PLEASE COMPLETE ALL QUESTIONS AND RETURN TO FRONT DESK WITH MEDICATION LIST

PARIS PULMONARY CLINIC

NAME: _____ DOB: _____

PHARMACY NAME/TOWN: _____

1. LIST ANY SIGNIFICANT ALLERGIES (ex: MEDICATION, DYE, ADHESIVE): _____
2. BRIEFLY DESCRIBE WHY YOU ARE HERE TODAY: _____

---

3. MARK ANY OF THE FOLLOWING SYMPTOMS YOU ARE EXPERIENCING: (CIRCLE ALL THAT APPLY)

INSOMNIA___	HEADACHES___	ITCHING___	NAUSEA___
SLEEP APNEA___	SINUS PRESSURE___	DIZZINESS___	VOMITING___
SNORING___	CHEST PAIN___	FAINTING___	EARACHE___
CHILLS___	HEART PALPITATION___	WEAKNESS___	OTHER_____
SWELLING___	RASH___	SWEATING___	_____

4. AT ANY TIME HAVE YOU HAD ANY OF THE FOLLOWING: (CIRCLE ALL THAT APPLY)

COPD___	DEPRESSION___	HYPERTHYROIDISM___	SEIZURES___
LIVER PROBLEMS___	ANXIETY___	ASTHMA___	ARTHRITIS___
REFLUX/HEARTBURN___	HEART DISEASE___	OSTEOPOROSIS___	CANCER (TYPE)___
ANEMIA ___	HIGH BLOOD ___	EMPHYSEMA___	_____
DIABETES___	PRESSURE	KIDNEY PROBLEMS___	OTHER_____
HIGH CHOLESTEROL___	HYPOTHROIDISM___		_____

5. IMMUNIZATIONS: (CIRCLE ONE & FILLE IN DATE IF APPLICABLE)

PNEUMONIA?	YES	NO	*MONTH_____ YEAR _____
FLU?	YES	NO	*MONTH_____ YEAR _____
PREVNAR?	YES	NO	*MONTH_____ YEAR _____

6. NEEDED ASSISTANCE: (CIRCLE ONE & FILL IN BLANKS IF APPLICABLE)

DO YOU USE OXYGEN? YES NO *IF YES: HOW MANY LITERS? _____AT BEDTIME OR PRN OR 24/7

DO YOU USE NEBULIZER? YES NO *IF YES: HOW MANY TIMES A DAY? _____

DO YOU USE AN INHALER? YES NO

DO YOU USE A MACHINE FOR SLEEP APNEA? YES NO

*IF YES: What machine do you use (circle one)? CPAP BIPAP TRILOGY/NIV

What are the settings?_____

What company (circle one)? AMS UNITED MEDICAL/LINCARE HMP OTHER: _____

PLEASE COMPLETE ALL QUESTIONS AND RETURN TO FRONT DESK WITH MEDICATION LIST

PARIS PULMONARY CLINIC

NAME: _____ DOB: _____

7. SURGICAL HISTORY: ("X" ALL THAT APPLY)

BACK___	THROID___	BREAST BIOPSY___	LIFEPORT___	GALL BLADDER___
CATARACT___	WRIST___	MASTECTOMY___	LOBECTOMY___	GI SURGERY___
FOOT___	FACIAL___	C-SECTION___	LUNG BIOPSY___	HERNIA REPAIR___
HAND___	NECK___	D&C___	LUNG SURGERY___	POLYP REMOVAL___
HIP___	NOSE___	HYSTERECTOMY___	CABG___	PROSTATECTOMY___
KNEE___	THROAT___	TUBAL___	HEART SURGERY___	TURBT___
SHOULDER___	TONSIL___	BRONCHOSCOPY___	APPENDECTOMY___	VASECTOMY___
SINUS___	ORAL/TOOTH___	DEFIBRILLATOR___	COLONOSCOPY___	OTHER:_____

8. FAMILY HISTORY: APPLIES TO YOUR PARENTS AND GRANDPARENTS ONLY: ("X" ALL THAT APPLY)

ALZHEIMERS___	DEPRESSION___	HIGH BLOOD PRESSURE___	SEIZURE DISORDER___
ANXIETY___	DIABETES___	HYPOTHYROIDISM____	STROKE___
ARTHRITIS___	EMPHYSEMA___	HYPERTHROIDISM___	CANCER (TYPE):_____

HIGH CHOLESTEROL___ HEART DISEASE ___ LIVER DISEASE___ _____

COPD ___

9. SOCIAL HISTORY: ("X" CURRENT MARITAL/EMPLOYMENT STATUS)

SINGLE___ MARRIED___ DIVORCED___ WIDOWED___

STUDENT___ FULL TIME___ PART TIME___ RETIRED___ DISABLED___ UNEMPLOYED___

****WHERE DO/DID YOU WORK?_____**
****WHAT WAS YOUR JOB TITLE?_____**
****HOW LONG DID YOU WORK THERE?_____**

CURRENT SMOKER___ FORMER SMOKER___ NEVER SMOKER___ VAPE___ DIP/CHEW___ AROUND 2ND HAND SMOKE___

****HOW MANY PACKS PER DAY DO/DID YOU SMOKE? ____ _____****HOW MANY YEARS HAVE/DID YOU SMOKE?_____**
****APPROX. WHAT YEAR DID YOU QUIT IF FORMER?_____**

DAILY ALCOHOL USE ___	OCCASSIONAL ALCOHOL USE___	NO ALCOHOL USE___
DAILY CAFFEINE USE___	OCCASSIONAL CAFFEINE USE___	NO CAFFEINE USE___
DAILY ILLICIT DRUG USE ___	OCCASSIONAL ILLICIT DRUG USE___	NO ILLICIT DRUG USE___

Patient Information

HC MEDICAL MC CLINICS

Please Print

Date: _____
Primary Care Provider: _____
Local Pharmacy: _____ Mail order: _____
PMB Consent: I consent to have my prescriptions list electronically pulled from my pharmacy: No☐ Yes☐
Last Name: _____ First Name: _____ MI: _____
DOB: _____ SSN: _____ Driver's License #: _____
Language: Spanish☐ English☐ Other☐ Sex: Male☐ Female☐ Other ☐ Decline to answer ☐
Mailing Address: _____ City: _____
State: _____ Zip: _____ Primary Phone #: _____ Home☐ Cell☐
Employer: _____ Employer Phone #: _____
Employer Address: _____ City: _____
State: _____ Zip: _____ Disability Status: No, I am NOT disabled☐ Yes, I am disabled☐

Mother's Name (*if minor*): _____ DOB: _____ SSN: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Father's Name (*if minor*): _____ DOB: _____ SSN: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____

Marital Status: Separated☐ Widowed☐ Divorced☐ Single☐ Married☐
Race: Declined☐ Other☐ Native Hawaiian/Pacific Islander☐ Caucasian/White☐ Native American☐ Asian☐ American Indian/Alaskan Native☐ African American/Black☐
Ethnicity: Not Hispanic/Latino☐ Hispanic/Latino☐

Person Responsible For Bill: _____
Primary Ins: _____ Subscriber ID: _____ Group ID: _____
Name of Subscriber: _____ DOB: _____
Secondary Ins: _____ Subscriber ID: _____ Group ID: _____
Name of Subscriber: _____ DOB: _____

Do you have a living will or POA? No☐ Yes☐
Is this visit accident related? Yes☐ No☐ If yes, accident details: _____

Assignment of Insurance Benefits and Authorization to Obtain or Release Patient Information

I hereby authorize the physician's office to release such information as may be necessary for claims to the insurance companies listed above. I also hereby authorize payment directly to the physician for any benefits otherwise payable directly to me, but not to exceed the regular charges for this period. I am financially responsible to the physicians for charges not covered by the assignment. Patients not covered by insurance are responsible at the time of service for charges incurred or arrangements for payment must be made with the business office. I authorize the physician's office to release or obtain such information as may be necessary to assist in my medical treatment, including available prescription history from external sources.

I understand concealment of insurance is considered fraud and will be grounds for instant dismissal from practice as well as possible criminal penalties. I agree to notify HCMC & affiliated clinics immediately of any change in insurance status.

Signature: _____ Relationship to Patient: _____

HC MEDICAL
MC CLINICS

Consent to Contact

We will need to contact you from time to time about your care at Henry County Medical Center or its affiliated clinics. To do so in the most effective manner, we ask that you provide us with your preferred phone number, workplace phone number, emergency contact and a number where they can be reached in case the need arises. We would also like you to include your email and preferred method of contact. Please help us update our records by providing the information below. Thank you.

Primary Phone Number: _____ Home ☐ Cell ☐

Secondary Phone Number: _____ Home ☐ Cell ☐

Work Phone Number: _____

Emergency Contact Name & Phone Number: _____

How is this person related to you? _____

Emergency Contact Name & Phone Number: _____

How is this person related to you? _____

I give permission to HCMC Clinics to disclose my Protected Health Information to the person I have listed above as my emergency contact. I understand that I may revoke or change this authorization at any time by filling out another "Consent to Contact" form.

No☐ Yes☐

Preferred Communications: Email ☐ Telephone ☐ Text ☐

Email: _____

I, _____, acknowledge and agree that Henry County Medical Center or its affiliated clinics may contact me or my guardian via text (SMS) or voice communications at the telephone number(s) I have listed as my primary and secondary phone numbers for purposes of confirming or rescheduling appointments, for reporting the results of laboratory or diagnostic results, or for responding to or initiating communications related to my health care. I understand that messages may be left on an answering service or sent via email or SMS to a number or address I have provided in regards to my recent or upcoming visit(s), and automated messages communicating normal laboratory results may be delivered to any party answering the number(s) I have provided. I understand I have the right to request to opt-out of automated calls at any time.

I further acknowledge and agree that Henry County Medical Center and any affiliates or vendor thereof, including collection or billing companies, may contact me or my guardian by telephone or text message to any telephone number I have provided to you, and any other telephone number associated with my account, including wireless or mobile telephone numbers. I further agree that you may use any method of contact to these numbers I have provided, such as an Automated Telephone Dialing System (ATDS) or prerecorded message. I also agree that I will notify Henry County Medical Center or its affiliated clinics if I have given up ownership or control of any such phone number that I have listed above.

_____

Patient Signature Print Name Date

HC MEDICAL
MC CLINICS

Consent for Medical Treatment

I hereby authorize Henry County Medical Center Clinics to render care, including diagnostic procedures, surgical and medical treatment, the use of medication, and other treatments deemed generally necessary in the professional judgment of Henry County Medical Center Hospital and Clinics which include the following: Innovative Orthopedics, Transitions Health, Eagle Creek, Kentucky Lake Urology, Paris Women Center, Paris Pulmonary and Paris Pediatrics. I understand that I have the right to participate actively in my healthcare, and I am encouraged to ask questions of anything unclear to me. I acknowledge that no guarantees have been or will be made to me as to the effect of such examinations or treatments on my conditions or treatments. I understand that I have the right to refuse any services at any time.

I understand that prescriptions will be sent electronically to my pharmacy or called into the pharmacy. All prescriptions issued will comply with State and Federal Law concerning the use of scheduled medications. This includes verification of my previous controlled medication history via the Tennessee Department of Health Controlled Substance Monitoring Database (CSMD). I agree to fully disclose all prescriptions for controlled substances I have received within the past 60 days.

I authorize the use of faxing or email to send my information to myself or to other parties that have a right to receive my information. I understand that every effort is made to protect my privacy, however, no absolute privacy guarantee is given when faxing or email is used.

Risk to women who are or may be pregnant: I understand that there are severe risks to unborn fetuses that are exposed to X-Rays and to the best of my knowledge I am not pregnant or believe there is any possibility that I may be pregnant. I will alert staff if this changes in the future.

I certify that I have read and understood the above statements and that I am the patient or the patient's legal guardian. This consent will remain effective until I revoke it in writing, which I may do so at any time.

Patient Signature Print Name Date

HCMC MEDICAL CLINICS

Patient Portal

The Patient Portal is a convenient and secure way for patients to access their health records, pay bills, and ask questions. You may sign up for this service by providing us with your email address. If you opt in for this service you will be sent an invitation and temporary password.

☐YES, I would like to participate in using the Patient Portal.

Print Name: _____ DOB: _____

Email Address: _____ *(You may update your email at any time)*

Is the patient a minor child or adult for whom you are the legal guardian authorized to make healthcare decisions? Yes☐ No☐

Name of primary email account holder: _____
Relationship to Patient: _____

I understand that the patient's protected health information (PHI) is protected by federal and state law. To safeguard this information, I understand that all PHI transmitted from medical record to my patient portal complies with federal and state regulations for the secure transmission of PHI.

I further understand that the correct operation of a patient portal requires me to maintain a valid email address and to update that address with my provider as needed. Access to my secure portal is an optional service, and I or my provider may discontinue participation in this service at any time. Participation in the patient portal is NOT necessary to receive medical care from HCMC Physicians Clinics.

I agree that it is my responsibility to safeguard the login information for the email address that I have provided, and that other individuals who have access to this email address may be able to use it to access my patient portal.

☐NO, I would not like to participate in using the Patient Portal. I understand that I may change my mind at any time.

If you need your provider to discuss treatment information with other providers, a current Release of Information Form is required.

I hereby authorize Henry County Medical Center's healthcare clinics to send electronic communications and health records to me and HCMC's authorized vendor (MyHealthRecord), electronically via a patient portal. I understand that communication about the patient portal will be sent to me at the email address that I provided above.

Patient Signature Print Name Date

HC MEDICAL
MC CLINICS

Notice of Privacy Practices

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. You have the right to obtain a paper copy of this notice.

This Notice describes the privacy practices of Henry County Medical Center Clinics and the health care professionals who provide services.

Patient Health Information

Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We Use Your Patient Health Information

We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment, and Health Care Operations

Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.

Payment: We will use and disclose your health information for payment purposes **unless you have paid in full for a service and request the information not to be disclosed.** For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan. If you have a legal claim against a third party for causing your injuries, we may file a hospital lien in court to collect payment from them.

Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to access the care and outcomes of your case and others like it.

Special Uses

We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest of you.

Other Uses and Disclosures

We may use or disclose identifiable health information about your for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes.

- *Required by Law:* We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
- *Public Health Activities:* As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
- *Health oversight:* We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
- *Judicial and administrative proceedings:* We may disclose information in response to an appropriate subpoena or court order.
- *Law enforcement purposes:* Subject to certain restrictions, we may disclose information required by law enforcement officials.
- *Deaths:* We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.
- *Serious threat to health or safety:* WE may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- *Military and Special Government Functions:* If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
- *Research:* We may use or disclose information for approved medical research.
- *Workers Compensation:* We may release information about you to workers compensation agencies and your employer to provide benefits for work related injuries or illness.

Fundraising: We may contact you, or allow an institutionally related foundation to contact you, for fundraising purposes. You can choose not receive or opt out of any communication regarding any fundraising.

We may also ask if we can disclose limited information about you to clergy or include it in the patient directory. You may choose not to have your information available in the directory, and your information will not be given to anyone who asks about you. Under limited circumstance, we may disclose information to notify or locate your relatives or to assist disaster relief agencies.

For any other use or disclosure not described in this Notice of Privacy Practices, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Use and Disclosures that Require an Authorization

Most uses and disclosures of psychotherapy notes (where appropriate), use and disclosures for marketing purposes, and disclosures that constitute a sale of protected health information require an authorization from you and will not be done until an authorization is signed by you giving the Medical Center permission to do so.

Individual Rights

You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.

Request Restrictions: You may request restrictions on certain use sand disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.

You have the right to restrict a disclosure or not to have any of the health information released to a health plan where you have paid in full for the health care item or service.

Where precertification is required for a health plan to pay for services, the Medical Center will require the individual to settle payments for the care prior to providing the service and implementing a restriction.

Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.

Inspect and Obtain Copies: In most case, you have the right to look at or get a copy of your health information. There may be a small charge for copies.

Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

Accounting of Disclosures: You may request a list of instance where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Notification of Breach: You have the right to and will receive notifications of breaches of unsecured protected health information in which the information has been given to the wrong person or place.

Our Legal Duty

We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices, regarding protected health information, and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices

We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the admissions area. For more information about our privacy practices, contact the person listed below.

Complaints

If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person

If you have any questions, requests, or complaints, please contact our Privacy Officer in the Health Information Management Dept. at (731) 644-8562.

Independent Contractors

Henry County Medical Center and the physicians who practice here are independent contractors and do not hereby assume any liability for the services or conduct of the other.

Effective Date: The effective date of this Notice is 8-11-2013

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I, _____, hereby acknowledge receipt of the Notice of Privacy Practices given to me by Henry County Medical Center & Clinics.

Signed: _____ Date: _____ Time: _____

For Medical Center Use ONLY: *If not signed, document good faith efforts to obtain acknowledgement:*

_____

Person seeking acknowledgement Date

Henry County Medical Center/ Paris Pulmonary Clinic
Dr. James Carruth and Lachelle Moss FNP
301 Hospital Circle Suite 201
Paris, TN 38242
Phone (731) 641-2765
Fax (731) 641-2764

All portions of this form must be completed to constitute a valid authorization for release of health information under the Health Insurance Portability and Accountability Act (HIPPA) privacy regulations. If any field is left blank, the authorization will be considered defective.

Patient Name	Date of Birth	SSN xxx-xx-
Address		Telephone#

I authorize the use and disclosure of health information about me as described below:

Facility Authorized to Release my health Information:
Agency or Individual(s) Authorized to Receive my Health Information: Paris Pulmonary Clinic
Health Information that may be used/disclosed is limited to the following: ___Discharge Summary ___Consultation(s) ___Pathology Report ___Lab ___History&Physical ___Imaging/X-Ray ___Operative Note(s)

___Entire Record ___Other (specify) _____

Health Information that may be used/disclosed is limited to the following Treatment Dates:

Health Information to be release to the above named agency/individual is to be used/disclosed for the following purpose(s) (include Research or Marketing, if appropriate)

____Treatment/Consultation ____At request of patient ____Research ____Marketing ____Billing or Claims Payment ____Continuity of Care ____Other (specify)_____

"Health Information": Identifies you (the patient) by name, and includes other demographic information about you. "Health Information" may include, but is not limited to: medical records, x-rays films, slides, tracings, strips, etc.

I hereby discharge the releasing facility, its agents and employees from any and all liabilities, damages, and claims which mit arise from the release of information authorized herein, to include alcohol, drug abuse, communicable disease including HIV status, and/or psychiatric diagnoses complied during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies of his facility.

Protected Health Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by this privacy rule. If research-related Health Information is used or disclosed for continued research purposes, and expiration date or event does not apply.

This authorization will automatically expire 60 days after the date below (except as indicated above), unless an earlier date is specified, or the conclusion of a specified event. I understand that I have right to revoke this authorization at any time, in writing, as stated in the notice of privacy Practices, except where the facility has already made disclosures in reliance upon my prior authorization.

Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining an authorization if the Health Information portability Accountability Act prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage.
Notice to receiving agency or individual: This information is to be treated in accordance with Health Insurance Portability and Accountability Act (HIPPA) privacy regulations.

Patient's or Authorized Personal Representative's Signature	Date	Time
Relationship to Patient/Authority to Act on Patient's Behalf		Interpreter, if utilized
Witness Signature		Expiration Date of Event Duration of Care @ Paris Pulmonary Clinic