His Hands Health Care Patient Intake

First Name: _____ Last Name: _____

Date of Birth: _____ SSN: _____

Phone: _____ Cell: _____

Home Address: _____ Apt# _____

City: _____ State: _____ Zip: _____

Email Address: _____

Parent or Guardian Information if patient is under 18 years of age

First Name: _____ Last Name: _____

Date of Birth: _____ SSN: _____

Phone: _____ Cell: _____

Home Address: _____ Apt# _____

City: _____ State: _____ Zip: _____

Email Address: _____

Emergency Contact

Name: _____ Relationship: _____

Phone: _____

Preferred Pharmacy

Pharmacy Name: _____ Phone: _____

His Hands Health Care

Urgent Care and Primary Care

Past Medical History

Eyes
- ☐ Blindness
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Wears glasses/contacts
- ☐ Macular degeneration
- ☐ Diabetic retinopathy
- ☐ Retinal disease
- ☐ Trauma

Ears
- ☐ Wears hearing aids
- ☐ Tinnitus
- ☐ Vertigo
- ☐ Meniere's disease

Nose/Sinuses
- ☐ Allergic rhinitis
- ☐ Sinus infections
- ☐ Nosebleeds

Mouth/Throat/Teeth
- ☐ Wears dentures
- ☐ Oral cancer

Infection
- ☐ HIV
- ☐ Tuberculosis

Cardiovascular
- ☐ Aortic aneurysm
- ☐ Chest pain
- ☐ Blood clot
- ☐ Irregular heart rhythm
- ☐ High blood pressure
- ☐ Murmur
- ☐ Heart attack
- ☐ Heart failure
- ☐ High cholesterol
- ☐ Other heart disease

Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ COPD
- ☐ Pneumonia

Gastrointestinal
- ☐ Cirrhosis
- ☐ GERD
- ☐ Celiac disease
- ☐ Barrett's esophagus
- ☐ Gallbladder disease
- ☐ Heartburn
- ☐ Hepatitis
- ☐ Hernia

Gastrointestinal continued
- ☐ Ulcer
- ☐ Hemorrhoids
- ☐ IBS
- ☐ Constipation
- ☐ Diarrhea
- ☐ Chrohn's disease
- ☐ Ulcerative colitis
- ☐ Diverticulitis/Diverticulosis

Genitourinary
- ☐ Inguinal hernia
- ☐ Kidney stones
- ☐ STDs
- ☐ UTIs
- ☐ Prostate problems
- ☐ Other kidney disease

Gynecology
- ☐ PCOS
- ☐ Endometriosis
- ☐ Overactive bladder
- ☐ Uterine fibroids

Musculoskeletal
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Arthritis
- ☐ Degenerative disk
- ☐ Radiculopathy
- ☐ Sciatica

Dermatology
- ☐ Psoriasis
- ☐ Skin cancer
- ☐ Dermatitis
- ☐ Other skin conditions

Neurology
- ☐ Seizures
- ☐ Migraines
- ☐ Stroke
- ☐ TIA
- ☐ Parkinson's Disease
- ☐ Cerebral Palsy
- ☐ Insomnia
- ☐ Neuropathy
- ☐ Sleep Apnea
- ☐ Tremor
- ☐ Head Trauma
- ☐ Aneurysm

Psychiatric
- ☐ Bipolar disorder
- ☐ Depression
- ☐ Anxiety
- ☐ ADHD
- ☐ PTSD
- ☐ Schizophrenia

Endocrine
- ☐ Type 1 diabetes
- ☐ Type 2 diabetes
- ☐ Thyroid disease
- ☐ Parathyroid disease
- ☐ Addison's disease
- ☐ Hypoglycemia
- ☐ Pre-diabetes
- ☐ Low testosterone
- ☐ Insulin resistance

Hematology/Oncology
- ☐ Anemia
- ☐ Cancer
- ☐ Bleeding disorder
- ☐ Vitamin D deficiency

☐ **Other/Explain** _____

Past Surgical History

- ☐ Aneurysm repair
- ☐ Appendectomy
- ☐ Back surgery
- ☐ Bariatric surgery
- ☐ Tubal ligation
- ☐ Mastectomy
- ☐ CABG
- ☐ Carotid stent
- ☐ Carpal tunnel surgery
- ☐ Cataract/lens surgery
- ☐ C-section
- ☐ Cholecystectomy
- ☐ Dilation and curettage
- ☐ Hemorrhoid surgery
- ☐ Hip replacement
- ☐ Hysterectomy
- ☐ Hernia repair
- ☐ Knee replacement
- ☐ Lasik
- ☐ Laminectomy
- ☐ Nasal surgery
- ☐ Prostate surgery
- ☐ Rotator cuff surgery
- ☐ Sinus surgery
- ☐ Spinal fusion
- ☐ TAH-BSO
- ☐ TURP
- ☐ Tonsillectomy
- ☐ Vasectomy

Other _____

Family History

- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ CAD <age 55
- ☐ COPD
- ☐ Diabetes
- ☐ Heart attack
- ☐ Heart disease
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Mental illness
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Breast cancer
- ☐ Colon cancer
- ☐ Ovarian cancer
- ☐ Prostate cancer
- ☐ Uterine cancer

Other _____

List of home medications

1
2
3
4
5
6
7
8
9
10

Allergies and Reactions

1
2
3
4
5
6
7
8
9
10

Pharmacy _____

Patient Rights Statement

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records- psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to members of friends who may be involved in your care of for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restrictions, and whom they apply.

Your provider is not required to agree to a restriction that you request. If your provider believes your restriction is unreasonable and it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted If you wish, you then have the right to use another healthcare professional.

You have the right to request and receive confidential communications from us by alternative means or at alternative location. You have the right to obtain a paper copy of this notice from us. Upon request, even if you have agreed to accept this notice alternatively, i.e, electronically or by fax.

You have the right to have your provider amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints- You may complain the U.S. Department of Health and Human Services, 200 Independence Avenue, S.W. Room 509F, HHH Building, Washington, D.C. 20201 if you believe your privacy rights have been violated by us; OR you may file a complaint with us by notifying our HIPAA Privacy Officer. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our privacy officer.

Your signature below is only acknowledgement that you have received this Notice of your Rights

Printed Name_____Signature_____Date_____

His Hands Health Care

Financial Agreement

Patient Name: _____

Thank you for Choosing His Hands Health Care as your health care provider. **Please read each statement carefully and initial acknowledging your understanding of each statement.** This policy has been initiated to ensure that financial payments due are recovered to allow us to continue to provide excellent medical care for all of our patients. Please contact our office with any billing questions and our billing department will be happy to assist you.

1._____ I understand that if I do not have my insurance card and or co-payments, that my appointment may be rescheduled until such time that I can provide the required documents and or payment.

2._____ I understand that His Hands Health Care will collect all copayments at the of the visit and any procedure deductibles up to an amount equal to payment in full for the planned procedure code. Payment in full and expected coinsurance payment responsibility are determined by the anticipated billing codes, details of your insurance policy and agreement between your insurance company and His Hands Health Care. Any overpayment to your account will be refunded to you at your request after payment and/or remittance has been received from your insurance company.

3._____ I understand that a $25 service fee will be added for any checks returned for any reason and I will be responsible for payment of this fee and the amount of the returned check. NSF checks must be redeemed with certified funds (cashier's check, money order, or cash).

4._____ I understand that if I am unable to make a scheduled appointment that I need to contact His Hands Health Care at least 24 hours prior to my scheduled appointment time. Due to high demand for appointments, missed appointments will prevent us from scheduling appropriately and keep others in need of urgent care from being seen. A $25 FEE WILL BE ASSESSED FOR ALL MISSED APPOINTMENTS.

5._____ His Hands Health Care will allow 60 days from the date of filing for my insurance company to process or pay a claim. State law allows insurance companies operating in the state of Tennessee no more than 60 days to process claims. It is my responsibility to provide my insurance company with requested information needed to process a claim for services. It is also my responsibility to notify His Hands Health Care if there is any change in my insurance coverage, residence, or phone number. **ULTIMATELY, IT IS UP TO ME TO KNOW MY INSURANCE BENEFITS.**

I have read and agree to all the provisions of the above financial policy. I understand that I am ultimately responsible for all professional fees incurred for professional services performed by the attending provider.

Signature of Responsible Party: _____ Date:_____

ASSIGNEMENT OF BENEFITS

We require insured patients to complete assignment of benefits authorizing insurance to remit payment to physician's office.

I hearby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, private insurance, and any other health plans to: His Hands Health Care. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges where or not paid by said insurance. I hereby authorize said assignee to release all medical information necessary to secure the payment.

Signature of Responsible Party: _____ Date:_____

His Hands Health Care: HIPAA Notice of Privacy Practices

Patient Name:_____THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for purposes required by law. It also describes your rights to access and control your PHI. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information (PHI)

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purposes of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care for you; OR your protected health information to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for medical procedures may require that your relevant protected health information be disclosed to the health plan to establish medial necessity.

Healthcare Operations: We may use or disclose, as needed your protected health information in order to conduct normal operations of the physician's practice. The activities include, but are not limited to:

- Quality Control
- Licensing
- Employee reviews
- Training medical students

For example, we may disclose your protected health information to medical students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you may be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary to contact you for test results or to remind you of your appointment.

We may use or disclose your protected health information in the following situation without your authorization. These situations include: as required by Law, Public Health Issues, Communicable Disease, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, Organ Donation, Research, Criminal Activity, Military Activity and National Security, Worker's Compensation, Inmates, Required Uses and Disclosures, Under Lay, we must make a disclosure to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirement of section 164.500.

Patient Name_____

Patient Signature_____

Date _____