Appalachian Family Care

1009 Lark Street Suite 1A Johnson City TN 37601

William D. Clever, FNP **Thatcher Card, FNP** **Amanda Cardin, FNP**

Patient Information

Patient Name:

Address:

Sex: M F Race: Marital Status:

Date of Birth: / / Social Security Number: - -

Primary Number: ( ) - Cell Number: ( ) -

Email:

Spouse or Emergency Contact:

Name:

Primary Number: ( ) - Cell Number: ( ) -

Relationship to patient:

Insurance Information:

Primary Insurance:

ID Number: Group Number:

Policy holder Name:

DOB: / / SSN: - -

Secondary Insurance:

ID Number: Group Number:

Policy holder Name:

DOB: / / SSN: - -

Information to patient:

I, (patient), a patient of Appalachian Family Care (AFC), hereby authorize AFC and its authorized agents to administer such treatment as necessary, and such additional procedures as are considered therapeutically necessary on the basis of findings during the course of said treatment including, but not limited to, studies, referrals, and consultations.

I, (patient), hereby certify that I understand the advantages, risks, and potential complications of medical treatments as explained to me by AFC. I also certify that no guarantee or assurance has been made to me as the results that may be obtained through medical treatment.

I authorize payment of medical benefits to AFC. I authorize the release of any medical records or other necessary information to process insurance claims on my behalf.

Signature: Date:

Appalachian Family Care
Medical History Form

Directions: Please answer the following questions to the best of your knowledge.

Name: **DOB:** **Date:**

Other Healthcare Provider(s)		
Name	Name	Name
Specialty:	Specialty:	Specialty:
Phone:	Phone:	Phone:

Medication Allergies? □ Yes □ No
If yes, what medication(s)_____

Substance or Food Allergies? □ Yes □ No
If yes, what substance(s) _____

FAMILY HISTORY: Please check the box if your family has a history of:

□ Diabetes □ High Blood Pressure □ Heart Attack, Heart Disease □ Blood Clots or Stroke □ Tuberculosis

□ Cancer □ Alzheimer's □ Family History Unknown □ Mental Illness □ Epilepsy/Seizure

Any other major conditions?_____

_____

_____

If you answered Yes to any of the above, please explain: _____

_____

Are you currently being treated for medical conditions? □ Yes □ No If yes, please list: _____

_____

MEDICATIONS (List more on separate page if necessary)

Current Medications	For what condition?	Dosage	Frequency	Date started	Comments / Problems / Concerns

Past Medications / For what condition? (List sedatives, pain medications, sleeping pills, antidepressants, etc.)			

Social/Sexual Risk History	
□ Yes □ No	Do you smoke? If yes, how many cigarettes per day?
□ Yes □ No	Do you use alcohol? If yes, how often, how much?
□ Yes □ No	Do you or your partner(s) use drugs? If yes, how much, how often? Ever injected drugs? (explain)
□ Yes □ No	Have you ever had or would you like help now with an alcohol or drug problem?
□ Yes □ No	Would you like to discuss problems related to a rape or emotional/physical/sexual abuse?
□ Yes □ No	Are you now or have you ever been in a relationship where you have been physically hurt or threatened?

Notes from Provider:

_____

_____

_____

Appalachian Family Care
Medical History Form

REVIEW OF SYSTEMS: Please check the box if you currently have or have ever had the following			
1. General			
Productive cough (3 weeks or more)	□ Current □ Past	Unusual discharge (vaginal or from penis)	□ Current □ Past
Dry, unproductive cough (3 wks. or more)	□ Current □ Past	Bloody or painful urination	□ Current □ Past
Shortness of breath	□ Current □ Past	Dark, bloody, or painful bowel movements	□ Current □ Past
Chest pain	□ Current □ Past	Hepatitis A	□ Current □ Past
Recurrent night sweats, chills, fevers	□ Current □ Past	Hepatitis B	□ Current □ Past
Swollen glands (neck, armpits, or groin)	□ Current □ Past	Hepatitis C	□ Current □ Past
Persistent weight loss without dieting	□ Current □ Past	Chronic Fatigue	□ Current □ Past
Weight problem/eating disorder	□ Current □ Past	Cancer	□ Current □ Past
2. Skin		**7. Gastrointestinal**	
Allergies/Rash/Itching	□ Current □ Past	Recurrent nausea/vomiting/diarrhea	□ Current □ Past
Psoriasis / Eczema	□ Current □ Past	Stomach/bowel problems	□ Current □ Past
		Gall bladder disease	□ Current □ Past
3. Eyes		Pancreatitis	□ Current □ Past
Vision problems	□ Current □ Past	Diabetes / hyperglycemia / hypoglycemia	□ Current □ Past
Eye infections	□ Current □ Past	Encopresis (incontinent of feces)	□ Current □ Past
4. Ears, Nose, Throat, Lungs		**8. Genitourinary**	
Hearing problems	□ Current □ Past	Bladder/kidney problems or infection	□ Current □ Past
Teeth/gum problems or disease	□ Current □ Past	Incontinence (unable to control bladder)	□ Current □ Past
Frequent nosebleeds	□ Current □ Past	Enuresis (bedwetting)	□ Current □ Past
Recurrent sinusitis	□ Current □ Past	Sexually transmitted diseases:	
Frequent sore throats	□ Current □ Past	Gonorrhea_____Syphilis___Herpes	
Recurrent Pneumonia	□ Current □ Past	Chlamydia_____Trichomonas	
Asthma	□ Current □ Past	HPV or genital warts	
5. Cardiac		**Females:**	
Palpitations/arrhythmia	□ Current □ Past	Menstrual Difficulties	□ Current □ Past
Heart disease/murmur	□ Current □ Past	Cycle: Regular__Irregular	
High blood pressure / Low blood pressure	□ Current □ Past	Pre-Menopause__Menopause	
High cholesterol	□ Current □ Past	Problems/infection of tubes/ovaries/uterus	□ Current □ Past
Thrombophlebitis/blood clots	□ Current □ Past	Abnormal Pap Smear(s)	□ Current □ Past
		Number of pregnancies	
6. Neurological		Number of births	
Stroke	□ Current □ Past	Problems with pregnancies/births (explain)	
Frequent Headaches or Migraines	□ Current □ Past		
Seizures/Epilepsy	□ Current □ Past	Breast disease / tumor / surgery (explain)	
Weakness/paralysis/unsteady walking	□ Current □ Past		
Dizziness/confusion/wandering	□ Current □ Past	**Miscellaneous:**	
Forgetfulness/memory lapse/memory loss	□ Current □ Past	Anemia / blood disorder	□ Current □ Past
		Arthritis	□ Current □ Past
Other conditions / problems not listed:		Sleep disturbance	□ Current □ Past

Notes from Provider:

_____

_____

_____

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Financial Policies

Co-Payments are expected prior to being seen by provider. Please be prepared with your co-payment at the time of your appointment. If you do not have your copayment at the time of your appointment, we reserve the right to re-schedule your appointment until time that payment arrangements can be made. Patients with an account balance of more than 60 days past due may be asked to reschedule their appointment until payment arrangements can be made. We reserve the right to discharge patients with balances over 90 days past due. Please be prepared to show your insurance card information at each appointment. Inform the staff before being seen if your insurance has changed since your last appointment. Account balances over 120 days past due will be forwarded to a collection agency for resolution.

Insurance Submission

If we have accepted assignment from your insurance, and you have given us permission to submit claims to your insurance company on your behalf, we will submit your claim in 1 -2 business days of your appointment. If your current insurance plan denies your claim for any reason, the financial responsible person on the account will be billed with the account balance with payment due upon receipt. We only send statements when there is an outstanding balance. if you do not receive a statement within 90 days of your office visit this means your insurance company has paid the balance in full, or your account balance has a zero balance. It is your responsibility to notify our office of address changes so that account statements can be mailed if you have an account balance. You are still responsible for outstanding balances if your billing statement is returned as undeliverable.

Collections

We try to avoid using a collection service as much as possible. However, there are two circumstances that will require the use of a third-party collection service. If your account balance is 120 days past due and you have not made special payment arrangement. If you have made payment arrangements with our office regarding your account and you fail to keep the terms of your agreement with us.

Right to Refuse Service

We reserve the right to refuse service and/or dismiss a patient based on their outstanding obligations with this practice. I agree to adhere to the financial policies of Appalachian Family Care as a condition of my being a patient of this practice.

Signature: Date:

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_____ _____

(Patient Full Name) (Birth Date: Month/Day/Year)

_____ _____

(Street Address) (Social Security Number)

_____ _____

(City, State, Zip Code) (Phone)

I do hereby authorize the following facility to release my medical information:

Appalachian Family Care **1009 Lark Street, Ste 1-A, Johnson City, TN 37604**

(Name of Facility) (Street Address) (City, State, Zip)

Dates: Between _____ to _____

___ Discharge Summary
___ Emergency Reports
___ Laboratory Reports
___ Operative Notes
___ Pathology Report
___ History and Physical
___ Progress Notes
___ Radiology Reports
Other: _____

___ I do ___ I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

Information Release To: **Appalachian Family Care**
1009 Lark Street, Ste 1-A
Johnson City, TN 37604
Fax: 888-264-2167

Purpose of Disclosure: Discharge Summary: ____ Insurance: ____ Personal: ____ Change of PCP: ____ Legal: ___ Disability: _____ Continuing Care: _____ Workers Comp: ____

I hereby authorize disclosure of the health information for the above-named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to redisclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether I sign the authorization.

Signature: Date:

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Confidentiality and Privacy of Medical Records

This notice describes the privacy practices of our office. PLEASE REVIEW CAREFULLY.

Our Pledge Regarding Health Information

The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) was drafted, in part, to control the privacy of, access to, and maintenance of confidential information. We understand that information about you, your health, and your health care is personal. We are committed to protecting your personal health information (PHI).

We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all records of your care generated by this health care practice, whether made by your personal physician or others working in this office. This notice will tell you about the ways in which we may use and disclose your PHI. We also describe your rights to the PHI we keep about you and describe certain obligations we have regarding the use and disclosure of your PHI.

We are required by law to:

- Make sure that health information that identifies you is kept private
- Give you this notice of our legal duties and privacy practices with respect to your PHI
- Follow the terms of the notice that is currently in effect

How We May Use and Disclose Your PHI

The following categories describe different ways that we use and disclose health information:

For Treatment: We may use health information about you to provide you with health care treatment or services. We may disclose health information about you to others involved in your healthcare treatment including other physicians, hospitals, labs, pharmacies, or other health care providers where we may have referred you.

For Payment: We may use and disclose information about treatment and services we provided to you for billing purposes. These fees may be collected from you, an insurance company, or a third party and include requests for payment/reimbursement and prior authorization for treatment.

Appointment Reminders: We may use and disclose health information to contact you as a reminder that you have an appointment or that you missed an appointment and should contact us to reschedule. Please let us know if you do not wish to have us contact you for this purpose or if you wish us to use a different method to contact you.

As Required by Law: We will disclose health information about you when required to do so by federal, state, military, or local law.

Organ and Tissue Donation: If you are an organ donor, we may release health information to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

To Avert a Serious Threat to Health or Safety: We may use and disclose health information about you when necessary to prevent a serious threat to the health and safety of you or another individual(s).

Workers' Compensation: We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose health information about you for public health reporting purposes. These activities generally include but are not limited to the following:

- Birth, death, abuse, neglect, communicable disease prevention and/or notification, medication adverse reactions, and product recalls.

Coroners, Health Examiners, and Funeral Directors: We may release health information to a coroner, health examiner, or funeral directors as necessary to carry out their duties.

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Scheduled Appointment Agreement

- Your health care is important. WE ARE NOT AWARE of how your insurance company determines which services/labs are paid and which services/labs are not paid, or which are subject to coinsurance or deductible. Some pay only for illness codes, and some only for prevention codes, and some do not pay for a myriad of other factors. Our responsibility to the patient is to provide care and order labs based on your individual medical needs and current prevention guidelines and the standard of medical care. There are no medical guidelines to support "routine labs" ordered without a medical evaluation whether it is a covered benefit or not. Please take the time to make yourself familiar with your insurance benefits. Feel free to call the insurance company and ask about coverage. There are many plans and their benefits change often we have no way of knowing what is current for you.
- You may schedule an appointment as a WELL EXAM, PREVENTIVE CARE or ROUTINE EXAM. It will be billed as such to your insurance plan. Due to coding laws, we MUST bill your exam as Preventive Care. If during your visit you have ADDITIONAL CONCERNS or PROBLEMS that require a diagnosis and/or other treatment it would be considered a Problem Oriented Exam and you may incur additional office or lab charges. These charges and any from your Preventive Care Exam will be billed to your insurance company. You may want to keep your Well Exam separate from your Problem-Oriented Exam and we would be happy to schedule it that way for you.
- If your insurance company does not cover some or all these charges, you will be billed directly for the balance they indicate is "patient responsibility". Please DO NOT ASK US TO RE-BILL your insurance by changing the procedure or diagnosis codes. We are unable to make a change once the insurance has been billed.
- Laboratory services are provided Quest Diagnostics and Synergy Laboratories and have no direct financial or other affiliation with Appalachian Family Care. This means the laboratory work done is billed entirely by those individual companies. The services and billing remain the same regardless of whether you had those laboratory services done at Appalachian Family Care or at an outside laboratory. The laboratory service, therefore, is offered as a convenience to our patients. If a billing question about laboratory service occurs, it is the responsibility of the patient to direct those questions to the laboratory billing department and please note that we will not change codes after the service is obtained.

I acknowledge that I have read and understand the information above. I understand I will be financially responsible for services that my insurance company indicates are "patient responsibility". **Printed Name: _____**

Signature: Date: