THERESA BUCK'S URGENT CARE FAMILY CLINIC
REGISTRATION FORM

(Please Print)

Today's date: PCP:

PATIENT INFORMATION

Patient's last name: First: Middle: ☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ☐ Yes ☐ No If not, what is your legal name? (Former name): Birth date: / / Age: Sex: ☐ M ☐ F

Street address: Social Security no.: Home phone no.: ( )

P.O. box: City: State: ZIP Code:

Email Address: Employer: Employer phone no.: ( )

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: Birth date: / / Address (if different): Home phone no.: ( )

Is this person a patient here? ☐ Yes ☐ No

Occupation: Employer: Employer address: Employer phone no.: ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance ☐ Amerigroup ☐ Bluecare ☐ Medicare ☐ BCBS ☐ Other _____

Subscriber's name: Subscriber's S.S. no.: Birth date: / / Group no.: Policy no.: Co-payment: $

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of secondary insurance (if applicable): Subscriber's name: Group no.: Policy no.:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Do you have a living will? YES NO Do you want information about a living will? Yes No

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): Relationship to patient: Home phone no.: ( ) Work phone no.: ( )

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. I also authorize Theresa Buck's Urgent Care Family clinic or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

MEDICAL HISTORY

Drug allergies:

_____

_____

Other allergies: (pollen, insects, foods)

_____

_____

List <u>all</u> medications that you are currently taking:

_____

_____

_____

_____

Do you smoke? _____ How long? _____
When did you quit? _____ Do you chew tobacco? _____
Do you use Vapor? _____

Circle all that you have received:

Vaccines: Tetanus Pneumonia Flu TB

<u>Children only:</u>

Are they up to date on their shots? _____
Do we have their shot record on file? _____

Females only:

Last menstrual cycle: _____ Last pap smear: _____

Are you currently taking birth control _____ what kind: _____

Ladies 40 plus: Last mammogram? _____

Family Medical History

Put a check mark under the person that had the disorder listed Patients name_____DOB_____

	Mother	Father	Siblings	Children
No Serious Illness Reported				
Cancer				
Heart Disease				
Liver Disease				
Bleeding Disorders				
Kidney Disease				
Psychiatric Disorders				
Seizures				
Diabetes				
Thyroid Issues				
Stroke				
Asthma, COPD				

Please list below any current problems you have. (Diabetes, Hypertension, Depression, etc):

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act — 45 CFR Parts 160 and 164)

1. I hereby authorize all medical service sources and health care providers to use and/or disclose the protected health information ("PHI") described below to my agent identified in my durable power of attorney for health care named Theresa Buck, FNP Fax: 931-507-9357.

2. Authorization for release of PHI covering the period of health care (check one)
   a. ☐ from (date) _____ - to (date)_____ OR
   b ☐ all past, present and future periods.

3. I hereby authorize the release of PHI as follows (check one):
   a. ☐ my complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse). OR
   b. ☐ my complete health record *with the exception of the following information* (check as appropriate):
      ☐ Mental health records
      ☐ Communicable diseases (including HIV and AIDS)
      ☐ Alcohol/drug abuse treatment
      ☐ Other (please specify): _____.

4. In addition to the authorization for release of my PHI described in paragraphs 3 a and 3 b of this Authorization, I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):

   Name _____ Relationship _____

   Name _____ Relationship _____

   Name _____ Relationship _____

5. This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

6. This authorization shall be in force and effect until nine (9) months after my death or _____, (date or event) at which time this authorization expires.

7. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

8. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

9. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ Date: _____
Signature of Patient

Keep original, and give copies to your health care provider, agent and family members

Notice of Myhealtware.com

June 2, 2015

We are required to offer a written summary for each office visit. We offer this through www.myhealthware.com and we will send an invitation on every visit you have. If you do not have an email address, we can create the account for you at your request. All accounts created will be done within one business day and you can pick up your username and password anytime at our office.

With www.myhealthware.com, you will have access to all of your medical records at our office no matter where you are as long as you have an internet connection.

- I have read and understand that I must give an email address to receive my invitation to myhealthware.com. I also understand that an account could be made for me and the username and password will be given to me.

_____

Patient signature **Print name** **Date**

Notice of Rights and responsibilities of Patients/Parents/Guardians

June 2, 2015

I have read and been offered a copy of Patients' rights and responsibilities. I also have read and been offered a notice of privacy practices.

_____

Patients name **Print name** Date

Theresa Bucks Urgent Care Clinic
1100 Smithville Hwy Suite 123
McMinnville, TN, 37110

Patient Responsibilities

Initial

I will give a 24 hour notice to cancel an appointment. ___

I understand if I am a NO CALL NO SHOW two times, I will be discharged from the clinic. ___

I understand that my prescription bottles may have no refills on it but there could be a new prescription already at the pharmacy. ___

I will call my pharmacy to check for refills before I call the office. ___

I will not call the office multiple times for the same request. ___

I will make sure my account is paid in a timely manner. ___

I will not seek narcotics from other clinics. ___

I will notify the clinic if I am prescribed a narcotic from another provider or ER. ___

I consent to random drug screens if I am prescribed a narcotic. ___

I understand if I do not follow these responsibilities I will be discharged from the clinic. ___

Signature_____ Date_____