Family Clinic of Parsons, LLC
Confidential
Registration Information
Please Print

___ New Patient
___ Existing Patient

Existing Patient: Revise all information that has changed since your last visit

Date ___/___/____ Email Address: _____ Home Phone: _____ Work Phone: _____

*Name Last _____First_____MI___ Cell Phone: _____

Street Address: _____ Mailing Address_____

City: _____ State _____ Zip_____

Gender: Male___ Female___ *SSN: _____ - _____- _____ *Birth-date ____/____/_____

Circle One: Married - Single - Partnered – Widowed Name of Partner/Spouse/Significant Other _____

---

*Name of Spouse/Responsible Party (If patient is minor): _____
Last First MI

*Responsible Party (Parent or Guardian) /Spouse SSN: _____-_____-_____ Birth-date ____/____/_____

Patient Employed by: _____

Business Address_____

Business Phone: _____ Occupation _____

Spouse/Responsible party Employed by: _____

Business Address: _____

Business Phone: _____ Occupation _____

Do you have medical Insurance? Circle One: No Yes If yes, please fill in the following information:

Name of Primary Insurance: _____ ID # _____ Group # _____

*Subscriber's Name: _____ *Birth-date: ____/____/____

Insurance Address _____

Name of Secondary Insurance: _____ ID # _____ Group # _____

*Subscriber's Name: _____ *Birth-date: ____/____/____

Insurance Address _____

In case of an emergency, who should be notified? _____

Relationship _____Phone: _____

Preferred Pharmacy: _____ How did you hear about us? _____

Do we have your consent to talk with the person that answers the phone or leave a message about any appointments?

Yes_____ No_____ Signature: _____

*This information is required by HIPPA and must be provided. REV. 10/12

Family Clinic of Parsons, LLC

766 Tennessee Ave. S. ● Parsons, TN 38363 ● (731) 847-7778

Today' s Date:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring provider:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
Immunizations and dates:	☐ Tetanus ☐ Pneumonia	**Last Mammogram:**
	☐ Hepatitis ☐ Chickenpox	**Last Pap Smear:**
	☐ Influenza ☐ MMR *Measles, Mumps, Rubella*	**Last Colonoscopy:**

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No

Allergies to medications	
Name the Drug	**Reaction You Had**

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
Personal Safety	Do you live alone?				☐ Yes	☐ No
	Do you have frequent falls?				☐ Yes	☐ No
	Do you have vision or hearing loss?				☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?				☐ Yes	☐ No
	Would you like information on the preparation of these?				☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?				☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** ***Maternal***		
	☐ M ☐ F		**Grandfather** ***Maternal***		
	☐ M ☐ F		**Grandmother** ***Paternal***		
	☐ M ☐ F		**Grandfather** ***Paternal***		

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Visual Changes/Loss	☐ Shortness of breath	☐ Changes in muscle strength
☐ Head Injury	☐ Asthma or Emphysema	☐ Falling
☐ Headaches	☐ High blood pressure	☐ Hepatitis A, B or C
☐ Seizures	☐ Chest pain, heart attack	☐ Sexually Transmitted Infections
☐ Hearing Loss	☐ Constipation or Diarrhea	☐ Elevated cholesterol or glucose levels
☐ Nose	☐ Difficulty controlling bowel or bladder	☐ Diabetes
☐ Throat	☐ GYN problems	☐ Memory problems
☐ Thyroid disorder	☐ Cancer/Tumors/Cysts	☐ Difficulty with sleep
☐ Allergies	☐ Back Pain	☐ Childhood Illness – specify
☐ Recent Weight Changes	☐ Other pain:	☐ Other chronic health issues:

MEDICATIONS

Please use the space below to share any other concerns:

List ALL medications, their dose and what time you take them. (Include vitamins, herbals, over the counter)

Name of Medication	Dose of Medication	Time you take Medication

PROVIDER'S COMMENTS

Family Clinic of Parsons, LLC

Patient Authorization Form
Advance Directives

Patient Authorization:

1. I consent to treatment necessary for the care of the below named patient.

2. I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable,

3. I allow fax transmittal of my medical records, if necessary.

4. I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment,

5. In the event the charges incurred are not paid-in-full when due and collection action is instituted, whether by collection agency, or attorney, or both; I agree to be responsible for and to pay in addition to the charges for services and treatment received all cost associated with such collection activity including, but not limited to, reasonable collection agency fees, attorney fees, and court costs,

6. I further authorize and request that insurance payments be made directly to the provider.

7. I have read and fully understand the above consent for treatment and financial responsibility, release of medical information, and insurance authorization.

8. I agree with all the above with the exception of number.

9. I acknowledge full financial responsibility for services rendered by Family Clinic of Parsons, LLC.

Patient (or Guardian) Signature: _____ Date: _____

Witness_____ Date: _____

Advanced Directives:
Do you have a living will or durable power of attorney? ____Yes ____No

If you have a durable power of attorney, please identify; _____

Patient Signature: _____

Witness: _____

Family Clinic of Parsons, LLC

FINANCIAL POLICY
NOTICE TO OUR PATIENTS REGARDING OUR GUIDELINES

The following is to inform patients of Family Clinic of Parsons, LLC guidelines.
Your time and health is valuable to us and when a patient does not show up for their appointment, they take the time that could be used to help the health of another fellow patient. If you are unable to make your appointment, please call the office at least 24 hours in advance to cancel or reschedule your appointment. **If you do not call and do not show up for your appointment, you will be charged a $25.00 fee.**

Your health is extremely important to us, but if patients do not pay for the services they receive from Family Clinic of Parsons, LLC, we will be unable to keep the clinic open to serve your health needs. Therefore, if you do not have health insurance, payment of the office visit fee is expected in full before you are seen. Any remainder balance for services deemed necessary by your healthcare provider will be expected to be paid in full before you leave the clinic.

If you do have health insurance, payment of your co-pay is expected in full before you are seen.
Family Clinic of Parsons, LLC will not be responsible for any labs or any other institutions bill that your health insurance does or did not cover. We file your insurance as a courtesy to you it does not mean the services will be covered. You as the patient will be responsible to call your insurance company and to find out the reason why your insurance didn't cover the services indicated by your healthcare provider. If for any reason your health insurance denied to cover services provided by Family Clinic of Parsons, LLC, you will be responsible for payment of your balance, including but not limited to any and all collection cost, attorney fees, legal fees and /or court cost occurred in the process of debt collection.

We are honored that you have chosen Family Clinic of Parsons, LLC for your healthcare needs.
We are committed to make your time with us as pleasant as possible and to give you the ultimate
in care. If for some reason, there is something that you feel we can do to better serve you, please don't hesitate to let us know. Thank you for choosing us for your healthcare needs.

By signing below, you agree that you have read and understand Family Clinic of Parsons, LLC guidelines as stated above.

Patient (Responsible Party) Name (Please Print):_____

Patient DOB: _____

Patient (Responsible Party) or Guardian Signature: _____
Date: _____

Assignment of Insurance Benefits

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my provider to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and even claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I _____ hereby authorize_____
(Name of Insured) (Name of Insurance Company)

to pay and hereby assign directly to (Family Clinic of Parsons, LLC. Kim Inman FNP-C) all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. I understand I am financially responsible for charges incurred.

I further acknowledge that any insurance benefits, when received by and paid to (Family Clinic of Parsons, LLC. Kim Inman FNP-C) will be credited to my account, in accordance with the above said assignment.

_____ _____
(Authorized Signature of Subscriber) (Date)

Medicare Authorization

IF YOU ARE COVERED BY MEDICARE, PLEASE SIGN AND DATE BELOW

I request payment of authorized Medicare benefits be made either to me or on my behalf to (Family Clinic of Parsons, LLC. Kim Inman FNP-C) for any services furnished to me by (Family Clinic of Parsons, LLC. Kim Inman FNP-C). I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the health care provider 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 the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Signature of Beneficiary Date

Financial Policy

I have read and understand the financial policies of Family Clinic of Parsons, LLC. By my signature I agree to the terms outlined in the financial policies.

_____ _____
Signature Date

Consent for Treatment

I (or my legal guardian/parent) authorize Family Clinic of Parsons, LLC to provide medical care reasonable by today's standards.

_____ _____
Signature of Patient/Legal Guardian Date

Family Clinic of Parsons, LLC

Medication Use Agreement

I, _____ understand that I have pain that has not been adequately controlled with other medication and that my function is limited by my pain. I understand that the intent of the medication is to increase my ability to do more, though the medication is unlikely to eliminate the pain.

I will take the medication only as prescribed. I will not take any sedative, alcohol or other pain medications without the prior approval of my prescribing health care provider.

I understand that the medication will be prescribed only by (Family Clinic of Parsons, LLC .Kim Inman FNP-C) and only according to the agreed-upon schedule. Prescriptions will be provided only during regularly scheduled appointments. Refills will never be provided by telephone.

I will not seek or accept any medications for pain other than those prescribed by my health care provider. “Medications for pain” includes prescriptions from other health care provider’s, medications borrowed or accepted from family or friends, and any illicit or street drugs.

Medication refills will be provided as written prescriptions only. No refills will be given prior to the next scheduled appointment date. If I do not keep my appointment, I will not receive a refill. Two (2) appointment cancellations with less than one working day’s notice or two (2) no-show appointments may constitute grounds for immediate termination of this agreement.

I understand that my health care provider is under no obligation to provide these medications to me, and that she or he reserves the right to discontinue these medications at any time. At my health care provider’s discretion, I agree to cooperate with random drug testing, which may be requested at any time, If I refuse, I understand the medication will be stopped. I understand that law enforcement agencies will be notified if there is evidence of prescription tampering or other illegal activity.

I understand that lost or stolen medications will not be refilled under any circumstances. It is my responsibility to protect and secure any medications. This includes keeping the medication out of reach of children

I understand that my health care provider may requite specialist evaluation of my treatment, and I agree to keep appointments when my physician refers me. My health care provider will send a report of my care and a copy of this agreement when a referral is made.

In addition to the above agreements, I accept the right of my health care provider’s clinical staff to terminate this agreement for any of the following reasons:

1. I seek or obtain any pain medication or other scheduled/psychoactive medication from a source other than my health care provider.
2. I give, sell or in any way distribute prescribed medications to any other person(s).
3. I in any way attempt to forge or alter a prescription.
4. My medical condition declines to the point at which, in the judgment of my health care provider, continued therapy with this medication presents a danger to my well-being or safety.
5. There is evidence that I am no longer receiving a reasonable therapeutic benefit from the medication, or my health care provider determines that I am no longer a good candidate to continue the medication.
6. If there is evidence of illicit drug use.

I agree to fill my prescriptions only at the pharmacy I list below. If I change pharmacies, I will contact my health care provider’s office and provide them with the name, address and phone number of the new pharmacy. Under no circumstances will I obtain medications from more than one pharmacy at a time. In order to verify appropriate medication use, my health care provider’s office will provide my chosen pharmacy with a copy of this agreement.

I understand that any alteration in my medication prescriptions will require a new written agreement.

Pharmacy name _____

Pharmacy telephone _____

Medication name, dose and directions _____

Number of pills prescribed _____ Frequency of appointments _____days

I understand that by signing this agreement, I must abide by the rules reviewed above and that failure to abide by these agreements will result in the termination of medication prescriptions and possibly the termination of services from my health care provider and his or her practice.

_____ _____

Patient signature Date Provider Signature Date

Family Clinic of Parsons, LLC
766 Tennessee Ave S. Parsons, TN 38363- Phone: (731) 847-7778 Fax: (731) 847-9993
CONSENT TO RELEASE MEDICAL RECORDS

NAME: _____

Address: _____

City: _____

Home Phone: _____ Work _____ Cell _____

This consent authorizes Kimberly Inman, FNP-C of Family Clinic of Parsons, LLC to:

___ release information regarding the above named patient to:
___ receive information regarding the above named patient from:

NAME: _____

Organization:_____

Address: _____

City: _____ State: _____ Zip _____

Phone: _____ Fax: _____

The information below will be disclosed/requested:

___ Entire Record
___ Psychotherapy Notes
___ Mental Health Notes
___ Hospital notes/discharge summaries
___ List of current/previous medications
___ History & Physical results
____ Initial Assessments & Final Diagnoses
____ Information regarding drugs and alcohol
____ Information regarding HIV/AIDS
____ Psychological testing results
____ Vocational testing results
____ Other: _____

The purpose of this disclosure/request is:

___ Coordination of Care ____ Treatment Plan
___ Other _____

This consent may be revoked at any time by providing written notice. By signing this form, the patient acknowledges that s/he has been given information about what is to be disclosed/requested, the purpose of this disclosure/request, and who will receive this information. Signing of this form by the patient also releases Family Clinic of Parsons, LLC from any legal liability resulting from the release of this information. Consent to this disclosure will expire in eighteen months from the date signed unless otherwise designated below.

Patient Signature_____ Date_____

Family Clinic of Parsons, LLC

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Family Clinic of Parsons, LLC (from this point on referred to as PRACTICE) to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations. (The Notice of Privacy Practices provided by PRACTICE describes such uses and disclosures more completely and is continually posted on the wall in the waiting room at PRACTICE.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. PRACTICE reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to attention Office Manager at PRACTICE

With this consent, PRACTICE may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, PRACTICE may mail to my home or other alternative location any items that assist the practice in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminder cards and patient statements."

With this consent, PRACTICE may e-mail to my home or other alternative location any items that assist the practice in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminder cards and patient statements. I have the right to request that PRACTICE restrict how it uses or discloses my PHI to carry out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow PRACTICE to use and disclose my PHI to carry out treatment, payment, and health care operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Family Clinic of Parsons, LLC may decline to provide treatment to me.

Signed by: _____ _____ _____

Signature of Patient or Legal Guardian | Date | Relationship to Patient

_____ _____

Print Patient's Name | Print Name of Legal Guardian, if applicable

Patient/guardian must be provided with a signed copy of this authorization form.