NORTH INTERNAL MEDICINE

Appointment is with: Douglas O'Dea, M.D. Debora Dowda, F.N.P.

Are you: New Patient Current Patient (seen in last 3years)

If NEW, were you referred by: Physician Relative Friend Insurance Carrier Other

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PATIENT INFORMATION

Date_____

Last Name_____ First Name_____ MI___

Street Address_____ City_____ ST ____ Zip_____

Home Phone ( )_____ Work ( )_____ Cell ( )_____

SS#_____ Date of Birth_____ Email_____

Sex: Female Male Marital Status: S M D W Other Employer_____

Race:

American Indian or Alaskan Native

Asian

Black or African American

White

Native Hawaiian or Pacific Islander

Other_____

Ethnicity:

Hispanic or Latino

Not Hispanic or Latino

Preferred Language:

English Spanish

EMERGENCY CONTACT INFORMATION

Name_____ Phone_____ Relation_____

PARENT/GUARDIAN INFORMATION **Complete if patient is a minor or legal dependent

Guardian's Name_____ Address_____

Contact Phone ( ) _____ Date of Birth_____ SS#_____

Employer_____ Work Phone ( ) _____

NORTH INTERNAL MEDICINE

Your insurance company requires us to keep your current insurance information and a signed authorization of benefits on file. Please complete the entire form and return it to the front desk receptionist along with you insurance card(s) and your driver license. Per our office policy, we will place copies in your file so we may make certain your insurance claims are filed properly.

PRIMARY INSURANCE	SECONDARY INSURANCE
Name of Insurance Carrier	Name of Insurance Carrier
_____	_____
Name of Policy Holder	Name of Policy Holder
_____	_____
Policy Holder's Date of Birth	Policy Holder's Date of Birth
_____	_____
Insurance ID #	Insurance ID #
_____	_____
Insurance Group #	Insurance Group #
_____	_____
Patient's Relation to Policy Holder	Patient's Relation to Policy Holder
_____	_____

Please print the telephone number where you want to receive calls about your scheduling, test results, and other health care information. ( )_____

I am fully aware that a cell phone is not a secure and/or private line.

Can we leave a general message requesting a return call to our office on your telephone answering machine or voicemail? Work _____ YES _____ Home _____ YES _____ NO

AUTHORIZATION: I hereby authorize North Internal Medicine, P.C. to provide information concerning any or all illness/accident to above listed insurance carriers, and herby assign to the physician all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance. I also certify the information I provided on this form is correct to the best of my knowledge.

_____ _____

Patient/ Guardian Signature **Date**

North Internal Medicine, P.C.
7378 Yale Road, Bartlett, TN 38133
Office (901) 387-0193 Fax (901) 387-0796

PAYMENT AGREEMENT

Patient Name _____

By signing the space below as patient, guardian or guarantor, or as the patient's guardian, spouse, or guarantor's spouse, I hereby agree that all charges connected with services performed by North Internal Medicine, P.C. not covered by any insurance program, sponsorship, or other third party coverage I may have are due and payable at the time of discharge (check out) or discontinuation of treatment.

I hereby acknowledge that North Internal Medicine, P.C. will bill my insurance or third party carrier. I understand that I shall be responsible for all my charges except those paid under medical insurance. I will be responsible for any and all non-covered services, the deductible, copays, and/or co-insurance amounts. Any and all known amounts are due at the time services and/or treatment is rendered. All other payments are due upon receipt of an itemized bill. I authorize North Internal Medicine, P.C. to release medical information necessary to process insurance claims. I further authorize payment of medical benefits directly to North Internal Medicine, P.C.

I agree if I am more than (30) days delinquent in the payment of my bill connected with these charges my account will be referred for collection. I further agree to pay attorney's fees, court cost, and/or collection fees associated with the collection process.

_____ _____

PATIENT/ GUARDIAN/GUARANTOR SIGNATURE DATE

FOR MEDICARE PATIENTS ONLY

ONE-TIME PAYMENT AUTHORIZATION AND ASSIGNMENT

Medicare Policy # _____

Medigap Insurance Company_____ Policy # _____

I request that payment of authorized Medicare benefits and authorized Medigap benefits be made on my behalf to North Internal Medicine, P.C. for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents and/or any.

_____ _____

PATIENT/ GUARDIAN SIGNATURE DATE

HIPAA Notice of Privacy Practices

North Internal Medicine
7378 Yale Rd. Bartlett, TN 38133
901-387-0193

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment:
We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment:
Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations:
We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, **authorization** or opportunity to object unless required by law. **You may revoke the authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Notice of Privacy Practices Acknowledgment

North Internal Medicine, PC

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

Patient Name or Legal Guardian (print) Date

_____

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date:_____ Attempt:_____

Staff Name:_____

PHI Use and Disclosure Authorization

North Internal Medicine

I authorize ____North Internal Medicine, PC____ to use and disclose of the following protected health information (PHI).

My complete health record, including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse.

PHI will only be released to entities on a "need-to-know" basis, just as Specialty Physician offices, (i.e., Cardiology), your insurance company, unless otherwise specified. Your PHI is never used for marketing purposes.

Name of Entity or Person(s) to Receive Information (i.e. spouse, family member): Relationship:

1)_____

2)_____

This authorization is effective through (check one):

☐ _____/_____/__2019___ or

☐ NO Expiration, unless revoked or terminated by the patient or the patient's personal representative.

This authorization shall be in force and effect until nine (9) months after my death or _____, (date or event) at which this authorization expires

I understand that I have the right to terminate or revoke this authorization at any time. To do so, my request must be provided to your office in writing. Written requests can be sent to: Lauren Butler 7378 Yale Rd. Bartlett, TN 38133 or emailed to . I understand that revocation is not effective if my authorization was obtained as a condition of obtaining insurance coverage.

I understand that information that is disclosed under this authorization may be disclosed by the recipient, as such the privacy of this information may not be protected under the Federal Privacy Rule depending on whom the information is disclosed to. I understand that my authorization is not required as a condition to receive treatment, payment, or enrollment or eligibility for benefits.

_____

Name of patient or Personal Representative (Type/Print)

_____ _____

Signature of Patient or Personal Representative Date

_____

Description of Personal Representative's Authority

HIPAA Privacy Rule

DATE:

PATIENT NAME:

DATE OF BIRTH:

HOW DID YOU HEAR ABOUT US?

FRIEND ☐

FAMILY MEMBER ☐

INTERNET ☐

OTHER ☐

ARE YOU ALLERGIC TO ANY MEDICATIONS (PLEASE LIST BELOW)?

CARDIOVASCULAR/ HEART HEALTH:

HAVE YOU EVER BEEN DIAGNOSED WITH THE FOLLOWING?

HIGH BLOOD PRESSURE?

AN IRREGULAR HEART BEAT?

ON A BLOOD THINNER?

DO YOU HAVE A PACEMAKER OR DEFIBRILLATOR (ICD)?

EVER HAD A HEART CATH?

EVER HAD BYPASS SURGERY (CABG)?

CONGESTIVE HEART FAILURE?

"BLOCKAGE IN YOUR LEGS?"

HEART STENT?

WHO IS YOUR CARDIOLOGIST?

GASTROENTEROLOGY:

ACID REFLUX "GERD?"

PEPTIC ULCER DISEASE?

LAST COLONOSCOPY DATE?

WHO IS YOUR GASROENTEROLOGIST?

BLADDER/PROSTATE/KIDNEY

RENAL (KIDNEY) CANCER?

KIDNEY STONE?

RENAL FAILURE/ESRD?

CHRONIC KIDNEY DISEASE/STAGE?

WHO IS YOUR KIDNEY DOCTOR?

ENDOCRINOLOGY:

DIABETES?

TYPE I OR TYPE II?

DO YOU REQUIRE INSULIN?

DO YOU HAVE AN INSULIN PUMP?

DO YOU HAVE RETINOPATHY IN YOUR EYES?

NEUROPATHY IN YOUR FEET OR HANDS?

DO YOU HAVE HIGH CHOLESTEROL?

WHO IS YOUR ENDOCRINOLOGIST?

CANCER/BLOOD/INFLAMMATORY:

HAVE YOU EVER HAD A BLOOD CLOT?

WHERE?

BEEN DIAGNOSED WITH ANEMIA?

WHAT ABOUT FOOD ALLERGIES?

ARE YOU A CURRENT SMOKER?

HAVE YOU EVER SMOKED?

DO YOU DRINK ALCOHOL?

HOW MUCH PER WEEK?

DO YOU HAVE A FAMILY HISTORY OF:

	MATERNAL	PATERNAL
ALZHEMIERS/DEMENTIA?	M	P
DEPRESSION?	M	P
HEART DISEASE?	M	P
HEART ATTACK?	M	P
HIGH BLOOD PRESSURE?	M	P
CANCER?	M	P
IF SO, WHAT TYPE?		
DIABETES?	M	P
KIDNEY DISEASE?	M	P

HAVE YOU BEEN IN THE HOSPITAL OR EMERGENCY ROOM RECENTLY?

WHICH HOSPITAL?

NAME:

DOB:

SICKLE CELL ANEMIA?

CANCER OF ANY KIND?

AUTO-IMMUNE DISEASE LIKE LUPUS?

WHO IS YOUR HEMATOLOGIST/ONCOLOGIST?

PULMONARY:

HAVE YOU EVER BEEN DIAGNOSED WITH COPD OR SLEEP APNEA?

DO YOU USE YOUR C-PAP?

MUSCULOSKELETAL:

DEGENERATIVE JOINTS (OSTEOARTHRITIS?)

GOUT?

WHO IS YOUR ORTHOPEDIC DOCTOR?

NEUROLOGICAL:

EVER HAD A STROKE OR TIA?

SEZUIRES?

DEPRESSION?

PSYCHIATRIC DISORDER?

WHO IS YOUR PSYCHIATRIST?

SUGICAL HISTORY:

HAVE YOU EVER HAD YOUR GALLBLADDER REMOVED? YEAR? SURGEON NAME:

HAVE YOU EVER HAD YOUR APPENDIX REMOVED?

HAVE YOU HAD BREAST SURGERY?

HAVE YOU HAD A JOINT REPLACED?

HAVE YOU HAD NECK OR BACK SURGERY? PLEASE SPECIFY:

FEMALE: HYSTERECTOMY?

TUBAL LIGATION

HOW MANY PREGNANCIES?

HOW MANY FULL-TERM PREGNANCIES?

HOW MANY PREGNANCY TERMINATIONS?

BLADDER SLING?

MALE: HAVE YOU HAD YOUR PROSTATE REMOVED?

VASECTOMY?

PLEASE LIST ANY OTHER SURGERIES YOU HAVE HAD:

PERSONAL MEDICATION RECORD

Complete the information and bring it with you when you come for your appointment. Thank you!

Date: **Name:**

Height: **Weight:**

List all prescription medications, over-the-counter medications, vitamins and herbal supplements that you are taking. List all prescribing phsycians. At the end, please answer the questions dealing with what you are allergic to. Thank you!

Medication	**Physician** (last name, first name)	**Strength** (of med eg., 10 mg)	**Time**	**Time**	**Time**	**Time**	**Time**	**Total Strength for this medication**	**Reason for taking this medication?**