PATIENT REGISTRATION

Patient Information:

Last Name: _____ First Name:_____ M.I: _____

Birth Date: _____ Social Security #: _____ Gender: Male / Female

Street Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email Address: _____

Marital Status: Minor / Single / Married / Divorced / Widowed Student: Yes / No

Race: _____ Occupation: _____

Emergency Contact:

Name: _____ Relation: _____

Home Phone: _____ Cell Phone: _____

Name: _____ Relation: _____

Home Phone: _____ Cell Phone: _____

Insurance Information:

Primary Insurance: _____ Insurance ID #: _____

Group #: _____ Policy Holders Name: _____

Policy Holder DOB: _____ Relationship to Policy Holder: _____

Secondary Insurance: _____ Insurance ID #: _____

Group #: _____ Policy Holders Name: _____

Policy Holder DOB: _____ Relationship to Policy Holder: _____

Preferred Pharmacy:

Mail Order:_____ Local Pharmacy: _____

Preferred Lab: (Please circle)

Local Labs: Quest / Labcorp / HCA Hospital

Preferred Imaging Facility: (Please Circle)

Local Imaging: Putnam Radiology / Express Imaging / HCA Hospital / Putnam Diagnostic

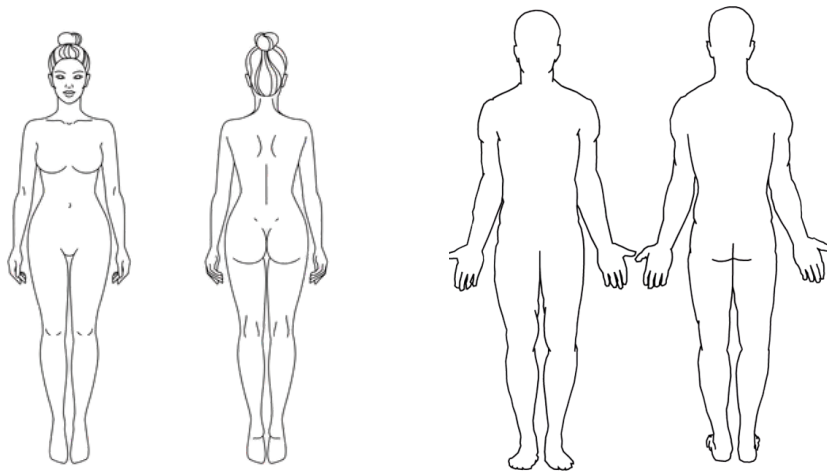
PATIENT
MEDICAL INFORMATION

Reason for today's visit:

Reason for today's visit? _____

Are you in pain? Yes / No

If Yes, What is your pain on a scale of 0 = No Pain - 10 = Severe: _____



(Please circle the areas of concerns for today's visit)

Personal Medical History:

Are you taking any of the following medications?

☐ Stimulants ☐ Insulin ☐ GLP-1 ☐ Blood Thinners ☐ Muscle Relaxers ☐ Pain Killer (including aspirin) ☐ Other(s)

_____

_____

Please list any other medications you are currently taking. Please include all over the counter medications.

Are you allergic to any medications? Yes / No

If yes, please list medication allergies: _____

Do you have or have had any of the following diseases, medical conditions, and/or procedures?:

(Please circle all that apply)

Hepatitis	STD	Emphysema	Anemia	Mental Illness	Environmental Allergies
Migraine/Headache	Stroke	Depression	Thyroid Issues	Diabetes	High / Low Blood Pressure
Arthritis	Cancer	Asthma	Joint Pain	Stomach Ulcers	
Leukemia	Sickle Cell	Heart Attack	Shingles	HIV +/ AIDS	Glaucoma/ Eye problems
Gallstones	Kidney Problems	Skin Rash	Alcohol/Drug Abuse	Bleeding Problems	
Heart Disease	Seizures	Anxiety	Other: _____		

Surgical History:

Surgery Date:	Surgical Procedure

Social History:

Do you exercise? Yes / No If yes, How many days/ hours per week? _____

Do you drink alcohol? Yes / No Do you drink caffeine? Yes / No

Do you smoke? Yes / No

If yes, which do you use? Cigarettes / Vape / Smokeless tabaco/ Other.

Which are you? Never Smoker / Current Smoker / Former Smoker

How many packs per day do you smoke? _____PPD.

How many years have you smoked? _____Years.

What age did you START smoking? _____. What age did you STOP smoking? _____.

Family History:

Please fill out the following to the best of your ability. **(Please circle all that apply)**

Mother: _____Age, Living / Deceased, Diabetic, High blood pressure, Heart Disease, Stroke, Heart Attack, Asthma / COPD, Arthritis, Anemia, Blood Clotting Disorder, Mental Illness, Alcohol Abuse, Cancer: _____.

Father: _____Age, Living / Deceased, Diabetic, High blood pressure, Heart Disease, Stroke, Heart Attack, Asthma / COPD, Arthritis, Anemia, Blood Clotting Disorder, Mental Illness, Cancer: _____.

Maternal Grandmother: _____Age, Living / Deceased, Diabetic, High blood pressure, Heart Disease, Stroke, Heart Attack, Asthma / COPD, Arthritis, Anemia, Blood Clotting Disorder, Mental Illness, Alcohol Abuse, Cancer: _____.

Maternal Grandfather: _____Age, Living / Deceased, Diabetic, High blood pressure, Heart Disease, Stroke, Heart Attack, Asthma / COPD, Arthritis, Anemia, Blood Clotting Disorder, Mental Illness, Alcohol Abuse, Cancer: _____.

Paternal Grandmother: _____Age, Living / Deceased, Diabetic, High blood pressure, Heart Disease, Stroke, Heart Attack, Asthma / COPD, Arthritis, Anemia, Blood Clotting Disorder, Mental Illness, Alcohol Abuse, Cancer: _____.

Paternal Grandfather: _____Age, Living / Deceased, Diabetic, High blood pressure, Heart Disease, Stroke, Heart Attack, Asthma / COPD, Arthritis, Anemia, Blood Clotting Disorder, Mental Illness, Alcohol Abuse, Cancer: _____.

Siblings: Brother / Sister: _____Age, Living / Deceased, Diabetic, High blood pressure, Heart Disease, Stroke, Heart Attack, Asthma / COPD, Arthritis, Anemia, Blood Clotting Disorder, Mental Illness, Alcohol Abuse, Cancer: _____.

Siblings: Brother / Sister: _____Age, Living / Deceased, Diabetic, High blood pressure, Heart Disease, Stroke, Heart Attack, Asthma / COPD, Arthritis, Anemia, Blood Clotting Disorder, Mental Illness, Alcohol Abuse, Cancer: _____.

OBGYN History - FEMALE ONLY

When was your last period? _____. How long does your period last? _____Days.

Age of first period? _____.

Are you experiencing any menopausal symptoms you would like to discuss at today's visit? Yes / No

When was your last pap smear? _____ When was your last mammogram? _____

Are you sexually active? Yes / No Do you practice safe sex? Yes / No

Do you use any form of birth control? Condoms / Birth control pills / Depo injection / IUD / Implant / Patch / Ring / None / Other: _____.

Do you experience bleeding after intercourse? Yes / No

Have you ever experienced sexual abuse or trauma? Yes / No

Pregnancy History:

Are you Pregnant? Yes / No If yes, How many weeks pregnant are you? _____ Weeks.

Are you trying to become pregnant? Yes / No

Number of pregnancies? _____ Number of Births? _____

Number of abortions / miscarriages? _____

Male History:

Are you experiencing any of the following?: **(Please circle all that apply)**

Fatigue / Erectile Disfunction / Decreased sex drive / Irritability / Depression / Anxiety / Decreased muscle mass / Low testosterone / Abnormal labs.

Do you currently take or have taken testosterone in the past? Yes / No

When was your last PSA screening? _____

FINANCIAL POLICY AGREEMENT

Thank you for choosing us as your health care provider. We are committed to your treatment. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our ***Financial Policy***, which we require you to read and sign prior to any treatment:

1. All patients must complete our information and insurance form before seeing the doctor.

2. For your convenience we accept cash, CashApp, Venmo, CareCredit, HSA/FSA, Visa, MasterCard, American Express and Discover.

We have contracts with most commonly used insurance companies. Please check to see if we accept your insurance. If we do not accept your insurance policy, we can provide an invoice or superbill for you to submit to your insurance company. Your insurance policy is a contract between you and your insurance company. Any subsequent visits must be paid in full at the time the services are rendered. Please be aware that some insurance companies, including Medicare, may determine treatment to be non-covered or find it not to be reasonable or necessary. If such a determination is made, you will be responsible for such services. Such services will be billed and payment is due upon receipt of bill.

Regarding insurance plans where we are a participating provider: All co-pays and deductibles are due at the time of treatment. If there are any additional procedures performed, they may be subject to an additional Co-Payment, Deductible or Co-Insurance. Please refer to your HealthCare Plan for additional information. In the event that your insurance coverage changes to a plan where we are not a participating provider, refer to the above paragraph.

Usual and customary rates: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of what constitutes a usual and customary rate.

Minor patients: The adults accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa, MasterCard, Discover or payment by cash at the time of service has been verified.

Missed appointment and late cancellation policy: A "no-show" is missing a scheduled appointment. A "late-cancellation" is canceling an appointment less than 1 business day prior to the scheduled appointment. A charge up to $50.00 will be assessed for each no show or late cancellation. When an appointment is made, it takes an available time slot away from another patient. No-shows and late cancellations delay the delivery of healthcare to other patients needing care.

Co-pays and Balances: Co-pays are due at the time of service. If we need to bill you for the co-pay, please speak to the front desk upon check-in .

Collection Fee: Unpaid balances may be turned over to an outside collection agency.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy and I understand and agree to its provisions.

_____ _____

Signature of patient or responsible party Date

CONTROLLED SUBSTANCES MEDICATION POLICY

It is the policy of Evolve Healthcare for its providers to not prescribe controlled substances, specifically opioids (e.g., Hydrocodone, Percocet, Tramadol, Norco), benzodiazepines (e.g., Klonopin, Valium, Xanax, Ativan), muscle relaxants (e.g., Soma), and hypnotics (e.g., Zolpidem, Lunesta). The drugs listed are just examples and are not meant to be a complete list.

We recommend patients who take these medications be under the care of physicians who specialize in pain management, addiction medicine and/or psychiatry. As appropriate our practice will refer you for specialist care to prescribe and manage any controlled medications.

_____
Print Patient Name

_____ _____
Signature of Patient or Guardian Relationship to Patient

_____ _____
Patient DOB Date

E-PRESCRIBING/MEDICATION HISTORY CONSENT FORM

e-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include:

- **Formulary and benefit transactions** — Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification** - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that Evolve Healthcare can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Evolve Healthcare to enroll me in the e-Prescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____
Print Patient Name

_____ _____
Signature of Patient or Guardian Relationship to Patient

_____ _____
Patient DOB Date

RELEASE OF MEDICAL INFORMATION

Authorization for use and disclosure of Protected Health Information PHI is only for the person or agency on this form.

Patient Name: _____ Patient Date of Birth: _____

Address: _____ Phone #: _____

I _____, hereby authorize Evolve Healthcare to:

☐ Exchange Information with ☐ Receive Information from ☐ Disclose Information to

Name of Agency/Person: _____ Phone #: _____

Full Address: _____

Information to be disclosed:

- ☐ All Medical Records
- ☐ Medications
- ☐ Operative Information
- ☐ Nursing Information
- ☐ ER Information
- ☐ Recommendations
- ☐ Diagnosis
- ☐ Treatment Planning Notes
- ☐ Admission Documentation
- ☐ Dictation Reports
- ☐ Physician Orders
- ☐ Medical/Clinical Test Results
- ☐ Other: _____
- ☐ Other: _____

Dates of records to be released:

_____

Release will expire:

- ☐ End of 60 Days
- ☐ Termination of Treatment
- ☐ As of: _____

For the purpose of: ☐ At my Request ☐ Continuity Care/Treatment ☐ Insurance ☐ Legal ☐ Other: _____

I hereby authorize Evolve Healthcare to share my PHI. I understand that any information will not be shared unless I specifically give permission by placing my initials in the appropriate space(s) above.

I can revoke this authorization at any time by providing written notice of revocation to the department at the address listed above for submission of this form.

All items on this form have be completed and my questions have been answered.
In addition, I have been provided a copy of this form.

Client Signature: _____ Date: _____

Parent/Legal Guardian/Legal Representative Signature: _____

Provider Signature: _____ Date: _____

COMMUNICATION CONSENT

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, billing statements, and to provide general health reminders/information.

If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

_____ (Patient Initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is . The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is .

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Patient Signature _____ Date: _____

Revocation:

_____*I hereby revoke my request for future communications via email and/or text messages.*

_____*I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email.*

_____*I hereby revoke my request to receive any future billing statement reminders via email or text.*

Note: This revocation only applies to communications from this Practice.

Patient Name: _____

Patient/Patient Representative: _____

Signature: _____ Date: _____

PATIENT PORTAL POLICY AND PROCEDURES

<u>DO NOT</u> use Portal to communicate if there is an emergency.

Proper subject matter:

- Prescriptions refills, medical questions, lab results, appointment reminders, routine follow-up questions, etc.
- Sensitive subject matter (HIV, Hepatitis panels etc) are not permitted
- We do not refill controlled substance medications drugs on the patient portal. You can request a refill but MUST come in for an appointment.
- Please be concise when typing a message.

Current functionality of Patient Portal:

- Email and secure messaging for non-urgent needs.
- Refill request (must include pharmacy information)
- Viewing of lab results that have been sent to you.
- Viewing and printing of continuity of health record.
- Viewing and updating of health information.
- Viewing of selected health information (allergies, medications, current problems, past medical history).
- Referral requests (must include provider / office details for referral).
- Appointment request.
- Billing questions.
- Updating your demographic information (address, phone #, insurance information, and ect).

All communication via portal will be included in your chart.

Privacy:

- All messages sent to you will be encrypted.
- Messages from you to the staff should be through this portal or they will not be secure.
- We will keep all email lists confidential and will not share this with other parties.
- Any member of our staff may read your messages or reply in order to help the Physician that has been e-mailed. This is similar to how a phone message is handled.

Response Time:

- We will normally respond to non-urgent message inquires within a timely manner. Please contact the office if you need a immediate response.

HIPAA NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of (Evolve Healthcare) Notice of Privacy Practices. By signing below I am “only” giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices

Patient Name (Print): _____

Patient’s Date of Birth: _____

Signature of Patient or Parent/Legal Guardian: _____

Date: _____