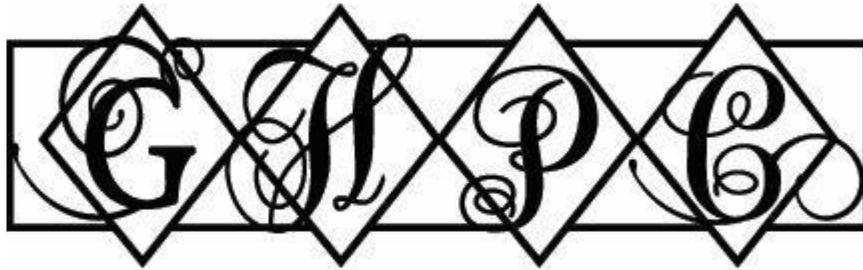

Sherry Glover MSN, FNP-C

Alicia Whitley FNP-C

3500 Dayton Blvd
Chattanooga, TN 37415
Phone: (423) 362-8400 Fax: (423) 362-8399
info@gracehomeprimary.com

We see patients in their "home" wherever that may be: a house, assisted living facility, or retirement community. Our Nurse Practitioners provide health promotion and maintenance through diagnosis and treatment of acute illness and chronic conditions through initial evaluations and follow up visits, labs, imaging, and more at the bedside in your home or assisted living facility. Our Nurse Practitioners provide routine monthly visits to our patients. Our friendly staff loves our patients.

- **Signed and completed paper work**
- **Copy of Insurance cards front and back**
- **Copy of COVID-19 Vaccination Card (if applicable)**
- **Copy of POA paper work**
- **Copy of Advance Directive or Living Will**
- **Copy of immunizations**
- **Email address**

GRACE HOME PRIMARY CARE

Sherry Glover, MSN, NP-C

Your Legal First Name______________________MI______________Last____________________

Address_____________________

Facility: ____ Apt./Room # _____________

Date of Birth __________________ **YOUR** SS# ____

Marital Status: S M W D Race: _______ Gender: F M Language: __________

Telephone # __________________________ E-mail address: _____________________________

Do you have a Power of Attorney? Yes No If so who: ______________________________

Do you have an Advance Directive or a Living will on file? Yes No

Responsible Party:

Name: __________________________________ Relationship: ______________________

Billing address: ____

Phone: ____

Email address: ____

Do you authorize us to communicate by text? Yes No By Email? Yes No

Primary contact:

Name: ___________________________________ Relationship: ______________________

Address: ____

Phone: ____

Email address: ____

Do you authorize us to communicate by text? Yes No By Email? Yes No

Primary Insurance____

Name on Insurance Card (exactly) ____

ID #_______________________________ Group or Other # ______________________________

Supplemental Insurance____

Name on Insurance Card (exactly)____

ID #__________________________________ Group or Other# __________________________________

**** Please include a copy of the front and back of your Insurance Cards ****

GRACE HOME PRIMARY CARE

CONSENT TO TREAT

I hereby consent to medical treatment as deemed necessary or advisable by my Nurse Practitioner /Physician at Grace Home Primary Care. I consent for my information to be sent/received by electronic means such as secure email, fax, or text message. I authorize GHPC to photograph myself or items as needed for medical treatment purposes. They will be kept in a chart bearing my name and used with the utmost respect.

ASSIGNMENT OF INSURANCE BENEFITS

I understand that all applicable copayments and deductibles are due at the time of billing. I agree to financially be responsible for all charges not covered by my insurance company. I authorize my insurance benefits to be paid directly to Grace Home Primary Care for services rendered. I authorize representatives of Grace Home Primary Care and/or the physician providing services, their billing agents, the Social Security Administration, its intermediaries and carries to release medical information to my insurance company when requested.

HIPPA NOTICE OF PRIVACY PRACTICES

As required by the Health Insurance Portability and Accountability Act (HIPPA) we are required to give you a copy of the Notice of Privacy Practices for Grace Home Primary Care. I have read and requested a copy, if desired, of the Privacy Practices.

I, ________________________________, authorize Grace Home Primary Care,
PATIENT NAME

Sherry Glover NP-C, Dr. Terry A. Melvin, M.D. and any GHPC staff member to release medical information to the following person(s) listed above. This release includes both phone and written data.

____ ______________________
PATIENT/LEGAL GUARDIAN SIGNATURE DATE

____
PATIENT NAME

GRACE HOME PRIMARY CARE
Sherry Glover, MSN, NP-C

3500 Dayton Blvd.
Chattanooga, TN 37415
Office (423) 362-8400 Fax (423) 362-8399

AUTHORIZATION

OBTAIN / RELEASE MEDICAL RECORDS

List all providers we need to contact

PATIENT NAME ____________________________________ DATE OF BIRTH___________________

____

____

____

____

____

____

I request and authorize the above documented provider(s) to release medical record information to this provider:

This request applies to

☐ All healthcare information on file for me

☐ Specific information as indicated here: ____

____

____ ______________________
PATIENT SIGNATURE DATE

If patient unable, legal representative please sign below

___________________________________ ____________________ _____________________
NAME RELATIONSHIP DATE

GRACE HOME PRIMARY CARE

YOUR HISTORY

Patient Name: ______________________________ Height:________ Weight:________

Allergies:____

Do you have, or have you had, any of the following:

Alzheimer's disease ☐

Dementia ☐

Anxiety/ depression ☐

Hx of CVA ☐

Anemia ☐

Hx of TIA ☐

Cardiovascular Disease ☐

Hx of heart Attack ☐

Heart Failure ☐

Heart Murmur ☐

Irregular heartbeat ☐

Parkinson's disease ☐

Hypertension ☐

Low Blood Pressure ☐

Pacemaker ☐

Cancer/Location____________☐

Chemotherapy/Radiation ☐

Glaucoma ☐

Cataracts ☐

Macular Degeneration ☐

GERD ☐

T2 or T1 Diabetes ☐

Hypothyroidism ☐

Hyperlipidemia ☐

COPD ☐

Urinary Incontinence ☐

Bronchitis ☐

Gout ☐

Seasonal Allergies ☐

Sinusitis ☐

Chronic Pain with location_________________ ☐

Neuropathy ☐

Recurrent UTIs ☐

Renal Dialysis ☐

Edema ☐

Epilepsy / Seizures ☐

Liver Disease ☐

Tobacco/ Alcohol use ☐

Osteoarthritis with location_________________ ☐

Other ______________________

Other ______________________

Please List any SURGERIES or MAJOR EVENTS

____

____

____

____

____

____

Please list any PRESCRIPTIONS and OVER THE COUNTER MEDICINES that you are currently taking. Include the **name, strength, and dosage**. Use the back of this sheet if necessary.

____

____

____

____

____

____

____

____

____

____

____

Do you currently use any ASSISTIVE DEVICES?

Wheelchair   Walker   Cane   Other Devices: ____

Please list previous Medical Providers ____

____

What Pharmacy do we call for your medications? ______________________________________

Please list Pharmacy address and telephone number ___________________________________

Controlled Substance Contract: Grace Home Primary Care

This agreement is between you (the patient) and Grace Home Primary Care (GHPC). It is agreed that narcotic medications will only be prescribed if the following terms are met:

1. By signing a contract for Opioid (and any controlled/schedule II) substances you are responsible for adhering to all instructions given here.
2. You indicate that you understand the discussion about the use of Opioid medications, including side effects, and are agreeable to start and continue this treatment under the terms set by Grace Home Primary Care (GHPC).
3. You have had the chance to ask questions regarding alternatives to the use of Opioids and other controlled medications.
4. GHPC should be **the one and only source** of these medications unless written permission is given by a GHPC provider for you to get the prescriptions from another source.
5. **Only one pharmacy** should be used for filling Opioid prescriptions. All Opioid prescriptions will be filled at the pharmacy listed below:

   Patient name and DOB:____

   The name of the pharmacy: ____

   Pharmacy phone number: ____

   If it is found that you have received prescriptions for controlled substances and/or Opioid medications from a source other than GHPC medical staff, without written permission, GHPC may void this agreement and discontinue any further prescriptions of these medications to you.
6. You agree to have **urine tests** for medications and illicit substances done randomly at the nurse practitioner's request.
7. You understand that your information in the Tennessee Controlled Substances Database will be reviewed with you as required.
8. You agree to allow the GHPC nurse practitioner to communicate with other care providers regarding your use of controlled substances.
9. You are expected to supply documentation of treatment by other physicians for co-existing, or related conditions, including psychiatric conditions.
10. You accept that GHPC can choose not to replace any lost, damaged, or inaccessible Opioid prescriptions or Opioid medications, at its discretion.
11. You will take these medications **exactly as instructed** by the GHPC provider.
12. Any unauthorized increase in the dose of Opioid medication may be viewed as a cause for discontinuation of the treatment with Opioid medications.
13. If you or any member of your family chooses to demonstrate unacceptable behaviors or attitudes, the GHPC nurse practitioner may immediately discontinue prescribing any further medications of any kind to you.
14. The patient must keep all regular follow up appointments as recommended by the GHPC nurse practitioners. Failure to comply may cause discontinuation of Opioid prescriptions.

Grace Home Primary Care

15. The patient must comply with all aspects of the treatment plan, including, but not limited to:
    - Physical Therapy
    - Behavioral management
    - Self-help programs
16. **No opioid prescriptions will be filled on weekends or over the phone. <u>There is a 72-hour notice requirement for all refills.</u>**
17. **Opioid prescriptions will not be filled early.**
18. The patient understands that the benefit of Opioid medications will be evaluated periodically.
19. The patient understands that the benefit of Opioid medications can be discontinued immediately, at the treating nurse practitioner's discretion, if the patient does not fulfill the terms of this agreement. Medication can also be discontinued if there is evidence of rapid tolerance, loss of effectiveness or significant side effects develop.
20. The patient certifies or agrees to the following:
    a) That he/she is **not currently abusing illicit** or prescription drugs.
    b) That he/she has never been involved in the sale, illegal possession, diversion or transport of controlled substances (Opioids, sleeping pills, nerve pills, or pain killers).
    c) Any legal action including DUI (driving under the influence) or medication theft involving you or a member of your household involving any medication or illicit drug use must be reported to us (GHPC) and local authorities immediately upon discovery.
21. **Sharing, selling, or diverting your medications or modifying a prescription is illegal and strictly prohibited.** Any such behavior may result in immediate cancellation of your prescriptions.
22. If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substances administration.

I fully understand the explanations regarding benefits and risks of this method of treatment. I agree to the use of Opioid medication in my medical treatment. This has been fully explained to me, I have read this agreement or have had it read to me, and I understand it. I have had the opportunity to ask questions, and have received acceptable answers. I agree to the terms of this contract.

Patient printed name: ____

Patient signature: ____ Date:___________________

PATIENT IMMUNIZATION HISTORY

Patient Name: ________________________________

COVID-19: Date_______________________

Flu Shot: Date______________________

Pneumonia Shot: Date__________________

Shingles Shot: Date_______________________