ None

Previous Surgeries: Please list past procedures with approximate dates. _____
_____
_____
_____

Serious Injury: Please describe any serious injuries you've had. _____
_____

Medications:

Drug	Dose/Frequency
_____	_____
_____	_____
_____	_____
_____	_____

Allergies: _____
Do you drink alcohol? _____ If yes, how much/week? _____
Do you smoke? _____ If yes, how many cigarettes/day? _____
Do you consume caffeine? _____ If yes, how many cups/week? _____
Do you use recreational drugs? ____ If yes, what type and frequency? _____
Are you on a special diet? _____ If yes, describe. _____

Family History: Do you have any blood relatives who has or has had any of the following?

□ Asthma	□ Headaches	□ Multiple sclerosis
□ Aneurysm	□ Heart problems	□ Psychiatric disorder
□ Brain Tumor	□ High blood pressure	□ Stroke
□ Cancer, type:	□ kidney disease	□ Thyroid
□ Diabetes	□ lung disease	□ None
□ Epilepsy/Seizures	□ Migraine	

Medina Family Medical Clinic
Authorization for Release of Protected Health Information

Patient Name: _____
Date of Birth: _____
Social Security Number: _____

Release Record To:
Medina Family Medical Clinic
209 Grace Cove – PO Box 100
Medina, TN 38355
Phone: 731-783-0400 Fax: 731-783-0402

Person/Organization Authorized to Disclose Protected Health Information

Clinic: _____
Address: _____ City: _____ State: _____
Phone: _____ Fax: _____

Choose From the Following:

____Entire Chart	____Radiology Reports	_____History & Physical
____ER Records	____Consultation	____Immunization(s)
____Operative/Procedure Report	____Discharge Summary	____Lab(s)

____Other (specify):_____

I Understand That:

1. I may revoke this authorization in writing at any time by notifying the person/organization providing or disclosing the information (releasing facility). However, if I revoke this authorization, it will not have any effect on any actions taken by the person/organization providing, disclosing, or receiving the information.
2. This authorization allows the facility to which records are being released to obtain all documents in my medical record. I understand that the information this is released or provided may be re-disclosed and no longer protected by federal privacy regulations.
3. Any disclosure of records concerning diagnosis and/or treatment of alcohol and/or drug abuse is covered by Title 42 CFR, and if there is any such information, I hereby authorize the release of information. This also includes any information related to the diagnosis/treatment of any psychiatric or mental illness or any state of infection with the HIV (AIDS) virus.
4. The receiving facility is hereby released from any liability and the undersigned with hold the receiving facility harmless for requesting or seeking my protected health information.
5. I understand this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal will affect my ability to obtain treatment.
6. This authorization will expire in 90 days unless I provide an alternative date or event. This authorization will not apply to any dates of service that occur after the date this authorization is signed.
7. A facsimile of this authorization or a copy of this shall be valid and binding with the same force as an original signature and the person/organization releasing the information shall be entitled to rely on the same.

I have read and understand this authorization. I hereby authorize the release of the above requested medical information about me to the receiving facility from the releasing facility named above.

_____ _____

Signature of Patient

_____ _____

Signature of Patient's Authorized Representative Representative's Authority

_____

Phone Number