Advanced Rehab and Medical/ 45 Urgent Care
Confidential Patient Data

PATIENT INFORMATION

Today's Date:_____

Name:_____Date of Birth:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____Work Phone: _____ Cell: _____

Email: _____Social Security #:_____ Age:_____

❑ Male ❑ Female Marital Status: ❑ Married ❑Single ❑Divorced ❑Other_____

Name of Spouse or Nearest Relative: _____ Phone:_____

Your Occupation_____ Your Employer: _____

How did you hear about us? _____

Name of Insurance Co.:_____Insured's Employer: _____

Insured's Social Security #:_____ Insured's Date of Birth: _____

Are you covered by more than one insurance company? ❑Yes ❑No Name _____

MEDICAL/FAMILY HISTORY S = Self M = Mother F = Father

(Please indicate which PAST conditions have been experienced prior to present complaint by marking appropriate boxes).

S	M	F		S	M	F		S	M	F	
❑	❑	❑	Heart Disease	❑	❑	❑	dislocated joints	❑	❑	❑	neck pain
❑	❑	❑	anemia	❑	❑	❑	epilepsy	❑	❑	❑	nervousness
❑	❑	❑	arthritis	❑	❑	❑	Measles	❑	❑	❑	numbness
❑	❑	❑	asthma	❑	❑	❑	headaches	❑	❑	❑	polio
❑	❑	❑	back pain	❑	❑	❑	heart trouble	❑	❑	❑	poor circulation
❑	❑	❑	bladder trouble	❑	❑	❑	reproductive disorders	❑	❑	❑	hepatitis
❑	❑	❑	bone fracture	❑	❑	❑	high blood pressure	❑	❑	❑	rheumatic fever
❑	❑	❑	cancer	❑	❑	❑	HIV/ARC	❑	❑	❑	rheumatism
❑	❑	❑	chest pain	❑	❑	❑	kidney disorder	❑	❑	❑	scarlet fever
❑	❑	❑	concussion	❑	❑	❑	bowel control loss	❑	❑	❑	serious injury
❑	❑	❑	convulsions	❑	❑	❑	menstrual cramps	❑	❑	❑	sinus trouble
❑	❑	❑	diabetes	❑	❑	❑	multiple sclerosis	❑	❑	❑	Stroke
❑	❑	❑	indigestion	❑	❑	❑	muscular dystrophy	❑	❑	❑	tuberculosis
								❑	❑	❑	venereal disease

Have you been treated by a physician for any health condition in the last year? ❑Yes ❑No

SURGICAL HISTORY:

1._____ Date:_____

2._____ Date:_____

3._____ Date:_____

ACCIDENT HISTORY: ❑Job ❑Auto ❑Other 1. _____Date:_____

❑Job ❑Auto ❑Other 2._____Date:_____

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

Please Rate your symptoms (1-10, with 1 being least serious)

1._____ _____

2._____ _____

3._____ _____

4._____ _____

SYMPTOMS ARE WORSE IN ❑MORNING ❑AFTERNOON ❑NIGHT ❑Consistent
WHEN AND HOW OCCURRED? _____

_____

SYMPTOMS DEVELOPED FROM: ❑JOB RELATED INJURY ❑AUTO ACCIDENT ❑OTHER ❑ACCIDENT
❑ILLNESS ❑UNKNOWN CAUSE ❑GRADUAL ONSET DATE OCCURRED: _____
SYMPTOMS HAVE PERSISTED FOR #____HOUR(S) ____DAY(S) __WEEK(S) ___MONTH(S) ___YEAR(S)
SYMPTOMS/COMPLAINTS: ❑COME & GO ❑ARE CONSTANT
NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S):

_____

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS ❑NO ❑YES WHAT KIND? _____

_____

ARE YOU TAKING ANY MEDICATIONS? ❑NO ❑YES WHAT KIND? _____

_____

_____

ARE YOU PREGNANT ❑NO ❑YES ❑MAYBE

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:
❑BENDING ❑REACHING ❑STRAINING AT STOOL ❑COUGHING ❑SITTING ❑TURNING HEAD
❑LIFTING ❑SNEEZING ❑WALKING ❑LYING DOWN ❑STANDING

SOCIAL HISTORY

DO YOU SMOKE? YES ____ NO ____ IF YES, HOW MUCH? _____

DO YOU DRINK ALCOHOL? YES ____ NO ____ IF YES, HOW OFTEN AND HOW MUCH? _____

ILLICIT DRUGS? YES ____ NO ____ IF YES, DESCRIBE _____

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and or my dependent(s), have insurance coverage with _____ and assign directly to Advanced Rehab and Medical/45 Urgent Care all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsibility for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information to the above-named Insurance Companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient or Guardian Date

_____ _____

Please print name of patient or guardian Relationship to Patient

Pt. Name: _____ Date of Birth: _____

Please list all medications, vitamins and nutritional supplements that you are currently taking:

Medication/Vitamin/Supplement	Dosage	Reason for Taking

Pt. Name: _____ Date of Birth: _____

Have you had ANY of the following in the last 12 months or currently? (Mark C for Current. X for in last 12 mos.)

GENERAL
____ Chills
____ Fatigue
____ Fever
____ Loss of Weight
____ Weight Loss

CARDIOVASCULAR
____ High Blood Pressure
____ Rapid Heartbeat
____ Previous Heart Problem
(Describe_____)
____ Slow Heartbeat
____ Stroke
____ TIA
____ Swollen Ankles
____ Chest Pain
____ Aortic Aneurysm
____ Bruise Easily

GASTRO-INTESTINAL

____ Constipation
____ Diarrhea
____ Nausea
____ Poor Appetite
____ Vomiting
____ Vomiting Blood
____ Rectal Bleeding

GENITO-URINARY
____ Blood in Urine
____ Frequent Urination
____ Inability to control urine
____ Kidney Infection
____ Painful Urination
____ Prostate Trouble
____ Painful Urination

RESPIRATORY
____ Chronic Cough
____ Coughing/Spitting Blood
____ Asthma
____ Shortness of breath
____ Wheezing

EARS/EYES/NOSE/THROAT
____ Double Vision
____ Blurred Vision
____ Difficulty Swallowing
____ Deafness
____ Hearing Loss
____ Ear Pain
____ Nose Bleeds
____ Sinus Problems
____ Sore Throats
____ Sinus Discharge
____ Hay Fever
____ Frequent colds
____ Sinus Infections

FOR WOMEN ONLY
____ Menstrual Cramps
____ Excessive menstrual flow
____ Hot Flashes
____ Irregular Cycle

MUSCLE/JOINT/BONE
____ Backache
____ Pain Between Shoulders
____ Painful Tailbone
____ Stiff Neck

NEUROLOGIC
____ Seizures
____ Dizziness
____ Tremors
____ Weakness
____ Headaches
____ Loss of memory
____ Loss of coordination

_____
Performing Physician Signature

Meredith Murray ACNP-BC
April Eddings, PA-C

_____
Supervising Physician Signature

Mark Fowler, MD

_____
Patient Signature

_____
Date

Advanced Rehab and Medical DBA: Back Pain Relief Clinic
2012 Greystone Square
Jackson, TN 38305

Disclosure for Treatment, Payment, and Health Care Operations

- *If you give us consent, we will use your health information for treatment.* Example: A physician, a physician's assistant, a therapist or a counselor, a nurse, or another member of your health care team will record information in your record to diagnose your condition and determine the best course of treatment for you. The primary caregiver will give treatment orders and document what he or she expects other members of the health care team to do to treat you. Those other members will then document the actions that they took and their observations. In that way, the primary caregiver will know how you are responding to treatment. We will also provide physician, other health care professionals, or a subsequent health care provider copies, of your records to assist them in treating you once we are no longer treating you.
- *If you give us consent, we will use your health information for payment.* Example: We may send a bill to you or to a third-party payer, such as a health insurer. The information on or accompanying the bill may include information that identifies you, your diagnosis, treatment received, and supplies used.
- *If you give us consent, we will use your health information for health care operations.* Examples: Members of the medical staff, the risk or quality improvement manager, or members of the quality assurance team may use information in your health record to assess the care and outcomes in your cases and the competence of the caregivers. We will use this information in an effort to continually improve the quality and effectiveness of the health care and services that we provide.
- *Business associates:* We provide some services through contracts with business associates. Examples include certain diagnostic tests, a copy service to make copies of medical records, and the like. When we use these services, we may disclose your health information to the business associates so that they can perform the function(s) what we have contracted with them to do and bill you or your third-party payer for services provided. To protect your health information, however, we require the business associates to appropriately safeguard your information. After February 17, 2010, business associates must comply with the same federal security and privacy rules as we do.
- *Directory:* Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.
- *Notification:* We may use or disclose information to notify or assist in notifying a family member, a personal representative, or another person responsible for your care, location, and general condition.
- *Communication with family:* Unless you object, health professionals, using their best judgment, may disclose to a family member, another relative, a close personal friend, or any other person that you identify health information in your care or payment related to your care.
- *Research:* We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.
- *Funeral directors:* We may disclose health information to funeral directors consistent with applicable law to enable them to carry out their duties.

- *Marketing/ continuity of care:* We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.
- *Fundraising:* We may contact you as part of a fundraising effort. You have the right to request not to receive subsequent fundraising materials.
- *Food and Drug Administration (FDA):* We may disclose to the FDA health information relative to adverse effects/events with respect to food, drugs, supplements, product or product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.
- *Workers compensation:* We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.
- *Public health:* As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.
- *Correctional institution:* If you are an inmate of a correctional institution we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.
- *Law enforcement:* We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.
- *Health oversight agencies and public health authorities:* If members of our work force or business associates believe in good faith that we have engaged in unlawful conduct or otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public, they may disclose your health information to health oversight agencies and/or public health authorities, such as the department of health.
- *The federal Department of Health and Human Services (DHHS):* Under the privacy standards, we must disclose your health information to DHHS as necessary to determine our compliance with those standards.

Please list below any individual(s) that you will allow us to discuss your medical condition for financial arrangements:

_____ _____

_____ _____

Effective Date: _____

Signature: _____

Title: _____

Covered Entity: Advanced Rehab and Medical, PC

Dba: Back Pain Relief Clinic

By signing below I certify that I have reviewed and agree to the above information:

_____ _____

Patient Signature Date

Authorization for Use or Disclosure of Protected Health Information

Name of Patient: _____
Date of Birth: _____ SS# _____ Medical Record _____
Daytime Phone # _____ Evening # _____
Address _____
City _____ State _____ Zip _____

I hereby authorize _____ to use or disclose my protected health information as indicated below to:

Name _____
Daytime Phone # _____ Fax # _____
Address _____
City _____ State _____ Zip _____

Information to be released:
From & To Dates _____
() History and physical Exam _____
() Lab Report _____
() X-ray report _____
() Consultation Report _____
() Other _____

Purpose of Disclosure:
() Changing Physician
() Continuing Care
() At my (patient) request
() Workers' Compensation
() Other _____
() Second Opinion
() Legal
() Insurance
() School

I understand that this health information may include HIV related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am specifically authorizing the release of information relating to:
() Substance Abuse (including alcohol/drug abuse)
() Mental Health
() Psychotherapy Notes
() HIV related information (including AIDS related testing)
This authorization was developed to comply with the provisions regarding disclosure of medical/health information under P. L. 104-191 ("HIPAA"); 45 Code of Federal Regulations parts 160 and 164; 42 U.S. Code Section 290dd-2; 42 CFR part 2.31; 38 U.S. Code section 7332 and T.C.A § 68-10-113

X _____ Date: _____
Signature of Patient or Legal Guardian

1. I understand that this authorization will expire two years from my last date of service visit. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying _____/Privacy Officer at the address indicated below, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.
4. My health care and payment for my health care will not be affected if I do not sign this form.
5. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.
6. I understand that I will get a copy of this form after I sign it.

By signing below, I acknowledge that I have read and understand this Authorization.

_____ OR _____ _____
Signature of Patient — Parent/Legal Guardian/Authorized Person — Date

_____
Relationship to Patient

_____ _____
Records Received By — Date

Date Request Filled _____ By _____
Account # _____
Identification Presented _____ Fee Collected _____