

NEW PATIENT INFORMATION

Sliding Scale

Chart # _____

\$ _____

Medical _____ Vision _____ Dental _____ (extractions, fillings)

Patient Name _____ Date of Birth _____ Gender: M F
First Middle Last

Address _____
Street (PO Box) City State Zip Code

Home Telephone # _____ SS # _____

Cell # _____ E-mail Address _____

Emergency Contact Name _____ Relationship _____

Emergency Contact Phone Number _____

Race _____ Language _____ Ethnicity _____

Patient Status: Single Married Divorced Widowed Other
 Unemployed Employed Retired Full Time Student Pt Time Student

Employer Name _____ Employer Phone # _____

Employer Address _____

Is Patient's Condition Related to: a) Employment (Current or Previous) _____ Yes _____ No

b) Auto Accident _____ Yes _____ No State _____

c) Other Accident _____ Yes _____ No

Dr & Hospital who have records _____

Previous Medical Condition(s) treated for past six (6) months or longer _____

I give my consent to receive treatment from Servolution Health Services.

If Minor:

Name of Parent, Guardian, or Legal Representative _____

Patients or Authorized Person's Signature

Date

HIPAA Expiration Date _____

(Office use only) Entered By

Servolution Health Services

MEDICAL HISTORY

Patient Name _____ Birthdate _____

Thank you for answering the following questions:

- Are you under a physician's care now? Yes No If yes, please explain: _____
- Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
- Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____
- Are you on a special diet? Yes No If yes, please explain: _____
- Do you use controlled substance? Yes No If yes, please explain: _____
- Do you currently use recreational or street drugs? Yes No If yes, please list: _____
- Have you had recent weight gain or loss? Yes No If yes, please explain: _____
- Have you traveled out of the United States? Yes No If yes, when and where: _____

Women: Are you

Pregnant/Trying to get pregnant? ___Yes ___No Taking oral contraceptives? ___Yes ___No Nursing? ___Yes ___No

Are you allergic to any of the following?

_____ Aspirin _____ Penicillin _____ Codeine _____ Acrylic _____ Metal _____ Latex _____ Local Anesthetics _____ Other

If yes, please explain:

Please Circle if you have, or have had, any of the following:

- | | | | |
|------------------------------------|--------------------------------|----------------------------------|-----------------------------------|
| Abdominal Pain | Congenital Heart Disorder | Hearing Loss | Osteoporosis |
| Abnormal Bleeding | Congestive Heart Failure (CHF) | Heart Attack (MI) | Ovarian Cancer |
| Abnormal Pap Smear | Constipation | Heart Murmur | Pain in Jaw Joints |
| Abuse/Domestic Violence | Convulsions | Heart Pacemaker | Parathyroid Disease |
| Acid Reflux (GERD) | COPD | Heart Problems | Parkinson's Disease |
| ADD/ADHD | Coronary Artery Disease | Hemophilia | Polio |
| Aids/HIV | Deep Vein Thrombosis (DVT) | Hepatitis A | Polyps |
| Allergies/Hay Fever | Dementia | Hepatitis B or C | Psychiatric Care |
| Alzheimer's Disease | Depression | Hernia _____ | Pulmonary Embolism |
| Anaphylaxis | Develop or Behavioral Disorder | Herpes | Radiation Treatment |
| Anemia | Diabetes | High Cholesterol | Rash |
| Anesthesia Complications | Difficulty Swallowing | Hives | Renal Dialysis |
| Angina | Diverticulitis | Hyperlipidemia | Respiratory Syncytial Virus (RSV) |
| Anxiety Disorder | Dizziness | Hypertension/High Blood Pressure | Rheumatic Fever |
| Arthritis | Drug Addiction | Hyperthyroidism | Rubella |
| Artificial Heart Valve | Ear or Hearing Problems | Hypoglycemia | Scarlet Fever |
| Artificial Joint | Easily Winded | Hypothyroidism | Seizures |
| Asthma | Eating Disorder | Incontinence | Shingles |
| Autism Spectrum Disorder(ASD) | Eczema | Infertility | Sickle Cell Disease |
| Back Problems | Edema | Intestinal Disease | Sinus Trouble |
| Bedwetting | Emphysema | Irregular Heartbeat | Skin Problems |
| Birth Defects or Inherited Disease | Endometriosis | Kidney Disease | Spina Bifida |
| Bladder or Kidney Problems | Epilepsy | Kidney Stones | Stomach/Intestinal Disease |
| Bleeding Disorder | Excessive Bleeding | Leukemia | Stroke |
| Blood Clots | Excessive Thirst | Liver Disease | Substance Abuse |
| Blood Diseases | Fainting Spells | Low Blood Pressure | Swelling of Limbs |
| Blood Transfusion | Fibromyalgia | Lung Disease | Thyroid Problems |
| Breast Problem | Frequent Cough | Measles | Tonsillitis |
| Breathing Problem | Frequent Diarrhea | Meniere's Disease | Tuberculosis |
| Bruise Easily | Frequent Headaches | Mental Disorder | Tumors or Growths |
| Cancer _____ | Genital Herpes | Mitral Valve Prolapse | Ulcers _____ |
| Chemotherapy | GI Problems | MRSA Exposure | Urinary Problems |
| Chest Pains | Glaucoma | Mumps | Venereal Disease |
| Chicken Pox | Gout | Muscle, Joint, or Bone Problems | Vision/Eye Problems |
| Chronic Ear Infections | Head Injury/Concussion | Nervous System Disorder | Whooping Cough |
| Cold Sores/Fever Blisters | Headaches | Obesity | Yellow Jaundice |
| | | | Other _____ |

Have you ever had any serious illness not listed above? ____ Yes ____ No If yes, please explain:

Have you ever been hospitalized or had a major operation? If yes, explain: _____

Comments: _____

Caffeine Intake: ____ None ____ Occasional ____ Moderate ____ Heavy # of cups/cans per day? _____

Do you use tobacco? ____ Yes ____ No,

If not currently, did you ever use tobacco? ____ Yes ____ No Number of years ____ or year quit _____

Cigarettes ____ pks/day Chew ____ /day Cigars ____ /day E-cig/Vape ____ /day

Do you drink alcohol? ____ Yes ____ No, If so, how often? ____ Occasionally ____ <3 times a week ____ >3 times a week

Exercise Level ____ None (No Exercise) ____ Occasional Exercise ____ Moderate Exercise ____ High Level Exercise

Do you belong to a church or faith group? _____

Is support for your faith available to you? _____

Does your faith help you cope with medical conditions? _____

Do any of your religious beliefs or spiritual practices conflict with medical treatment? _____

Would you like for someone to pray with or for you? _____

Would you like to talk with a pastor about where you are or where you would like to be spiritually? _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the medical office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____

DATE _____

**SERVOLUTION HEALTH SERVICES
INCOME VERIFICATION**

PATIENT _____ **CHART #** _____

TOTAL NUMBER IN HOUSEHOLD: _____

Patient	Self	Age	Type of Income	\$	Amount
_____	_____	_____	_____	\$	_____
Name	Relationship	Age	Type of Income	\$	Amount
_____	_____	_____	_____	\$	_____
Name	Relationship	Age	Type of Income	\$	Amount
_____	_____	_____	_____	\$	_____
Name	Relationship	Age	Type of Income	\$	Amount
_____	_____	_____	_____	\$	_____
Name	Relationship	Age	Type of Income	\$	Amount

TYPES OF INCOME (Abbreviations) (CIRCLE ANY/ALL THAT APPLIES)

Social Security	SS	Pension/Retirement	PEN/RET
Social Security Disability	SSI	Bank Statement	BS
Child Support	CS	Tax Return	TR
Family First	FF	Pay Check Stub	PS
Unemployment	UEMP	Food Stamp Approval Letter	FS
Employer Letter	EL	Support Letter	SL
VA Benefits	VA		
Other (O) _____			

To the best of my knowledge, the information is complete, accurate, free from any misstatements and is not misleading in any respect.

Signature

Date

Signature of Servolution Employee

Date

Information Expires one (1) year from date.

**SERVOLUTION HEALTH SERVICES
181 POWELL VALLEY SCHOOL LANE
SPEEDWELL, TENNESSEE 37870
(423)419-5070 (423)419-5071 FAX (423)869-0081**

CONSENT FOR PATIENT CONTACT

Date _____

Patient's Full Name _____

Date of Birth: ____/____/____ **Social Security Number** _____

From time to time, it may be necessary for Servolution Health Services to contact you concerning a variety of issues that pertain to your medical care. While the following list is not all-inclusive, we might need to contact you to:

- **Make an appointment**
- **Cancel an appointment**
- **Inform you that your prescriptions have been called in or need to be picked up**
- **Discuss your medical care and treatment**
- **Verify address and phone numbers, etc.**

To assist you with your needs and to address the patient privacy issues described in the Health Insurance Portability and Accountability Act of 1996, we need you to specify the alternative ways we may contact you in the event we cannot reach you personally.

You may contact me by: (Please check the box(s) that apply)

- Leaving a recorded voicemail on my: home phone or cell phone work phone e-mail
e-mail address _____ cell phone carrier _____
- Text Leaving a message with anyone who answers my telephone at home
- (Specify) _____

In the event you cannot contact me personally, you may discuss my care with any of the following individuals:

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

No One

I give my consent for any representative of Servolution Health Services to contact me regarding my care using the means I have indicated by the checked boxes above. Further, I give my permission to discuss my care with the individuals whose names are listed.

Amendment: I give my consent for electronic access to records via secured electronic medical (EMR) patient portal using above e-mail address or cell.

Alternate contact who may access my records via secured EMR patient portal.

Name _____ **E-Mail** _____

Signature

Date

**SERVOLUTION HEALTH SERVICES
181 POWELL VALLEY SCHOOL LANE
SPEEDWELL, TENNESSEE 37870
(423)419-5070, (423)419-5071, FAX (423)869-0081**

RELEASE OF INFORMATION/AUTHORIZATION

Patient's Full Name _____ Expiration Date _____

Date of Birth: ____/____/____ Social Security Number _____

Servolution Health Services (SHS) knows that health information is personal, and we are committed to protecting the privacy of your information. As a patient of SHS, the care and treatment you receive is recorded in a healthcare record. In order to best serve your medical needs, we sometimes must share your medical record, in whole or in part, with other healthcare providers involved in your treatment or with other entities during the normal business operations. We will not use or disclose your health information for any other purpose without your permission.

I _____, give my consent and authorize Servolution Health Services
PRINT NAME HERE
to release information from my records to other healthcare providers for purposes of continuity of care.

In addition, I give SHS my consent and authorization to obtain my medical, dental, and/or behavioral/mental health records from other providers for purposes of continuity of care.

Also, I give my consent for electronic access to records via secured electronic medical record (EMR) patient portal.

This authorization may be revoked by me at any time by written notice to SHS, except to the extent that action has already been taken.

I have the right to refuse to sign this authorization, and my refusal to sign will not affect my ability to obtain treatment unless allowed by law. However, refusal to sign may limit our ability to further your treatment beyond what can be done in house.

This **consent expires one year** from its date of acceptance.

Signature of Patient: _____ Date: _____

Signature of Witness: _____

Signature of Parent, Guardian, or Legal Representative: _____ Date: _____

**ALL AUTHORIZATIONS MUST BE MAILED TO ADDRESS AT TOP OF THE FORM.
WE CAN ACCEPT FAXED REQUESTS FROM HEALTHCARE PROVIDERS ONLY.**

SHS POLICY

NOTICE OF PRIVACY PRACTICES

As required by the Privacy Regulations Created as a Result of the Health Insurance Portability Act of 1995 (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU (AS A PATIENT OF SHS) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

SHS is dedicated to maintaining the privacy of your protected health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of your PHI. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time. We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use the disclose your PHI
- Your privacy rights in regard to your PHI
- Our obligations concerning the use and disclosure of your PHI
- How you can lodge a complaint about how we handle your HI without your approval for certain matters

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice, in our office in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Privacy Officer: Deborah Chumley
181 Powell Valley School Lane
Speedwell, Tennessee 37870

C. WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS

- **Treatment.** Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your friends or family members involved in your care.
- **Treatment Options.** Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.
- **Release of Information to Family/Friends.** Our practice may release your PHI to a friend of family member who is involved in your care or who assists in taking care of you. For example, a guardian may ask that a neighbor take their parent or child to the physician's office for treatment. This neighbor may have access to this patient's medical information. We may also release information to friends of family members involved in your payment for health services we provide.
- **Disclosures Required by Law.** Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES WITHOUT YOUR APPROVAL

The following categories describe unique scenarios in which we may use or disclose your PHI without your consent or authorization

1. **Public Health Risks.** Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths
- Reporting child abuse or neglect
- Preventing or controlling disease, injury or disability
- Notifying a person regarding potential exposure to a communicable disease
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition
- Reporting reactions to drugs or problems with products or devices
- Notifying individuals if a product or device they may be using has been recalled
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance

2. **Health Oversight Activities.** Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general. We may use your information to report diseases to the health department.

3. **Lawsuits and Similar Proceedings.** Our practice may disclose your PHI in response to a court or administrative order if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. **Law Enforcement.** We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. **Serious Threats to Health of Safety.** Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

6. **National Security.** Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

E. YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding the PHI that we maintain:

Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work, or to send communications in a sealed envelope instead of a postcard. You may be asked to pay for additional costs incurred to comply with your request. In order to request a type of confidential communication, you must make written request to our Privacy Officer specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI only to certain individuals involved in your care or the payment for your care, such as family members and friends. You may request to not have trainees or interns involved in your care. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to our Privacy Officer. Your request must describe in a clear and concise fashion; the information you wish restricted; whether you are requesting to limit our practice's use, disclosure or both; and to whom you want the limits to apply.

Inspection and Copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Privacy Officer: Deborah Chumley, 181 Powell Valley School Lane, Speedwell, TN 37870 in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying associated with your request.

Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to our Privacy Officer. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request and the reason supporting your request in writing. Also, we may deny your request if you ask us to amend information that is in our opinion (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy of (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." "An accounting of disclosures" is a list of certain disclosures that our practice has made of your PHI. We are not required to list use of your PHI as part of the routine patient care, payment or health operations in our practice for paper records. Example of routine patient care, payment, or health operations excluded from an accounting from paper charts include: the doctor sharing information with the nurse, the billing department using your information to file your insurance claim and discussion of your PHI for purposes of improving our health care delivery system. In order to obtain an accounting of disclosures, you must submit your request in writing to Privacy Officer: Deborah Chumley, 181 Powell Valley School Lane, Speedwell, TN 37870. All requests for an "accounting of disclosures: must state a time period, which may not be longer than six (6) years with paper charts or (3) years for listings to include treatment and payment from electronic records, from the date of the request and may not include dates before December 12, 2013. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests and you may withdraw your request before you incur any costs.

Right to Paper Copy of This Notice. You are entitled to receive a paper copy of our Notice of Privacy Practices. You will be offered a copy on your first visit to the practice. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact our Privacy Officer at 423-419-5070.

Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice, or with the U.S. Department of Health and Human Services; Atlanta Federal Center, Suite 3B70, 61 Forsyth St., S.W., Atlanta, GA 30303-8909; Voice Phone (404)562-7881; TDD (404) 441-2867. To file a complaint with our

practice contact Privacy Officer: Deborah Chumley, 181 Powell Valley School Lane, Speedwell, TN 37870. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not covered by this notice or permitted by applicable law, such as for research or marketing. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note, we are required to retain records of your case.

Again, if you have any question regarding this notice or our health information privacy policies, please contact our Privacy Officer at 423-419-5070.

This Notice of Privacy Practices is effective _____.

I acknowledge receipt of the SHS HIPAA policy.

SIGNATURE _____ **DATE** _____