PLEASE READ THIS BEFORE PROCEEDING WITH COMPLETING THE NEW PATIENT INFORMATION PACKET.

ATTENTION TRANSITIONS HEALTH PAITENTS:

Transitions Health is NOT a chronic pain management clinic. Pain Management is a specialty in itself, much like cardiology, pulmonology, or gynecology. We do not provide this specialty service. If you are currently receiving pain management from another provider, we will gladly manage your medical conditions (diabetes, heart failure, high blood pressure, chronic lung disease, etc…) **but will not provide pain medicine.** I will not provide for pain medicines while referring you to a pain management clinic. Patients are given **ONE REFERRAL TO A PAIN CLINIC**.

WE DO NOT PROVIDE FOR CHRONIC LONG TERM ANTI - ANXIETY AGENTS.

If you need chronic anxiety medication, please seek help from a psychiatrist or psychologist or Carey Counseling Center that can help with you with this issue. Care Counseling Center takes self-referrals only, meaning you must go to their office seeking care. This includes Xanax, Ativan, Valium, etc. that are controlled substances.

WE DO NOT PROVIDE CONTROLLED SUBSTANCES FOR ADHD/ADD.

Your care to us is very important and we value you as one of our patients. Please return this courtesy of mutual respect and understanding concerning our discretion with chronic controlled substances policy. As always, it is up to the provider to prescribe your medications in a safe and therapeutic manner.

Sincerely,

Tammie Holcomb, *Doctor of Nursing Practice*
Adult-Geriatric Acute Care Nurse Practitioner

_____

Patient Signature

HC MEDICAL MC CLINICS

Patient Information

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

HIC MEDICAL
MIC CLINICS

Consent to Treatment of a Minor when Parents/Guardians are Temporarily Unavailable

The undersigned parent or legal guardian of _____ authorizes the person (s) listed below to consent to treatment of the child, including, but not limited to, emergency, x-ray, anesthetic, or surgical services when I am not immediately available in person, or by phone. It is understood that this consent is given in advance of any specific diagnosis of treatment and allows the physicians/providers to diagnose and treat the child even when the parent or guardian is not present.

Person(s) who may consent to treatment (Please Print):

Name: _____ Relation to Child: _____ Phone: _____

Name: _____ Relation to Child: _____ Phone: _____

Name: _____ Relation to Child: _____ Phone: _____

Name of Parent of Legal Guardian: _____ Relation to Child: _____

Contact Number: _____ Address: _____

City: _____ State: _____ Zip: _____

This Consent is effective until withdrawn in writing by the child's parent or guardian.

_____

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.

HC MEDICAL
MC CLINICS

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

HC MEDICAL
MC CLINICS

Clinical Intake Form

Date: _____

Patient Name: _____ DOB: _____

Chief Complaint: _____ **Date Onset:** _____

Have you ever been treated for this condition in the past? Yes ☐ No ☐ If yes, please explain _____

_____

Other Concerns: _____

Where were you getting your care before? _____

Marital Status: (circle one) Married Single Separated Widowed

If Married: Spouse name _____

How many children? _____ **How many grandchildren?** _____

Who lives at home with you? _____

Employed: (circle one) Yes No Occupation? _____

In the past 2 weeks, have you been bothered by: Little interest or pleasure in doing things?___No ___Yes

Feeling down, depressed or hopeless? ____No ___Yes

Gender Identity: *Male ☐* *Female ☐*

What sex was originally listed on your birth certificate? *Male ☐ Female ☐ Decline to answer ☐*

Tobacco Use: Yes ☐ No ☐ Former smoker ☐ If yes, how many years? _____ How much? _____
Age Start: _____ Age Stop: _____ Cigs ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew ☐

Alcohol Use: Yes ☐ No ☐ Former alcoholic ☐ Number of drinks per week: _____ Age start: ___ Age Stop: ___
Beer ☐ Wine ☐ Liquor ☐

Recreational Drugs: Yes ☐ No ☐ Have you ever used needles to inject drugs? Yes ☐ No ☐ Age Start: _____
Age Stop: _____ Marijuana ☐ Barbiturates ☐ Amphetamines ☐ Methamphetamine ☐ Opiates ☐ Cocaine ☐

Sexually Active? Yes ☐ No ☐ If yes, what contraceptive (condoms, pill, diaphragm, etc)? _____

Exercise Regularly? Yes ☐ No ☐ How often? _____ How would you rate your diet? Good ☐ Fair ☐ Poor ☐
Uses Seatbelt Regularly? Yes ☐ No ☐ **Hand Dominance?** Right ☐ Left ☐

Current Medications (please list ALL medications including over the counter, inhalers, eye drops, herbs)

Medications	Dosage

Please use the back of the paper if you need to add more medications.

Allergies

No Known Drug Allergies ☐

Medications	*Reaction*	Food	*Reaction*	Environmental	*Reaction*

Surgical History

No Surgical History ☐

Surgical Procedure	Yes	Surgical Procedure	Yes
Abdominal Surgery		Hip (Left) (Right) (Total)	
Amputation: _____		Hysterectomy (total, including ovaries)	
Aneurysm (AAA)		Hysterectomy (partial, ovaries left)	
Appendectomy		Kidney	
Biopsy (location) _____		Knee Scope (Left) (Right)	
Carpal Tunnel Release (Left) (Right)		Knee Total (Left) (Right)	
Cataract		Mastectomy (Left) (Right) (Total)	
Colonoscopy		Neck	
Coronary Bypass		Ovary Ligation (Tubal)	
Coronary Stent		Ovary Removal	
EGD (Stomach Endoscopy)		Sinus	
Foot (Left) (Right)		Shoulder Scope (Left) (Right)	
Gallbladder		Shoulder Total (Left) (Right)	
Heart Cath		Spine	
Heart Bypass		Tonsils/Adenoids	
Heart Surgery (other than coronary bypass)		Vasectomy	

Other surgeries not listed: _____

_____

Personal Medical History (Currently have or have had in the past) No Medical History to Report ☐

Condition	Yes	Comments	Conditions	Yes	Comments
Adrenal gland disease			High Cholesterol		
Alcohol Abuse			HIV/AIDS		
Allergy			Hyperthyroidism		
Anemia			Hypothyroidism		
Arthritis			Irritable Bowel Syndrome		
Asthma			Kidney Disease/Failure		
Back or neck problems			Kidney Stones		
Bladder/Kidney problems			Liver Disease		
Bleeding Tendency			Lupus		
Blood Clot/DVT (Leg) (Lung)			Migraine Headaches		
Blood Transfusion			Mitral Valve Prolapse		
Cancer			MRSA		
Cataracts			Multiple Sclerosis		
Colon Polyps			Myasthenia Gravis		
Congestive Heart Failure (CHF)			Osteoporosis		

(Cont.) Condition	Yes	Comments	Conditions	Yes	Comments
Coronary Heart Disease			Paralysis		
Depression/Anxiety			Pneumonia		
Diabetes (adult onset) (childhood onset)			Poor Circulation		
Dialysis			Prostate Nodules		
Diverticulosis			Psoriasis		
Eczema			Rash of Skin		
Emphysema/COPD			Reflux/GERD		
Enlarged Prostate			Rhythm Disturbance/AFIB		
Epilepsy/Seizures			Sickle Cell		
Fibromyalgia			Sleep Apnea		
Gallbladder Disease			Stomach Ulcer		
Glaucoma			Thyroid Nodules		
Gout			Tuberculosis		
Heart Attack			Ulcer-Gastric		
Heart Disease			Valve Disease		
Hepatitis (Type A) (Type B) (Type C)			VRE		
Hernia			Wound Infection		
High Blood Pressure					

Other medical issues not listed: _____

_____

_____

Family Medical History **Unknown ☐** **Adopted ☐**

Condition	Yes	Family Members/Comments
Alcoholism		
Alzheimers		
Asthma or Lung Disease		
Autoimmune Disease		
Cancer		
Coronary Artery Disease (Heart Attack, Angina)		
Diabetes		
Emphysema (COPD)		
Genetic Disorder (Explain)		
Heart Disease/Heart Problems		
High Blood pressure		
Kidney Disease		
Liver Disease		
Tuberculosis		
Cancer of:_____		

Significant medical history not listed: _____

_____

_____

Is there anything else you would like us to know? _____

_____

_____

_____

_____

Immunizations: Check off any vaccinations you have had. Add year, if known. Check the box if you don't know the information. ☐

Tetanus (Td)____ With Pertussis (Tdap)_____ Varicella (Chicken Pox) shot or illness____ Pneumovax (pneumonia)____
Influenza(flu shot)___ Hepatitis A___ Hepatitis B____ MMR____ Meningitis____ Zostavax(shingles)____ HPV____
COVID#1___ COVID#2___

HEALTH MAINTENANCE SCREENING TESTS:

Date of last Colonoscopy or Sigmoidoscopy? (circle one) _____ Polyp? _____No _____Yes
Date of last Lipid? _____ Abnormal? ____No ____Yes

Women only:

Date of last Mammo? _____ Abnormal? ____No ____Yes
Date of last Pap smear? _____ Abnormal? ____No ____Yes
Total number of pregnancies: _____ Number of births:_____
Date (month/day if known) of last menstrual period if you are still menstruating: _____
Age at beginning of periods (menstruation): _____
Age at end of periods (menopause): _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance and any collection fees or court costs incurred as a result of my failure to make satisfactory payments. I also authorize Transitions Health or my insurance company to release any information required to process my claims.

_____ _____

Patient Signature **Date**

Transitions Health
300 Hospital Circle, Suite 204
Paris, TN 38242
Phone (731) 641-2707
Fax (731) 641-2708
Authorization for Release of Information

I, _____; do hereby give my consent to and authorize

_____ to release unto Henry County Medical Center d/b/a

Transitions Health medical information contained my medical record complied during the

course of my treatment and do hereby release said clinic from all legal liability that may

arise from the release of the information requested. I understand that this information is to

be disclosed for my treatment at Transitions Health only. I understand that this consent is

subject to revocation by me at any time, and unless an earlier date is specified, that is

automatically expires sixty (60) days after the date affixed below.

Date: _____ D.O.B_____

Signed: _____

Relationship to Patient: Self Guardian Other

Witness: _____