Grace FAMILY HEALTH

AUTHORIZATION TO DISCUSS MEDICAL INFORMATION

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties also described below.

Description of the specific information to be discussed:

___Appointment Date/Times ___Diagnosis ___X-ray Results ___Medications
___Lab Tests/Results ___ Summary of Medical Record ___Care Plan
___ Other (specify):_____

Indicate Confidential Information: ____Mental Health ___HIV information ____ Alcohol/Drug Information

Patient Name: _____

Date of Birth: _____

Information to be given to:

Name: _____

Relationship:_____

Address: _____

Phone:_____

This authorization shall remain in effect from the date signed below until (please check one):

☐ _____ *(specify expiration date or event)*

☐ NO EXPIRATION DATE

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office, attention Administrator.
- This authorization is giving Health Center Name the right to discuss my medical information with the one or more people listed above.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the HIPAA.
- I may refuse to sign this authorization and you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment).

Signature: _____ Date:_____

Relationship to Patient (If signed by personal representative of Patient):_____

2900 Kirby Parkway Suite 14
MEMPHIS, TN 38119
PHONE: 901.752.3200

_____/_____ ***Staff Int./Date***

Grace Family Health

AUTHORIZATIONS AND ACKNOWLEDGMENTS

Consent to Treatment and Test

_____ Initial

I am voluntarily seeking medical treatment. I hereby consent to any and all reasonably Necessary medical examination(s) and health care procedures performed by the physicians and/or any of the nurses or medical staff employed by Grace Family Health PLLC, including but not limited to administration of medication, any lab procedures, x-rays, drawing of blood or any other treatments that may be deemed as reasonably necessary by my physician(s), nurse practitioner(s) or physician assistant(s) at the time of my examination. I understand that I may refuse specific treatments or procedures by informing the health care team.

Release of Information

_____ Initial

I authorize Grace Family Health PLLC to release any medical information necessary to process payment of my claim.

Assignments of Insurance Benefits and Acceptance of Financial Responsibility

_____ Initial

I authorize payment directly to Grace Family Health PLLC for their fees. Payment is required at the time of service for all co-payments, deductible, and co-insurance or past due balances. The patient is responsible for all incurred charges. We will file insurance as a courtesy; however it is your responsibility to provide us with complete and accurate information at each office visit. Failure to do so will result in the patient incurring complete and total financial responsibility for all charges.

_____ Initial

Patients are expected to make our office aware of any changes in insurance, telephone numbers or any demographic information. Please bring your insurance card with you to every visit. Additionally, a photo ID will be requested from all patients.

_____ Initial

Federal laws addressing all insurance companies require that we submit every claim accurately, reporting the exact services performed and the exact reason for performing them. We are unable to change this information simply for purposes of getting the claim covered. It is your responsibility to know and understand the services covered by your insurance, and if your insurance company does not cover these services, you will be responsible for payment. Patients may be required to make payment arrangements on any outstanding balance with our billing department prior to seeing a Provider. All patients are expected to provide their insurance card at the time of check in at each visit. All patients are responsible for making sure they know and understand what benefits are included under their insurance plan and ensure they are following all the regulations/rules defined in their plan. It is also your responsibility to inform us of any special requirement or specific facilities associated with your benefit plan. IF we inadvertently order services, such as lab work, diagnostic tests, etc. that are not covered or ordered at an out-of-network facility. We or the selected medical facility will have no choice but to bill you directly for those charges. Payment for those charges is then your responsibility. We are more than willing to provide the care within your insurance contract guidelines if you let us know at EACH time of service.

_____ Initial

A deposit will be required for all patients that do not have insurance coverage prior to seeing a Provider. Payment in full is expected at the time of service. We accept Cash, Checks, Visa, MasterCard, American Express and Cashier's checks. All patients are financially responsible for any associated bank fees related to a retuned check. This fee will automatically be assessed and must be paid in full prior to the next visit.

_____ Initial

Payment in full or payment arrangements can be arranged on any outstanding balance. Failure to make monthly/weekly payments as scheduled or no payment activity within 120 days will result in account being turned over to an outside collection agency. The patient will be responsible for all collection fees, costs, interest, and /or attorney fees and will be applied to the outstanding balance. Any account that has a "bad debt" applied to it or has been turned over to a collection agency **MUST** be paid fully in cash or credit card before any treatment is rendered. Checks will not be accepted. **Failure to meet your financial responsibilities may result in discharge from the Practice.**

Communications Regarding Your Account

_____ Initial

I agree that the facility, Grace Family Health PLLC or any other collection or servicing agency or agencies retained by the Practice, may contact me by telephone or text message at any number given by me or becomes associated with me or my account from sources other than me, including but not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages.

Acknowledgment of Notice of Privacy Practices

_____ Initial

I acknowledge that a copy of the Notice of Privacy Practices was provided to me.

Form Fees/Medical Records

_____

Below are charges for forms completed by a Provider outside of an OV. These are not covered by insurance and must be paid in full when forms are picked up.

- FMLA $50.00
- Disability $50.00
- Handicap Access $25.00
- Power Mobility $50.00
- Sports/Camp $25.00
- Fitness for Duty $25.00

Wellness/Annual Visits with Other Problems

_____ Initial

If during your annual/well-woman preventive care exam, you have or need treatment for a problem, if the problem is addressed during the visit in lieu of scheduling a separate appointment, in addition to the preventive exam it may be necessary that a problem/E&M visit be billed along with other labs, testing, and/or procedures, which may be subject to copays and/or deductibles.

_____ _____

SIGNATURE OF PATIENT/PARENT/GUARDIAN/PERSON AUTHORIZED TO SIGN FOR PATIENT DATE

Grace Family Health - Medical History Form

Date____/____/____

Name_____ male female Birthdate____/____/_____ Age___
Address_____ City_____ State_____ Zip_____
Phone Numbers: (H)_____ (O)_____ (Cell)_____
Occupation_____ Company_____

Your Past History: *Have YOU ever had any of these conditions? If so, when? Please write approximate year or age.*

- ☐ Heart Bypass Surgery
- ☐ Angioplasty/Stents
- ☐ Heart attack
- ☐ Stroke
- ☐ Diabetes
- ☐ High Cholesterol

- ☐ High Blood Pressure
- ☐ Blood Clots
- ☐ Easy Bleeding
- ☐ Abnormal Pap
- ☐ Pregnancy #___ Births #___ Miscarriage #___ Abortion #___

- ☐ Anemia
- ☐ Stomach Ulcer
- ☐ Asthma
- ☐ Depression
- ☐ Suicide Attempt
- ☐ Alcohol/Drug Dependency
- ☐ Osteoporosis

- ☐ Gout
- ☐ Migraines
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Glaucoma
- ☐ Colon Polyps
- ☐ Seizures

Cancer/Type:
- ☐ Colon
- ☐ Breast
- ☐ Prostate
- ☐ Lung
- ☐ Other

Other Medical Conditions You Have or Details from above:

Drug Allergies: List Drug and reaction

Your Past Surgeries: *Have YOU ever had any surgeries? If so, when? Please write approximate year or age.*

- ☐ Appendix
- ☐ Gallbladder
- ☐ Tonsillectomy
- ☐ Sinus
- ☐ Spleen Removed
- ☐ Colon/ Bowel

- ☐ Heart Bypass
- ☐ Blood Vessel (aorta, carotid-neck, legs)
- ☐ Knee: L R
- ☐ Hip: L R
- ☐ Disc: Neck Back

Females:
- ☐ Hysterectomy
- ☐ Ovaries Removed
- ☐ C-Section
- ☐ Tubal Ligation

Males:
- ☐ Prostate
- ☐ Vasectomy

Other Surgery or comments:

Family History: Do any of your BLOOD RELATIVES have any of these conditions? State approximate age the condition developed.

These initials can be used: Father = F Mother = M Brother = B Sister = S Grandparents = GP Child = C

Example: Diabetes: M(50), B(35), B(40), S(28) = (Mother, 2 brothers and 1 sister with diabetes; Mother diagnosed at age 50, etc.)

- ☐ ADOPTED/ or No History Known
- ☐ Heart Bypass Surgery
- ☐ Angioplasty/Stents
- ☐ Heart attack
- ☐ Stroke
- ☐ Diabetes
- ☐ High Blood Pressure

- ☐ High Cholesterol
- ☐ Blood Clots
- ☐ Prolonged Bleeding
- ☐ Thyroid Disease
- ☐ Seizures
- ☐ Asthma
- ☐

- ☐ Depression
- ☐ Suicide
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Kidney Failure
- ☐ Liver Failure
- ☐

Cancer/Type:
- ☐ Colon
- ☐ Breast
- ☐ Prostate
- ☐ Lung
- ☐

Social History

- ☐ **Smoking:** Current___ Past___ Cigs/day___ for___years Year Stopped_____
- ☐ Smokeless Tobacco
- ☐ Drugs

- ☐ **Alcohol:** Current____ Past____ # per week: beer___ wine___ liquor____ Year Stopped_____ In Recovery?_____

Immunizations

Childhood imm. current/complete: Yes____ No____
Last Tetanus Shot_____
Hepatitis A: Yes___No___ Hepatitis B: Yes___No___
Pneumococcal: Yes___(year_____) No___

(REV. 2/23)

that you have authorized to receive this information. Please inform the practice when you do not wish a family member or other individual to have authorization to receive your information.

Research / Teaching / Training. We may use your information for the purpose of research, teaching, and training.

Healthcare Oversight. Federal law requires us to release your information to an appropriate health oversight agency, public health authority or attorney, or other federal/state appointee if there are circumstances that require us to do so.

Public health reporting. Your health information may be disclosed to public health agencies as required by law.

Law enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Appointment reminders. The practice may use your information to remind you about upcoming appointments. Typically, appointment reminders are sent by mail in a closed envelope, or, a brief, non-specific message may be left on your answering machine. If you don't approve of these methods, or, if you prefer alternative methods (i.e., email) please inform the practice.

Other uses and disclosures. **D**isclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have complaints, questions or would like additional information regarding this notice or the privacy practices of Grace Family Medicine, LLC please contact:

Privacy Officer
Grace Family Health, PLLC
2900 Kirby Parkway Ste 14
901.754.3200

If you believe that your privacy rights have been violated, please contact the aforementioned practice Privacy Official, or you may file a complaint with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the practice's Privacy Official or with the Office for Civil Rights. The address for the Office for Civil Rights is listed below:

OFFICE FOR CIVIL RIGHTS
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C., 20201

NOTICE OF PRIVACY POLICIES AND PRACTICES

FOR

Grace Family Health, PLLC

DEAR PATIENT:

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

INTRODUCTION

At **Grace Family Health, PLLC**, we are committed to treating and using protected health information about you responsibly. This Notice describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective August 1, 2007, and applies to all protected health information as defined by federal regulations.

UNDERSTANDING YOUR MEDICAL RECORD / HEALTH INFORMATION

Each time you visit **Grace Family Health, PLLC** a record of your visit is made. Typically, this record contains information about your visit including your examination, diagnosis, test results, treatment as well as other pertinent healthcare data. This information, often

referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication with other health professionals involved in your care
- Legal document outlining and describing the care you received
- A tool that you, or another payer (your insurance company) will use to verify that services billed were provided
- An education tool for medical health providers
- A source for medical research
- Basis for public health officials who might use this information to assess and/or improve state as well as national healthcare standards
- A source of data for planning and / or marketing
- A tool that we can reference to ensure the highest quality of care and patient satisfaction

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, determine what entities have access to your health information, and make an informed decision when authorizing the disclosure of this information to other individuals.

YOUR RIGHTS

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

OUR RESPONSIBILITIES

Grace Family Health, PLLC is required to:

- Maintain the privacy of your health information
- Provide you with this Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have regarding communication of health information via alternative means and/ locations

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.
We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to procedures included in the authorization.

HOW WE MAY USE AND/OR DISCLOSE YOUR HEALTH INFORMATION

We will use your health information for treatment. **Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example: results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.**

We will use your information for payment. **Your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated in order to pay for the service rendered to you.**

We will use your information for regular health operations**. Your health information may be used as necessary to support the day-to-day activities and management of Grace Family Health, PLLC. For example: information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.**

Business Associates. In some instances, we have contracted separate entities to provide services for us. These "associates" require your health information in order to accomplish the tasks that we ask them to provide. Some examples of these "business associates" might be a billing service, collection agency, answering services and computer software/hardware provider.

Communication with family**.** Due to the nature of our field, we will use our best judgment when disclosing health information to a family member, other relatives, or any other person that is involved in your care or

Grace Family Health, PLLC
Patient Registration Form
(Please Print)

Name:_____
(Last) (First) (Initial)
Address:_____
(Street) (City) (State) (Zip)
Home Phone_____ Cell Phone_____

Date of Birth:_____Marital Status: ( ) S ( ) M ( ) D ( ) W

Social Security #:_____

Employer:_____Work Phone:_____Ext:_____

Employer Address:_____Occupation: _____
(Street)
_____
(City) (State) (Zip)

Emergency Contact Person:_____
(Name) (Relationship) (Phone)

Billing Information-Person Responsible for Paying this Bill:

Name:_____Relationship to Patient:_____

Street:_____City:_____State:_____Zip:_____

Primary Insurance Company:_____Policy #:_____Group #:_____

Street:_____City:_____State:_____Zip:_____

Relationship to Patient:_____Policy Holder:_____DOB:_____

Secondary Insurance Company:_____Policy #_____Group #_____

Street:_____City:_____State:_____Zip:_____

Relationship to Patient:_____Policy Holder:_____DOB:_____

Email Address:

_____

How were you referred to our practice? ____Friend/Relative, if so name :_____

____Yellow Pages ____Physician, if so name: _____

____ Newspaper ____ Hospital Referral ____Other? _____

Please remember insurance is considered a method of reimbursing and is not designed to pay the entire fee. Because insurance carriers vary in the amount they will pay for various services, it is ultimately your responsibility to pay the portion of your bill that insurance does not. If insurance does not pay your bill in 60 days you will be responsible for it.

I understand that I must pay all co-payment/deductibles associated with my insurance at the time of service, and a $30.00 fee will be added for all return checks.

Signature_____ Date_____