PATIENT REGISTRATION

Patient Information	Patient Information			
	Last Name:	First Name: M.I.:		Previous Name (if applicable)
	Mailing Address:		Apt #	
	City/State/Zip:			
	Home Phone:	Cell Phone:		Work Phone:
	Date of Birth:	O Male O Female		Family Physician or Pediatrician:
	Marital Status:	Social Security #:		
	Employer Name:	Emergency Contact Name:		
	Emergency Contact Phone #:			Relationship to Patient:
Additional Information and Responsible Party	Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be: listed as the guarantor			
	Last Name:	First Name:		
	Date of Birth:	Social Security #:		Phone:
	Address of Person Responsible:			
	City/State/Zip:	Relationship to Patient:		
	Additional Information (PLEASE FILL OUT ALL SECTIONS BELOW)			
	Email Address:		Can we leave a message regarding your medical care & test results?	
	Race (please select): O White O Hispanic O American Indian or Alaska Native O Asian O Hispanic O Black or African America O Native Hawaiian or Pacific Islander O Other O Decline		Ethnicity (please select one): O Hispanic or Latino O Not Hispanic or Latino O Decline	
	Preferred Language (please select one):	O English O Sign Language	O Bosnian O Indian (including Hindi & Tamil) O Spanish O Russian O Other	
	<u>Preferred</u> Pharmacy Name & Location:			
	<u>Secondary</u> Pharmacy Name & Location:			
Insurance Information	Primary Medical Insurance	Secondary Medical Insurance		
	Ins. Co. Name	Ins. Co. Name		
	Policy Holder Name:	Policy Holder Name:		
	Policy Holder's Date of Birth:	Policy Holder's Date of Birth:		
	Policy Holder's Social Security #:	Policy Holder's Social Security #:		
	Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:		

I have read and agree to Mt. Juliet Health and Wellness payment policy. I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to Mt. Juliet Health and Wellness all money to which I am entitled for medical expenses related to the services performed from time to time by Mt. Juliet Health and Wellness, but not to exceed my indebtedness to Mt. Juliet Health and Wellness. I authorize Mt. Juliet Health and Wellness to release any medical information to my insurance carrier or third-party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 45 days of notification of the amount due will result in submission to an outside collection agency. A $25.00 returned check fee will be charged for checks returned due to insufficient funds.

I have reviewed a copy of Mt. Juliet Health and Wellness Privacy Notice.

Signature of Responsible Party:____ Date:_________________

PATIENT HISTORY FORM

Date: _______/_________/________

NAME: ____ Birthdate: _____/______/_____

Last First M. I.

How did you hear about this clinic?

Describe briefly your present symptoms:

Please list the names of other practitioners you have seen for this problem:

CURRENT MEDICATIONS		
Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:		
Name of drug	**Dose (include strength & number of pills per day)**	**How long have you been taking this?**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

CURRENT ALLERGIES
Drug allergies: ❑ No ❑ Yes If yes, please list allergies below.
1.
2.
3.
4.
5.

PATIENT NAME: ____ DOB: ____/____/____

PATIENT HISTORY FORM

PAST MEDICAL HISTORY

Do you now or have you ever had:

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Thyroid problems
- ❑ Positive TB skin test
- ❑ Cancer (type) ___________________
- ❑ Leukemia
- ❑ Psoriasis
- ❑ Arthritis
- ❑ Heart problems
- ❑ Heart murmur
- ❑ Sleep Apnea
- ❑ Blood Clots
- ❑ Asthma
- ❑ Emphysema
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Cataracts
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Osteoporosis
- ❑ Colitis
- ❑ Anemia
- ❑ Anxiety
- ❑ Hepatitis
- ❑ Stomach or peptic ulcer
- ❑ Rheumatic fever
- ❑ Depression
- ❑ HIV/AIDS

Other medical conditions (please list):

1.) ____

2.) ____

3.) ____

4.) ____

5.) ____

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age (s)	Health Problems	Age(s) at death	Cause
Father				
Mother				
Siblings				
Children				

PATIENT NAME: ____ DOB: ____/____/____

PATIENT HISTORY FORM

SOCIAL HISTORY

	Do you currently use this?	Age when you first used this:	How much & how often do you use this?	How many years have you use this?	When did you last use this?
ALCOHOL	Yes □ No □				
TOBACCO	Yes □ No □				
DRUG	Yes □ No □				

SURGICAL HISTORY

- ❑ Appendix removed
- ❑ Cardiac stent/catheterization/bypass
- ❑ Cesarean Section x_____
- ❑ Gallbladder ________________________________
- ❑ Hysterectomy ________________________________
- ❑ Tonsillectomy ________________________________

Other:____

____

SYSTEMS REVIEW

Do any of the following symptoms relate to the reason for your visit today?

GENERAL

- ❑ Recent weight gain; how much____
- ❑ Recent weight loss: how much____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

MUSCLE/JOINTS/BONES

- ❑ Numbness
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

Where?

NERVOUS SYSTEM

- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss

STOMACH AND INTESTINES

- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Yellow jaundice
- ❑ Constipation

PSYCHIATRIC

- ❑ Depression
- ❑ Excessive worries
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep
- ❑ Difficulties with sexual arousal
- ❑ Poor appetite
- ❑ Food cravings
- ❑ Sensitivity
- ❑ Thoughts of suicide / attempts
- ❑ Stress
- ❑ Irritability
- ❑ Poor concentration
- ❑ Hallucinations

PATIENT NAME: ____ DOB: ____/____/____

PATIENT HISTORY FORM

EARS

- ❑ Ringing in ears
- ❑ Loss of hearing

EYES

- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness

THROAT

- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing
- ❑ Pain in jaw

HEART AND LUNGS

- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Swollen legs or feet
- ❑ Cough

- ❑ Persistent diarrhea
- ❑ Blood in stools

SKIN

- ❑ Hair loss
- ❑ Color changes of hands or feet
- ❑ Redness
- ❑ Rash
- ❑ Nodules/bumps

Blood

- ❑ Anemia
- ❑ Blood clots

KIDNEY/URINE/BLADDER

- ❑ Frequent or painful urination
- ❑ Blood in urine

DATE OF:

Tetanus Vaccine: ____/____/____

Pneumonia Vaccine: ____/____/____

Shingles Vaccine: ____/____/____

Colonoscopy: ____/____/_____

Bone Density: ____/_____/_____

- ❑ Rapid speech
- ❑ Guilty thoughts
- ❑ Paranoia
- ❑ Mood swings
- ❑ Anxiety

WOMEN ONLY

- ❑ Irregular periods
- ❑ Bleeding between periods
- ❑ PMS
- ❑ Abnormal Pap smear

Age at 1st period: _____

Normal Cycles: Y / N

Total # Pregnancies: ______

Vaginal Deliveries: ______

C/Section Deliveries: _____

Miscarriages: _____

Abortions: _____

Menopause? ______What age? _____

Hormone Replacement? Y / N

Mammogram: ____/_______

Pap Smear: ___/_______

Date of last period: ____/_____/____

PATIENT NAME: ____ DOB: ____/____/____

MEDICAL RECORDS RELEASE FORM

By signing this form, I authorize the release of confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name: ________________________________ Date of Birth: ____________

The information you may release subject to this signed release form is as follows:

- ☐ Complete Records
- ☐ History & Physical
- ☐ Progress Notes
- ☐ Care Plan
- ☐ Lab Reports
- ☐ Radiology Reports
- ☐ Pathology Reports
- ☐ Medication Records
- ☐ Operative Reports
- ☐ Hospital Reports
- ☐ Other: ____________________________

Requesting the release of my protected health information:

From : ____

Phone: ____________________________ Fax: ____________________________

Release To: Mt. Juliet Health and Wellness, LLC
1097 Weston Drive Ste. B
Mt. Juliet, TN 37122
Fax: 615-288-4133 ***DO NOT FAX MORE THAN 10 PAGES-Please mail.***
Phone: 615-553-5002

The purpose/reason for this release of information is as follows:

____

____________________________ ____________________________

Patient Name | Signature of Patient or Representative

____________________________ ____________________________

Date | Relationship to Patient

PATIENT FINANCIAL POLICY

Regarding Insurance:

As a courtesy to our patients, we gladly file your insurance claims for you. However, per our contract with your insurance company, ***all co-payments, co-insurance and deductible fees are due at the time of service.*** ***The balance is your responsibility whether your insurance company pays or not.*** If your insurance company has not paid your account in full within 45 days, the balance will be automatically due and we will expect payment from you in full at that time. We will continue to re-file and work with you and your insurance company to get the payment due and reimburse you, if needed.

Collection Charges and Legal Fees:

In the event your account is placed with an outside agency for collection, you agree to pay all collection costs, court costs and attorney fees incurred to collect your account. Carrying a balance with this office constitutes a credit transaction and as such, you authorize us, or our agent, to report credit activity to the credit bureaus. You also authorize us, or our agent, to check for address and employment should that be necessary for the collection process. **Furthermore, if your account is placed with an outside collection agency, you will not be able to schedule any further appointments with us, until your debt is paid in full.**

Cancellation / No Show Policy:

A fee of $25.00 will be issued to your account ***if an appointment is cancelled within 24 hours of the scheduled time OR you do not show up for your appointment. A fee of $100.00 will be issued*** to your account ***if an annual exam or procedure is cancelled within 24 hours of the scheduled time or you do not show up for your appointment.*** These fees are non-negotiable and will need to be paid ***BEFORE*** you will be able to be seen again by a provider.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

By signing below, you are stating that you have read the above information, understand your part and agree.

Patient Signature: ____

Printed Name: ______________________________ Date: ________________

NOTICE OF PRIVACY-PLEASE RETAIN FOR YOUR RECORDS

THIS NOTICE DESCRIBES HOW MT. JULIET HEALTH AND WELLNESS (MJHW) MAY USE AND DISCLOSE YOUR HEALTHCARE INFORMATION AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Mt. Juliet Health and Wellness is required by law to maintain the privacy of your protected health information. This information consists of all records related to your health, including demographic information, created by MJHW. An individual may obtain a copy of the current Notice from our office at any time.

Uses and Disclosures of Your Protected Health Information not requiring your consent:
MJHW may use and disclose your protected health information, without your written consent or authorization, for certain treatment, payment and healthcare operations. There are certain restrictions on uses and disclosure of treatment recorded which included registration and all other records concerning individuals who are receiving, or who at any time have received services or mental illness, developmental disabilities, alcoholism, or drug dependence. There are also restrictions on disclosing HIV test results.
Treatment may include:

Providing, coordinating, or managing healthcare and related services by one or more healthcare providers.
Consultations between healthcare providers concerning a patient.
Referral to other providers for treatment.
Referral to nursing homes, foster care homes, or home health agencies.

Payment activities may include:

Activities undertaken by MJHW to obtain reimbursement of services provided to you.
Determining your eligibility for benefits or health insurance coverage.
Collection activities to obtain payment for services provided to you.
Reviewing healthcare services and discussing with your insurance company the medical necessity of certain services or procedures, coverage under your health plan, appropriateness of care, of justification of charges.
Obtaining pre-certification and pre-authorization of services to be provided to you.

Healthcare operation may include:

Contacting healthcare providers and patients with this information about treatment alternatives, conducting quality assessment and improvement activities.
Protocol development, case management, or care coordination.
Conducting or arranging for medical review, legal review and auditing functions.

We may not disclose your protected health information to family members or friends who may be involved with your treatment or care without your written permission. Health information may be released without written permission to a parent, guardian or legal custodian of a child; the guardian of an incompetent adult; the healthcare agent designated in a incapacitated patient's healthcare power of attorney of the personal representative or spouse of a deceased patient.

There are additional situations when MJHW is permitted or required to use or disclose your protected health information without your consent or authorization. Examples include the following:

As permitted or required by law. In certain circumstances we may be required to report individual health information to legal authorities, such as law enforcement officials, court officials or government agencies. We are required to or any other wounds to law enforcement officials if there is reasonable cause to believe that wound occurred as a result of a crime. Mental health records may be disclosed to law enforcement authorities for the purpose of reporting an apparent crime on the premises.
For public health activities. We may release healthcare records, with the exception of treatment records, to certain government agencies or public health authority authorized by law upon receipt of written request from that agency. We are required to report positive HIV test results to the state epidemiologist. We may also disclose HIV test results to other providers or persons when there has been or will be risk of exposure.

THIS NOTICE IS PREPARED IN ACCORDANCE WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT 45 C.F.R. 164.520.

We may report to the state epidemiologist the name of any person known to have been significantly exposed to a patient who tests positive for HIV. We are required by law to report suspected child abuse and neglect and suspected abuse of an unborn child, but cannot disclose HIV test results in connection with the reporting or prosecution of alleged abuse or neglect. We may release healthcare records, including treatment records and HIV test results, to the Food and Drug Administration when required by federal law. We may disclose healthcare records, except for HIV test results, for the purpose of reporting elder abuse or neglect, provided the subject of the abuse or neglect agrees, or if necessary to prevent serious harm. Records may be released for the reporting of domestic violence if necessary to protect the patient or community from imminent and substantial danger.

For health oversight activities:

We may disclose healthcare records, including treatment records, in response to a written request by any federal or state governmental agency to perform legally authorized functions, such as management of audits, financial audits, program monitoring and evaluation, and facility or individual licensure or certification. HIV test results may not be released to federal or state governmental agencies, without written permission, except to the state epidemiologist for surveillance, investigation or to control communicable diseases.

Judicial and Administrative Proceedings:

Patient healthcare records, including records and HIV test results, may be disclosed pursuant to a lawful court order. A subpoena signed by a judge is sufficient to permit disclosure of all healthcare records except for HIV test results.

For activities related to death:

We may disclose patient healthcare records, except for treatment records, to a coroner or medical examiner for the purpose of completing a medical certificate or investigating a death. HIV test results may be disclosed under certain circumstances.

For research:

Under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct research.

To avoid a serious threat to health or safety:

We may report a patient's name and other relevant data to the Department of Transportation if it is believed the patient's vision or physical or mental condition affects the patient's ability to exercise reasonable or ordinary control over a motor vehicle. Healthcare information, including treatment records and HIV test results may be disclosed if necessary to protect the patient or community from imminent and substantial danger.

For Workers Compensation:

We may disclose your health information to the extent such records is reasonably related to an injury.

MJHW will not make any other use of disclosure of your protected health information without your written authorization. You may revoke such authorization at any time, except to the extent that MJHW has taken in action in reliance thereon. Any revocation must be in writing.

Your Rights Regarding Your Protected Health Information:

You are permitted to request that restrictions be placed on certain users or disclosures of your protected health record by MJHW to carry out treatment, payment or healthcare operations. You must request such a restriction in writing. We are not required to agree to your request, but if we do agree, we must adhere to the restriction except when your protected health information is needed in an emergency treatment situation. In this event, information may be disclosed only to healthcare providers treating you. A restriction would not apply when we are required by law to disclose certain healthcare information.
You have the right to review and/or obtain a copy of your healthcare records, with exception of psychotherapy notes or information compiled for use (or anticipation for use) in a civil, criminal, or administrative action or proceeding. MJHW may deny access under other circumstance, in which case you have the right to have such a denial reviewed. We may charge a reasonable fee for copying your records. You may request that MJHW send protected health information, including billing information, to you by alternative means or to alternative locations. You may also request MJHW not send information to a particular address or location or contact you at a specific location. This request must be submitted in writing. We will accommodate reasonable requests made by you. You have the right to request that MJHW amend portions of your healthcare records, so long as such information is maintained by us. You must submit this request in writing, and under certain circumstances the request may be denied. You may request to receive an accounting disclosure of your protected medical record made by MJHW for six years prior to the date of the request, beginning with disclosure made after March 1, 2017. We are not required, however, to records disclosures we make pursuant to a signed consent or authorization. You may request and receive a paper copy of this Notice, if you had previously received one electronically.
Any person or patient may file a complaint with MJHW and/or the Secretary of Health and Human Services if they believe their privacy rights have been violated. Please contact the Privacy Officer at Mt. Juliet Health and Wellness.
It is the policy of MJHW that no retaliatory action will be made against an individual who submits or conveys a complaint of suspected or actual non-compliance or violation of the privacy standards.

This Notice of Privacy Practices Mt. Juliet Health and Wellness March 1st, 2017

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ________________________________, acknowledge that I have received a copy of Mt. Juliet Health and Wellness' notice of Privacy Practices. This notice describes how Mt. Juliet Health and Wellness may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

Signature of Patient/Patient Representative: ______________________________ Date: __________

Relationship if not patient: ____

Employee Witness: ____ Date: __________

HOW I PREFER TO BE CONTACTED

Leave **DETAILED** message at:

- Cell: _____________________________
- Home: ___________________________
- Work: ___________________________

Leave basic voicemail to call office ONLY:

- Cell: _____________________________
- Home: ___________________________
- Work: ___________________________

Written Communication:

- Home address in chart
- Other address: ____
- Email: ____

My medical information may be released to the following people:

____

I verify the accuracy of the above information, and authorize the release of any medical information to any physician and insurance carriers.

A copy of this authorization may be used in lieu of the original.

Signature of Patient: _______________________________________ Date: ________________