LEAVITT FAMILY MEDICINE

Patient Registration Form

First Name _____ Last Name _____ MI ____ Gender M ☐ F ☐

Date of Birth _____ Social Security # _____ Marital Status S ☐ M ☐ W ☐ D ☐

*Race (please circle one) American Indian ☐ Asian ☐ Native Hawaiian ☐ African American ☐ White ☐ Hispanic ☐ Other ☐

*Ethnicity (please circle one) Hispanic ☐ Not Hispanic ☐ Refuse to Answer ☐ *Preferred Language _____

*Government requires this information to protect patients against discrimination.

Address _____

City _____ State _____ Zip _____

Best # to reach you _____ Home phone _____

Cell phone _____ Work phone _____

Confidential Email _____ Employer _____

Employed (please circle one) Full-time ☐ Part-time ☐ Not Employed ☐ Student ☐

Pharmacy of Choice _____ Location of Pharmacy _____

How did you hear about us? _____

Person Responsible for Bill (if different from Patient) _____

Relationship _____ Social Security # _____ DOB _____

Address _____

City _____ State _____ Zip _____

Home phone _____ Work phone _____ Cell phone _____

Primary Insurance Company _____

Policyholder _____ Social Security # _____ Date of Birth _____

Relationship of Policyholder to patient _____

Address (if different than above) _____

City _____ State _____ Zip _____

Home phone _____

ID/Policy # _____ Group # _____ Employer _____

Secondary Insurance Company _____

Policyholder _____ Social Security # _____ Date of Birth _____

Relationship of Policyholder to patient _____

Address (if different than above) _____

City _____ State _____ Zip _____

Home phone _____ Cell Phone _____ Work Phone _____

ID/Policy # _____ Group # _____ Employer _____

I hereby authorize (a) payment of insurance benefits otherwise due to me to be made directly to ea tt Family Medicine, PLLC, (b) release of information including protected health information to insurance companies as needed to file payment for services incurred, (c) ea tt Family Medicine, PLLC to obtain records from other sources as may be necessary in the diagnosis or treatment, and (d) understand that I am financially responsible to ea tt Family Medicine, PLLC for charges related to services provided or incurred by me or my dependents.

Signature (Responsible Party) _____ Date _____

/

Patient Name _____ DOB _____

Please list your ***current medications***. We need the Name, Dose, How often taken and who started the medication:

_____

_____

_____

_____

_____

_____

To avoid dangerous interactions, please list any ***supplements***, ***vitamins*** or ***over the counter*** products you use regularly:

_____

_____

_____

_____

_____

_____

_____

_____

List any ***allergies*** to medications or other:

_____

_____

_____

_____

_____

_____

_____

_____

Last Colonoscopy _____ Doctor that performed _____
(Colon Cancer Screening)

Last Pap and Breast Exam _____

Last Tetanus booster _____

Last Pneumonia Vaccine _____

ast n uen a a ne u S ot

Please list any Hospitalizations _ _____

_____

_____

Current Symptoms and anything else we need to know:_____

_____

_____

_____

Please provide your **PAST MEDICAL HISTORY**:

___Allergies
___Anemia
___Angina/Chest Pain
___Anxiety
___Arthritis
___Asthma
___Atrial Fibrillation
___BPH/Enlarged Prostate
___Blood Clots
___Cancer, Type,____
___CVA/Stroke
___COPD/Emphysema
___CAD/Heart Disease
___Crohn's Disease
___Depression
___Diabetes, Type,____
___Gallbladder Disease
___GERD/Acid Reflux
___Hepatitis C
___High Cholesterol
___High Blood Pressure
___Irritable Bowel Disease
___Liver Disease
___Migraines
___MI/Heart Attack
___Osteoarthritis
___Osteoporosis
___Peptic Ulcer Disease
___Renal Disease/Kidneys
___Seizure Disorder
___Thyroid Disease
___Other:_____

Please tell us about any **SURGERIES** you have had, you may indicate the date/year if known:

___Angioplasty
___Angioplasty with stent
___Appendix
___Arthroscopy knee
___Back Surgery
___Breast Augmentation
___Bilateral Tubal Ligation
___CABG (open heart surgery)
___Carpal tunnel release
___Cataract
___Cholecystectomy (gallbladder)
___Cholectomy (colon removed)
___Cesarean section
___Colostomy
___D&C
___Gastric bypass
___Hernia repair
___Hip replacement
___Knee replacement
___LASIK
___Liver biopsy
___ORIF (repair broken bone)
___Pacemaker
___Small bowel resection
___Thyroidectomy
___Tonsillectomy
___Prostatectomy/ TURP
___Vasectomy
___Hysterectomy
___Mastectomy
___Breast Reduction
___Other:_____
_____

Please Provide vour **FAMILY HISTORY**:

	MOTHER	FATHER	GRANDPARENTS	SIBLINGS	CHILDREN
ADD/ADHD					
ALCOHOLISM					
ALLERGIES					
ALZHEIMER'S/DEMENTIA					
ASTHMA					
BLOOD DISEASE					
CORONARY ARTERY DISEASE (HEART					
HEART DISEASE					
CANCER, TYPE:					
CVA (STROKE)					
DEPRESSION					
DEVELOPMENTAL DELAY					
DIABETES					
ECZEMA					

	MOTHER	FATHER	GRANDPARENTS	SIBLINGS	CHILDREN
HEARING LOSS					
HIGH CHOLESTEROL					
HIGH BLOOD PRESSURE					
IRRITABLE BOWEL DISEASE					
KIDNEY DISEASE					
MENTAL ILLNESS					
MIGRAINES					
OBESITY					
OSTEOARTHRITIS					
OSTEOPOROSIS					
PERIPHERAL VASCULAR DISEASE					
KIDNEY DISEASE					
SEIZURE DISORDER					
OTHER:					

Please provide your **SOCIAL HISTORY**:

Do you Smoke? Yes No Former
Type of Tobacco: _____
Packs per day: _____
Years smoked: _____
Year Quit: _____

Do you drink Alcohol? Yes No Former
Type of Alcohol: _____
Frequency: _____
Amount: _____
When was your last drink? _____

LEAVITT
FAMILY MEDICINE

Release of Information

Patient ame _____

I give permission to ea tt Family Medicine to discuss my medical condition(s), my treatment, and information regarding my appointments with the following individuals:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Emergency Contact _____ Relationship _____

Ce phone _____ ome phone _____ Other _____

May we leave a message on your o ema ? YES ☐ NO ☐

Consent to Treat

I hereby authorize ea tt Family Medicine, PLLC and any of its physicians and/or staff to treat my medical condition(s). The risks, benefits and alternatives will be explained at the time of service. I have the right to question and/or refuse treatment.

_____ _____

Patient Signature Date

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Consent to Disclose Health Care Information

It is important for you to know how your rights concerning your records and how your Personal Health Information (PHI) is used in our office. Before we begin any health care operations, we must require you read and sign this consent form stating you understand and agree with how your records will be used.

1. I understand and agree to allow ea tt Family Medicine, PLLC to use my Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care.
2. ea tt Family Medicine, PLLC has a document called the "Notice of Privacy Practices" that contains more information about policies and practices used to protect our patients' privacy. I understand that I have the right to read the "Notice of Privacy Practices" before signing this agreement. The notice is posted in the office of ea tt Family Medicine, PLLC. A written copy will be provided upon request. ea tt Family Medicine, PLLC may update the "Notice of Privacy Practices" at any time. A copy of the most recent update is available upon request.
3. Under the terms of this consent, I can ask ea tt Family Medicine, PLLC to restrict how my personal health information is used or disclosed to carry out treatment, payment or health care operations.
4. I understand that ea tt Family Medicine, PLLC does not have to agree to my request. If ea tt Family Medicine, PLLC does agree to my request, I understand that agreed limits would be followed.
5. I understand that I have the right to cancel this consent in writing to the Privacy Officer of ea tt Family Medicine, PLLC. If I do cancel this consent, I understand that ea tt Family Medicine, PLLC may have used or disclosed information about me and canceling this consent would not apply to information already used or disclosed.
6. I understand that if I cancel this consent, ea tt Family Medicine, PLLC does not have to provide further healthcare services to me.
7. I grant ea tt Family Medicine permission to view my prescription history from external sources.

I have read and understand how my Patient Health Information (PHI) will be used and I agree to these policies and procedures.

_____ _____

Patient Signature Date

_____

Printed Name

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Financial Policy

Thank you for choosing ea tt Family Medicine, PLLC.

It is our policy that all fees including co-pays, deductibles and non-covered services are due and payable on the date of service unless other payment arrangements have been made.

As a service to our patients, we will file a claim with your insurance company. The filing of insurance does NOT release the patient from responsibility for charges for services which have been provided. Please make sure we have a current copy of your insurance card. ***If we do not have the correct insurance information on the date of service and your claim is denied, you are responsible for payment.*** It is your responsibility to verify if our office is in network with your plan.

Accounts which are not paid within a reasonable period of time, and for which no special arrangements have been made, will be subject to placement with collection agencies following due notice.

Having read and understood the above statements, I agree to the terms set forth:

1. I understand my co-pay, deductible or non-covered service fee is due and payable at my appointment or I will need to reschedule my appointment.
2. I understand that I am financially responsible for all charges, even if they are not covered by insurance.
3. If my insurance does not pay, I understand that I am responsible for those charges.
4. In the event that I do not pay in accordance with the above policy and my account is sent to a collection agency, I agree to pay all costs of collection, including attorney fees.
5. If my account is sent to collection, I understand I will be dismissed from this practice.
6. I understand if I fail to show up for a scheduled appointment w t out a n to an e w t ours not e, I will receive a bill for the missed appointment. I understand a third missed appointment is grounds for dismissal from the practice.

I, the patient or guarantor/guardian hereby authorize the release of all applicable medical information including, without limitation, copies of all records and test results produced to the designated attending, referral and/or follow-up physicians and such other healthcare practitioners or organizations which will be providing subsequent monitoring, care or treatment in connection with care provided by ea tt Family Medicine, PLLC. I also authorize the release of information from my medical record in order to comply with applicable law, to facilitate the performance of utilization review and quality assurance activities and to facilitate third-party accreditation/certification activities. I accept responsibility for the medical charges incurred by the patient and agree to pay all bills at the time of service, unless other arrangements are made. I authorize physi-cian and/or clinic to render medical treatment and to release information to process insurance claims and to determine Medicare benefits. I also authorize my insurance claim and/or authorized Medicare benefits to be paid directly to ea tt Family Medicine, PLLC. I further agree that a photocopy of this document is to be considered as valid as an original.

Signature of Responsible Party _____ Date _____

Printed Name _____ Relationship to patient _____

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Consent for Release of Prescription History

I authorize ea tt Family Medicine to access my prescription history from outside sources to help keep my medical record as complete as possible. This includes many but not necessarily all medication used in the past.

yes
Initials

no
Initials

Name Signature Date

Notice of Advanced Directives

I have formal advanced directives that dictate my preferences for medical management should I be incapacitated or unable to make decisions with good judgement.

yes
Initials

no
Initials

I have durable power of attorney for my health care and will provide copies to the clinic. A **durable power of attorney (DPA)** for health care is another kind of advance directive. A DPA states whom you have chosen to make health care decisions for you. It becomes active any time you are unconscious or unable to make medical decisions. A DPA is generally more useful than a living will. But a DPA may not be a good choice if you don't have another person you trust to make these decisions for you.

yes
Initials

no
Initials

I have a **living will** and will provide copies to the clinic. A living will is one type of advance directive. It is a written, legal document that describes the kind of medical treatments or life-sustaining treatments you would want if you were seriously or terminally ill. A living will doesn't let you select someone to make decisions for you.

yes
Initials

no
Initials

I have a **Do Not Resuscitate** order. A do not resuscitate (DNR) order is another kind of advance directive. A DNR is a request not to have cardiopulmonary resuscitation (CPR) if your heart stops or if you stop breathing. (Unless given other instructions, hospital staff will try to help all patients whose heart has stopped or who have stopped breathing.) You can use an advance directive form or tell your doctor that you don't want to be resuscitated. Forms available on our website.

LEAVITT
FAMILY MEDICINE

Patient Portal
Informed Consent

Purpose of this Form

ea tt Family Medicine offers secure, HIPAA compliant viewing of parts of your medical record and communication from our staff as a service to our patients. Secure messaging can be a valuable communications tool, but has certain risks. In order to manage these risks we need to impose some conditions of participation. This form is intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation. This service is optional and not necessary to interact and communicate with our clinic.

How the secure Patient Portal works

A secure web portal is a kind of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password to log into the portal site.

How to participate in our Patient Portal

You can pick up secure messages or view information sent to you through a website. Once this form is agreed to and signed, we will provide you a user name and password with instructions that tell you how to register for the first time. Next you will be able to look in your message box and see any new or old messages or view other parts of your electronic medical record. You can read or view information on your computer, but it is still encrypted in transmission between the website and your computer. You can view more clinic specific information or access the Patient Portal through our clinic web page at www ea tt am y ed ne om at ent orta

Protecting your private health information and risks

This encrypted method of communication prevents unauthorized parties from being able to access or read messages while they are in transmission. When you pick up your secure messages from the portal, you need to keep unauthorized individuals from learning your password and gaining access to your account. If you think someone has learned your password, you should promptly go to the website and change it. If you are unable to, please call so we may de-activate your account. You need to make sure we have your correct e-mail address and are informed if it ever changes. We understand the importance of privacy in regards to your health care and will continue to strive to make all information as confidential as possible and will never sell or give away any private information, including email addresses.

Conditions of participating in the patient portal

Access to the secure web portal is an optional but highly recommended service. We reserve the right to suspend or terminate it at any time and for any reason. If we do suspend or terminate the service we will notify you as promptly as we reasonably can. You agree to not hold ea tt Family Medicine or any of its staff liable for network infractions beyond their control.

☐ I ACCEPT Patient Portal. ☐ I Decline Patient Portal at this time

Print Name _____ Patient email _____

Patient Signature _____ Date _____

LEAVITT
FAMILY MEDICINE

353 New Shackle Island Road Suite 140C
Hendersonville, TN 37075
Tel: (615)826-5664 Fax: (615)826-5665

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(All sections must be completed)

Patient Name: _____Date of Birth: _____

I hereby authorize the release of medical records from:

Doctor/Clinic_____

Address_____

Phone_____ Fax_____

I hereby authorize the release of medical records to: Leavitt Family Medicine

Purpose of disclosure: _____

The authorization will expire on: _____

Date or Event may not exceed one year

This request and authorization applies to:

_____ All medical records

_____ Health care information relating to the following treatment, condition, or dates of treatment:
_____

_____ Specific records to be released (eg. Labs, imaging reports, other):
_____

If you DO NOT WANT certain portions of your medical records released, please initial the box for the information you do not want released.

_____Substance abuse _____ Psychological or psychiatric treatment ____HIV/AIDS/STD I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.

_____ _____

Signature of Patient or Authorized Representative — Date Signed

_____

Relationship to Patient