NEW PATIENT INFORMATION

Insured **Chart # _____**

Co Payment $_____ 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 # _____

Race _____ Language _____ Ethnicity _____

Cell # _____ E-mail Address _____

Emergency Contact Name _____ Phone No _____Relationship _____

Patient Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other ☐ Unemployed ☐ Employed ☐ 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

Insurance

Patient Relationship to Insured _____ None _____ Self _____ Spouse _____Child _____Other _____

☐ Medicare ☐ Medicaid ☐ BlueCross/BlueShield ☐ Champus ☐ Champ VA ☐ Humana ☐ United Health Care

☐ Group Health Plan Other _____

Primary Insured Information

MEMBER ID # _____

Policy Group or FECA # _____

_____
First Middle Last

Date of Birth _____ Gender ____M ____F

Telephone # _____

_____
Insurance Plan Name or Program Name

Secondary Insured Information

Other Insured ☐ Same as Insured ☐

ID #_____

Policy Group or FECA # _____

_____
First Middle Last

Date of Birth _____ Gender ___M ___ F

Telephone # _____

_____
Insurance Plan Name or Program Name

Dr & Hospital who have records _____

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

_____

_____

If Minor:

Name of Parent, Guardian, or Legal Representative _____

_____
Patient's 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? O Yes O No If yes, please explain:_____
Have you ever had a serious head or neck injury? O Yes O No If yes, please explain:_____
Are you taking any medications, pills, or drugs? O Yes O No If yes, please explain:_____
Are you on a special diet? O Yes O No If yes, please explain:_____
Do you use controlled substance? O Yes O No If yes, please explain:_____
Do you currently use recreational or street drugs? O Yes O No If yes, please list:_____
Have you had recent weight gain or loss? O Yes O No If yes, please explain:_____
Have you traveled out of the United States? O Yes O 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
Abnormal Bleeding
Abnormal Pap Smear
Abuse/Domestic Violence
Acid Reflux (GERD)
ADD/ADHD
Aids/HIV
Allergies/Hay Fever
Alzheimer's Disease
Anaphylaxis
Anemia
Anesthesia Complications
Angina
Anxiety Disorder
Arthritis
Artificial Heart Valve
Artificial Joint
Asthma
Autism Spectrum Disorder(ASD)
Back Problems
Bedwetting
Birth Defects or Inherited Disease
Bladder or Kidney Problems
Bleeding Disorder
Blood Clots
Blood Diseases
Blood Transfusion
Breast Problem
Breathing Problem
Bruise Easily
Cancer _____
Chemotherapy
Chest Pains
Chicken Pox
Chronic Ear Infections
Cold Sores/Fever Blisters
Congenital Heart Disorder
Congestive Heart Failure (CHF)
Constipation
Convulsions
COPD
Coronary Artery Disease
Deep Vein Thrombosis (DVT)
Dementia
Depression
Develop or Behavioral Disorder
Diabetes
Difficulty Swallowing
Diverticulitis
Dizziness
Drug Addiction
Ear or Hearing Problems
Easily Winded
Eating Disorder
Eczema
Edema
Emphysema
Endometriosis
Epilepsy
Excessive Bleeding
Excessive Thirst
Fainting Spells
Fibromyalgia
Frequent Cough
Frequent Diarrhea
Frequent Headaches
Genital Herpes
GI Problems
Glaucoma
Gout
Head Injury/Concussion
Headaches
Hearing Loss
Heart Attack (MI)
Heart Murmur
Heart Pacemaker
Heart Problems
Hemophilia
Hepatitis A
Hepatitis B or C
Hernia _____
Herpes
High Cholesterol
Hives
Hyperlipidemia
Hypertension/High Blood Pressure
Hyperthyroidism
Hypoglycemia
Hypothyroidism
Incontinence
Infertility
Intestinal Disease
Irregular Heartbeat
Kidney Disease
Kidney Stones
Leukemia
Liver Disease
Low Blood Pressure
Lung Disease
Measles
Meniere's Disease
Mental Disorder
Mitral Valve Prolapse
MRSA Exposure
Mumps
Muscle, Joint, or Bone Problems
Nervous System Disorder
Obesity
Osteoporosis
Ovarian Cancer
Pain in Jaw Joints
Parathyroid Disease
Parkinson's Disease
Polio
Polyps
Psychiatric Care
Pulmonary Embolism
Radiation Treatment
Rash
Renal Dialysis
Respiratory Syncytial Virus (RSV)
Rheumatic Fever
Rubella
Scarlet Fever
Seizures
Shingles
Sickle Cell Disease
Sinus Trouble
Skin Problems
Spina Bifida
Stomach/Intestinal Disease
Stroke
Substance Abuse
Swelling of Limbs
Thyroid Problems
Tonsillitis
Tuberculosis
Tumors or Growths
Ulcers _____
Urinary Problems
Venereal Disease
Vision/Eye Problems
Whooping Cough
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, Inc.
181 Powell Valley School Lane
Speedwell, Tennessee 37870

AUTHORIZATION AND CARE/RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS CONSENT TO TREAT

The term "health care provider" in this document means Servolution Health Services (SHS), its agent and employees, members of the medical staff, their agents and employees, and other health care practitioners who provide care to patients.

I understand that as part of my health care, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plan for care including future treatment. I understand that this information serves as:

1. Basis for planning my treatment and care.
2. Information used to file my claim with the insurance company (procedure and diagnosis)
3. Means by which a third-party payer can verify that billed services were actually provided
4. A tool for routine health care operations including assessing quality and reviewing competency of your staff and/or other health care providers.

I understand that I have been provided with the Notice of Privacy Practices that provides more complete information of uses and disclosures. I understand that I have the right to review the notice before signing this consent. I understand that the organization reserves the right to change their notice and practices. I understand that I have the right to restrict how my health information may be used or disclosed to carry out payment, treatment or health care operations and that the organization is not required to agree with the restrictions requested. I understand that I have the right to revoke this consent in writing, except to the extent that the organization has already taken action on my behalf. Permission is hereby granted to all health care providers involved in my care to administer such examination, treatment, testing, and procedures as are deemed necessary while my care.

RELEASE OF INFORMATION

Information about me necessary to substantiate my insurance claims may be released by the health care provider involved in my care.

FINANCIAL RESPONSIBILITY/ASSIGNMENT OF BENEFITS

For those health care providers who accept assignment, I hereby authorize any insurance carrier with whom I have a policy to pay directly to the provider any benefits of any policies of insurance to those health care providers who have rendered services to me and who accept such assignment. I agree to pay **all** charges that are not paid in full by assigned insurance. If such amounts due to the health care providers are not paid after a reasonable notice, that account shall be deemed delinquent and a service charge shall be added to the amount due. In the event that I default on payment of my account, I agree to be responsible for collection fees and interest due on amounts in default, including court costs and reasonable attorney's fees. If the debt is assigned to a third party for collection, I agree to be responsible for collection fees and interest due on amounts in default.

MEDICARE LIFETIME BENEFICIARY CLAIM AUTHORIZATION AND RELEASE OF INFORMATION

I request that payment of authorized medical benefits be made either to me or on my behalf to Servolution Health Services for any services furnished me by the physician/supplier. I authorize any holder of medical information about me to release it to the Centers for Medicare and Medicaid Services and its agents any information needed to determine benefits or the benefits payable for related services.

I understand my signature requests that payment be made, and I authorize release of medical information necessary to pay the claim. If other health insurance is indicated on item 9 of the CMS-1500 claim form or elsewhere on the approved claim form or electronically submitted claim, my signature authorizes release of information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and deductible are based upon the charge determination of the Medicare carrier.

SIGNATURE **DATE**

SHS WITNESS **TITLE** **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 record (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, expect 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 devise 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 of 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 PHY. 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 _____

Rev. 11/5/2020