PATIENT REGISTRATION

Name _____ Birthday _____

Mailing Address _____ SS # _____

City _____ State _____ Zip _____

(Please ✓ preferred contact number)

☐ Home Phone _____ Local Pharmacy _____

☐ Cell Phone _____ Mail Order Pharmacy _____

☐ Work Phone _____ Employer _____

☐ Yes ☐ No - My test results can be left on my home answering machine or my cell phone voice mail.

Marital Status: *(circle one)* Married Single Divorced Widowed

Email Address _____

SPOUSE or (Name on insurance card if different from above):

Name _____

Birthday _____

SS # _____

Employer _____

MEDICAL RECORDS CONFIDENTIALITY LIST:

To maintain strict patient confidentiality, we will release personal information only to the persons you have listed below, and NO others. Please put your spouse on this list if you wish for us to give them any information.

Name _____ Name _____ Name _____

Relationship _____ Relationship _____ Relationship _____

Phone _____ Phone _____ Phone _____

ASSIGNMENT OF BENEFITS / AUTHORIZATION FOR TREATMENT: I hereby authorize treatment and authorize the provider of medical services to release information for these services to my insurance carrier for payment. I further authorize that payment of benefits be made to the provider on my behalf or to myself. I understand that I am financially responsible for all co-payments, deductibles, and outstanding balances at the time services are rendered.

_____ _____

Signature of Patient or Authorized Representative Date

INTERNAL MEDICINE

HEALTH QUESTIONNAIRE

DATE: PATIENT NAME:

MEDICAL HISTORY

CHECK BOX AND INDICATE AT WHAT AGE SYMPTOM OR DISEASE OCCURRED.
IF APPLIES TO ONLY CURRENT CONDITION, WRITE "NOW".

AGE		AGE		AGE	
☐ _____	ABDOMINAL PAIN	☐ _____	WEIGHT LOSS	☐ _____	OSTEOPOROSIS
☐ _____	ALLERGIES	☐ _____	GALL BLADDER TROUBLE	☐ _____	PEPTIC ULCER
☐ _____	ANEMIA	☐ _____	GERMAN MEASLES	☐ _____	PHOBIAS
☐ _____	ARTHRITIS	☐ _____	GOUT	☐ _____	PNEUMONIA
☐ _____	ASTHMA	☐ _____	HEADACHES (FREQUENT)	☐ _____	POLIO
☐ _____	BACK PAIN	☐ _____	HEART MURMUR	☐ _____	PSORIASIS
☐ _____	BLOOD IN URINE	☐ _____	HEARTBURN	☐ _____	RASHES
☐ _____	BLOODY OR TARRY STOOLS	☐ _____	HEMORRHOIDS	☐ _____	RHEUMATIC FEVER
☐ _____	BONE FRACTURE	☐ _____	HERNIA	☐ _____	RINGING IN EAR
☐ _____	BRONCHITIS	☐ _____	HERPES	☐ _____	SCARLET FEVER
☐ _____	CANCER	☐ _____	HIGH BLOOD PRESSURE	☐ _____	SEIZURES
☐ _____	CHEST PAIN	☐ _____	HIVES	☐ _____	SHORTNESS OF BREATH
☐ _____	CHICKEN POX	☐ _____	IRREGULAR PULSE	☐ _____	SINUS TROUBLES
☐ _____	CHRONIC FATIGUE	☐ _____	JAUNDICE / HEPATITIS	☐ _____	SLEEPING PROBLEM
☐ _____	CONSTIPATION	☐ _____	JOINT INJURY	☐ _____	SORE THROAT (FREQUENT)
☐ _____	CROHN'S / COLITIS	☐ _____	KIDNEY STONES	☐ _____	STROKE
☐ _____	DECREASED HEARING	☐ _____	LEG PAIN	☐ _____	THYROID DISEASE
☐ _____	DEPRESSION	☐ _____	LOSS OF APPETITE	☐ _____	TREMOR / HAND SHAKING
☐ _____	DIABETES	☐ _____	MEASLES	☐ _____	TUBERCULOSIS
☐ _____	DIARRHEA	☐ _____	MEMORY LOSS	☐ _____	URETHRAL DISCHARGE
☐ _____	DIFFICULTY SWALLOWING	☐ _____	MENTAL ILLNESS	☐ _____	URINATION - PAINFUL
☐ _____	DIVERTICULOSIS	☐ _____	MOODINESS	☐ _____	URINATION - LOSS OF CONTROL
☐ _____	DIZZY OR FAINTING SPELLS	☐ _____	MUMPS	☐ _____	URINE INFECTIONS (FREQUENT)
☐ _____	EAR INFECTIONS (FREQUENT)	☐ _____	MUSCLE WEAKNESS	☐ _____	VARICOSE VEINS
☐ _____	ECZEMA	☐ _____	NAUSEA / VOMITING	☐ _____	VENEREAL DISEASE
☐ _____	EYE PROBLEMS	☐ _____	NOSE BLEEDS	☐ _____	VISION PROBLEMS
☐ _____	FOOT PAIN	☐ _____	NUMBNESS / TINGLING	☐ _____	WEIGHT GAIN

ANSWER "YES" OR "NO" IN BLANK

- ☐ _____ ALCOHOL
- ☐ _____ DRUGS
- ☐ _____ COFFEE/TEA _____ CUPS/DAY
- ☐ _____ REGULAR EXERCISE
- ☐ _____ SMOKING _____ CIG/DAY
  - # YRS. SMOKING _____
  - # YRS. QUIT _____

MALES

☐ _____ PROSTATE ☐ _____ PSA TEST

FEMALES

NUMBER OF:

- ☐ _____ ABORTIONS
- ☐ _____ LIVE BIRTHS
- ☐ _____ PREGNANCIES
- ☐ _____ MISCARRIAGES

FEMALES

MENSTRUAL FLOW:

☐ REG. ☐ IRREG. ☐ PAIN ☐ CRAMPS

_____ DAYS OF FLOW

_____ LENGTH OF CYCLE

DATE - 1st DAY OF LAST PERIOD _____

☐ PAIN / BLEEDING DURING OR AFTER SEX

NUMBER OF:

_____ ABORTIONS
_____ LIVE BIRTHS
_____ PREGNANCIES
_____ MISCARRIAGES

BIRTH CONTROL METHOD _____

B.C. PILL (NAME) _____

☐ FLUSHING / MENOPAUSE

DATE OF LAST PAP SMEAR _____

☐ NORMAL ☐ ABNORMAL

DATE OF LAST MAMMOGRAM _____

FAMILY HISTORY

IF ANY BLOOD RELATIVE HAS SUFFERED ANY OF THE FOLLOWING — PLEASE CIRCLE THE NUMBER & INDICATE WHICH RELATIVE

1) EPILEPSY	11) OSTEOPOROSIS	_____
2) MIGRAINE	12) ARTHRITIS	_____
3) MENTAL ILL.	13) HEART DISEASE	_____
4) GLAUCOMA	14) STROKE	_____
5) DIABETES	15) HYPERTENSION	_____
6) THYROID	16) HIGH CHOLESTEROL	_____
7) HAYFEVER	17) ALCOHOLISM	_____
8) ASTHMA	18) CANCER	_____
9) ANEMIA	19)	_____
10) BLEEDS EASILY	20)	_____

IMMUNIZATIONS

	DATE (Mo./Yr.)
HEPATITIS	
TETANUS	
FLU	
TB	

Welcome to Internal Medicine Associates

Dr's Riley, Watters, Khan, Trentham, and Olsen
Larry Crisp and Jamie Miller, NP's

Insurance:
Please be sure to bring your insurance cards with you at each visit. If you do not have your insurance cards please, make sure to get a copy of them from your insurance company before coming to the doctor. Please note: We must have a copy of the front and back of your insurance card, before billing your health insurance. It is the responsibility of the patient to provide our office with insurance information at the time of his/her office visit. If we are unable to get a copy of your insurance card, it will be your responsibility to pay the claim until we can properly file your insurance. Make sure you notify our office of any insurance changes as they occur.

Change of Address or phone number:
You will need to provide us with all current demographical information such as the following: Name, address, phone number, date of birth, social security number, and a copy of your driver's license (Photo ID for picking up prescriptions). This information helps us so that we can properly file your medical claims. If at any time, any of this information changes please contact our office as soon as possible.

Co-Pays/Deductibles/Co-Insurance:
Co-Pays **must be paid** as you check in to see your Physician. We accept cash, check, Visa, MasterCard and Discover for your convenience. You will also be responsible for paying any past balances at the time of your visit. If you are Medicare only, you are responsible for any deductible plus 20% Co-insurance at each time of service.

Referrals:
If your insurance requires that you have a referral to a specialist office you will need to give us ample time to complete this task. We will do your referral as soon as possible but we require at least 1 week notice.

Medications:
If you have a prescription that you need us to call in or if you need a written prescription, please call the office 1 week before you are out of medicine. We will do our best to get with your Doctor and have this completed within 48 hours. Please leave full name, date of birth, medication name, and how often it's taken daily and pharmacy. All RX's that are considered controlled substances must be written and picked up at the office.

Regular office hours - Monday thru Thursday 8:30am to 12 noon & 1:15pm to 5pm
Friday Walk-in Clinic Only 8:30 to 12 noon

Lab and Shot Hours – Monday thru Thursday 8:30am to 11:30am & 1:15pm to 4:30pm

Angie Barnett, Office Manager
October 1, 2013

Internal Medicine Associates of McMinn County, PC
NOTICE OF PRIVACY PRACTICES

Effective Date: November 1, 2006.
This Notice was most recently revised on May 25, 2013.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE OR IF YOU NEED MORE INFORMATION, PLEASE CONTACT OUR PRIVACY OFFICER:

Privacy Officer: Angie Barnett
Mailing Address: 301 Grady Rd Etowah, TN 37331
Telephone: 423-263-2444
Fax: 423-263-1553
E-mail: angiebarnett2081@yahoo.com

About This Notice

We are required by law to maintain the privacy of Protected Health Information (PHI) and to give you this Notice explaining our privacy practices with regard to that information. You have certain rights – and we have certain legal obligations – regarding the privacy of your PHI, and this Notice also explains your rights and our obligations. We are required to abide by the terms of the current version of this Notice.

What is Protected Health Information (PHI)?

Protected Health Information (PHI) is information that individually identifies you and that we create or get from you or from another health care provider, a health plan, your employer, or a health care clearinghouse and that relates to (1) your past, present, or future physical or mental health or conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

How We May Use and Disclose Your PHI

We may use and disclose your PHI in the following circumstances:

For Treatment. We may use PHI to give you medical treatment or services and to manage and coordinate your medical care. For example, we may disclose PHI to doctors, nurses, technicians, or other personnel who are involved in taking care of you, including people outside our practice, such as referring or specialist physicians.

For Payment. We may use and disclose PHI so that we can bill for the treatment and services you get from us and can collect payment from you, an insurance company, or another third party. For example, we may need to give your health plan information about your treatment in order for your health plan to pay for that treatment. We also may tell your health plan

about a treatment you are going to receive to find out if your plan will cover the treatment. If a bill is overdue we may need to give PHI to a collection agency to the extent necessary to help collect the bill, and we may disclose an outstanding debt to credit reporting agencies.

For Health Care Operations. We may use and disclose PHI for our health care operations. For example, we may use PHI for our general business management activities, for checking on the performance of our staff in caring for you, for our cost-management activities, for audits, or to get legal services. We may give PHI to other health care entities for their health care operations, for example, to your health insurer for its quality review purposes.

Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services. We may use and disclose PHI to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

Minors. We may disclose the PHI of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

Personal Representative. If you have a personal representative, such as a legal guardian (or an executor or administrator of your estate after your death), we will treat that person as if that person is you with respect to disclosures of your PHI.

As Required by Law. We will disclose PHI about you when required to do so by international, federal, state, or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose PHI when necessary to prevent a serious threat to your health or safety or to the health or safety of others. But we will only disclosure the information to someone who may be able to help prevent the threat.

Business Associates. We may disclose PHI to our business associates who perform functions on our behalf or provide us with services if the PHI is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy of your PHI.

Organ and Tissue Donation. If you are an organ or tissue donor, we may use or disclose your PHI to organizations that handle organ procurement or transplantation – such as an organ donation bank – as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release PHI as required by military command authorities. We also may release PHI to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may use or disclose PHI for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose PHI for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and (8) the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.

Health Oversight Activities. We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose PHI in response to a court or administrative order. We also may disclose PHI in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your PHI to defend ourselves if you sue us.

Law Enforcement. We may release PHI if asked by a law enforcement official for the following reasons: in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if; about a death we believe may be the result of criminal conduct; about criminal conduct on our premises; and in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.

National Security. We may release PHI to authorized federal officials for national security activities authorized by law. For example, we may disclose PHI to those officials so they may protect the President.

Coroners, Medical Examiners, and Funeral Directors. We may release PHI to a coroner, medical examiner, or funeral director so that they can carry out their duties.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose PHI to the correctional institution or law enforcement official if the disclosure is necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

<u>Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out</u>

Individuals Involved in Your Care or Payment for Your Care. We may disclose PHI to a person who is involved in your medical care or helps pay for your care, such as a family

member or friend, to the extent it is relevant to that person's involvement in your care or payment related to your care. We will provide you with an opportunity to object to and opt out of such a disclosure whenever we practicably can do so.

Disaster Relief. We may disclose your PHI to disaster relief organizations that seek your PHI to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

Your Written Authorization is Required for Other Uses and Disclosures

Uses and disclosures for marketing purposes and disclosures that constitute a sale of PHI can only be made with your written authorization. Other uses and disclosures of PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose PHI under the authorization. Disclosures that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Special Protections for HIV, Alcohol and Substance Abuse, Mental Health, and Genetic Information

Special privacy protections apply to HIV-related information, alcohol and substance abuse, mental health, and genetic information. Some parts of this general Notice of Privacy Practices may not apply to these kinds of PHI. Please check with our Privacy Officer for information about the special protections that do apply. For example, if we give you a test to determine if you have been exposed to HIV, we will not disclose the fact that you have taken the test to anyone without your written consent unless otherwise required by law.

Your Rights Regarding Your PHI

You have the following rights, subject to certain limitations, regarding your PHI:

Right to Inspect and Copy. You have the right to inspect and/or receive a copy of PHI that may be used to make decisions about your care or payment for your care. But you do not have a right to inspect or copy psychotherapy notes. We may charge you a fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your PHI is maintained in one or more designated record sets electronically (for example an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We may charge you a reasonable, cost-based fee for the labor associated with copying or transmitting the electronic PHI. If you chose to have your PHI transmitted electronically, you will need to

provide a written request to this office listing the contact information of the individual or entity who should receive your electronic PHI.

Right to Receive Notice of a Breach. We are required to notify you by first class mail or by e-mail (if you have indicated a preference to receive information by e-mail), of any breach of your Unsecured PHI.

Right to Request Amendments. If you feel that PHI we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning of this Notice and it must tell us the reason for your request. We may deny your request if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (1) was not created by us, (2) is not part of the medical information kept by or for us, (3) is not information that you would be permitted to inspect and copy, or (2) is accurate and complete. If we deny your request, you may submit a written statement of disagreement of reasonable length. Your statement of disagreement will be included in your medical record, but we may also include a rebuttal statement.

Right to an Accounting of Disclosures. You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your PHI. We are not required to list certain disclosures, including (1) disclosures made for treatment, payment, and health care operations purposes, (2) disclosures made with your authorization, (3) disclosures made to create a limited data set, and (4) disclosures made directly to you. You must submit your request in writing to our Privacy Officer. Your request must state a time period which may not be longer than 6 years before your request. Your request should indicate in what form you would like the accounting (for example, on paper or by e-mail). The first accounting of disclosures you request within any 12-month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting. We will tell you what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the PHI we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the PHI we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request. If we agree, we will comply with your request unless we terminate our agreement or the information is needed to provide you with emergency treatment.

Right to Restrict Certain Disclosures to Your Health Plan. You have the right to restrict certain disclosures of PHI to a health plan if the disclosure is for payment or health care operations and pertains to a health care item or service for which you have paid out of pocket in full. We will honor this request unless we are otherwise required by law to disclose this information. This request must be made at the time of service.

Right to Request Confidential Communications. You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a special address or call you only at your work

number. Your must make any such request in writing and you must specify how or where we are to contact you. We will accommodate all reasonable requests. We will not ask you the reason for your request.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time.

How to Exercise Your Rights

To exercise your rights described in this Notice, send your request, in writing, to our Privacy Officer at the address listed at the beginning of this Notice. We may ask you to fill out a form that we will supply. To get a paper copy of this Notice, contact our Privacy Officer by phone or mail.

Changes To This Notice

The effective date of the Notice is stated at the beginning. We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for PHI we already have as well as for any PHI we create or receive in the future. A copy of our current Notice is posted in our office and on our website.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact our Privacy Officer at the address listed at the beginning of this Notice. All complaints must be made in writing and should be submitted within 180 days of when you knew or should have known of the suspected violation. There will be no retaliation against you for filing a complaint.