OLE TOWN MED 2580 Jackson Avenue West Suite 44, Oxford, MS 38655
oletownmed@gmail.com 662.234.9112

☐ NONE	***DAILY MEDICATIONS*** *(You may continue list on back of page if needed)*		
	MEDICATION NAME	DOSE	REASON
1.			
2.			
3.			
4.			

☐ NONE	***MEDICAL HISTORY*** *(check all that apply)*
☐ ADHD ☐ Anemia ☐ Anxiety/Depression ☐ Arthritis/Gout ☐ Asthma ☐ Blood Clots ☐ Cancer Type:_____ ☐ COVID-19 When:_____ ☐ Diabetes Type:_____ ☐ Frequent bladder infections ☐ Glaucoma ☐ Heart Attack When:_____	☐ Heartburn ☐ High blood pressure ☐ High Cholesterol ☐ Insomnia ☐ Kidney Disease ☐ Kidney Stones ☐ Lung Disease Type: _____ ☐ Pacemaker ☐ Pneumonia ☐ Stroke When:_____ ☐ Thyroid ☐ High ☐ Low ☐ Other:

☐ NONE	***FAMILY HISTORY***
FAMILY MEMBER	MEDICAL CONDITION
☐ FATHER	
☐ MOTHER	
☐ OTHER	

☐ NONE	***SURGICAL HISTORY***		
#	SURGERY/DATE	#	SURGERY/DATE
1.		3.	
2.		4.	

☐ NONE	***SOCIAL HISTORY***
DO YOU USE TOBACCO PRODUCTS ? ☐ YES ☐ NO	AMOUNT PER DAY:_____
DO YOU DRINK ALCOHOL? ☐ YES ☐ NO	TYPE:_____ AMOUNT PER WK:_____
DO YOU USE ILLEGAL SUBSTANCES? ☐ YES ☐ NO	SUBSTANCE:_____ TIMES PER WK:_____

OLE TOWN MED 2580 Jackson Avenue West Suite 44, Oxford, MS 38655
oletownmed@gmail.com 662.234.9112

DATE:_____TIME:_____PHONE#:_____VEHICLE:_____
NAME:_____BIRTHDAY:_____AGE:_____
HEIGHT:_____ WEIGHT:_____
DATE OF LAST DAY OF MENSTRUAL PERIOD: _____PREGNANT: ☐YES ☐NO
MEDICATION ALLERGIES:_____☐NONE_____
PHARMACY NAME:_____CITY:_____STATE:_____

*********DO YOU NEED A COVID-19 TEST DONE TODAY? ☐YES ☐NO********
(ONLY FILL OUT THE NEXT BOX IF YOU CHECKED "YES" ABOVE)

REASON: (check all that apply)	☐SYMPTOMS_____ When did they start?_____ ☐EXPOSED How many days ago?_____ ☐TRAVEL When:_____Where:_____ ☐WORK ☐SCHOOL ☐OTHER:_____
COVID-19 VACCINE:	☐NO

	DATE	TYPE
☐YES		

WHAT IS THE REASON FOR YOUR VISIT TODAY? (check all that apply)
☐ ILLNESS ☐ INJURY ☐ MEDICATION REFILLS ☐ CHECK-UP ☐ NEW PROBLEM ☐ OTHER

DETAILS:_____
_____
_____
_____

**********THIS BOX IS FOR OFFICE USE ONLY**********

ROOM/CAR#	TIME	TECH INIT	VITAL SIGNS
	:		BP:_____/_____ HR:_____O2:_____% RR:_____TEMP:_____F
ORDERS:			
MISC:			

OLE TOWN MED 2580 Jackson Avenue West Suite 44, Oxford, MS 38655

oletownmed@gmail.com 662.234.9112

NOTICE OF PRIVACY PRACTICES

- This notice describes how your health information may be used, disclosed and how you can access this information.
- At Ole Town Med, we strive to keep your health information secure and confidential. A new law requires us to maintain your privacy, to give you this notice and to follow the terms of this notice.
- The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file or a referral to a specialist doctor whom we may involve in your care.
- We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.
- We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.
- We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.
- We may use your information to contact you. For example, we may send newsletters or other information. We may also need to call and remind you about appointments. If you are not at home, we may leave this information on your answering machine or with a person who answers the phone.
- If an emergency, we may disclose your health information to a family member or another person responsible for your care.
- We may release some or all of your health information when required by law.
- If this practice is sold, your information will become the property of the new owner.
- Except as described above, this practice will not use or disclose your health information without prior written authorization.
- You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.
- You have the right to know of any uses or disclosures we make with your health information beyond and above normal uses.
- As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.
- You have the right to transfer copies of your health information to another practice. We will mail your files for you.
- You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.
- You have the right to request an amendment or change to your health information. Give us your request to make changes in writing, if you wish to include a statement in your file. If we agree to an amendment or change, we will not remove or alter earlier documents, but will add new information.
- You have the right to receive a copy of this notice. If we change any details of this notice, we will notify you of the changes at your next appointment / visit after the effective date of change.
- You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, SW, Room 509-F, Washington, DC 20201. You will not be retaliated against for filing a complaint.
- However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer at 662-234-9112.

This notice became effective as of April 14, 2003.

PATIENT ARBITRATION AGREEMENT

Agreement to Arbitrate: It is understood that any dispute, claim or controversy arising out of or relating to the performance of medical services, including but not limited to patient fees, informed consent, negligence or medical malpractice between Patient (whether a minor or an adult), or the heirs-at-law or personal representative of Patient, as the case may be, and the clinic will be determined by submission to arbitration as provided by Mississippi law, and not by a lawsuit or resort to court process except as Mississippi law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such disputes decided on by a court of law before a jury, and instead are accepting the use of arbitration.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician / practitioner, and the physician's / practitioner's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any court by the physician / practitioner to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

All parties agree that their relationship affects interstate commerce, and that this Agreement shall be governed by the Federal Arbitration Act, and, if not, by Mississippi Law. The party requesting arbitration shall bear all costs of the arbitration, except the Patient is not required to pay any more than $125, with the Clinic bearing the other arbitration costs. However, each party is solely responsible for their own attorney, expert, and other associated costs, expenses, and litigation fees on their behalf.

This agreement may be rescinded by written notice by either party within fifteen (15) days of signature. However, any claim or dispute related to medical services rendered after execution of this Agreement and prior to the date of such written notice of rescission shall be subject to the terms of this Agreement. Written notice of such rescission may be given by a guardian or conservator of Patient if the Patient is a minor or incapacitated. This agreement may be modified only by the signed agreement by each party or its authorized representative. If any portion of this Agreement is found unenforceable, that portion shall be stricken, and the remainder of this Agreement fully enforced. If a court rules that the dispute must be litigated and not arbitrated, Patient agrees the suit will be heard in the county where the services were rendered.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY CLAIM OF NEGLIGENCE OR MEDICAL MALPRACTICE DECIDED BY NEUTRAL BINDING ARBITRATION AND YOU ARE GIVING UP YOUR STATUTORY AND CONSTITUTIONAL RIGHT TO A JURY OR COURT TRIAL.

If a parent or guardian has signed on behalf of their minor child or ward, such parent or guardian hereby attests that he / she has full legal authority to execute this Arbitration Agreement on behalf of said child or ward. Furthermore, said parent or guardian hereby agrees to indemnify and hold harmless the Clinic from any claim, demand or loss which may occur in the event said parent or guardian does not, in fact, have such legal authority.

Acknowledgement

I have read and acknowledged the Ole Town Med Privacy Practices stated above.

I hereby acknowledge and agree to all information provided on this page by signing, whether electronically or manually.

Signature of Patient or Guardian: _____ ***Date:*** _____

Signature of Clinic Representative: _____ ***Date:*** _____

OLE TOWN MED 2580 Jackson Avenue West Suite 44, Oxford, MS 38655
oletownmed@gmail.com 662.234.9112

CONSENT FOR EVALUATION AND TREATMENT

The undersigned hereby consents to whatever evaluation or treatment the assigned healthcare provider may deem necessary to the patient named below.

Insurance Agreement

I hereby authorize my insurance benefits to be paid directly to Ole Town Med. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.

For Medicare Patients

Medicare Part B Signature Authorization for Lifetime

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to be released to the Social Security Administration or its intermediaries or carriers of any information needed for this or a related Medicare Claim. I permit a copy of this authorization to be used in place of the original. I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment.

Authorization of Medical Records

You authorize Ole Town Med to obtain & release medical records to your Primary Care doctor for continuum of care.
You authorize Ole Town Med to obtain & release medical records to your Referring doctor needed for continuum of care.
You authorize Ole Town Med to release medical records to your Insurance companies needed for payment of care.

FINANCIAL POLICY

Healthcare and coverage options have become increasingly complex. We have developed this policy to detail our financial requirements to help you better understand your responsibilities.

*Policy is subject to change at any time.

Insurance Patients

It is your responsibility to know if your insurance has specific rules or regulations, such as the need for precertification, limits on outpatient charges, specific physicians and/or hospitals to use. You should be knowledgeable of any deductibles, co-payments, and or coinsurance. This applies to all payers regardless of whether or not our providers participate.

The responsibility for payment of services is the direct responsibility of the patient. Your health benefit plan is an arrangement between you, the enrollee, and the insurance company, HMO, or your employer. Your health benefit plan determines your coverage, requirements, and establishes the limit on your coverage for medical services based on what they determine is medically necessary. It is your responsibility to return all requested information to your insurance company and our office. If this information is not returned within a specific time frame so the claim may be processed, then the entire balance becomes your responsibility. However, we will do our best to assist you with the understanding of your proposed treatment and in answering questions related to your insurance.

Copays, Coinsurance, Deductibles, and Non-Covered Services

Insurances will be verified during the check-in process. Our staff will then have access to your insurance information. Copays will be expected before your visit during this time. During check- out, your coinsurance and deductibles will be figured and collected. Payment must be paid in full before receiving prescriptions or school/work excuses. If non covered services are performed during your visit, then you are responsible for these at the time of services.

Cash Pay Patients

Payment is due in full when services are rendered. If you need an estimate of cost, please let the provider know before services are performed.

Medical Records Charge

Ole Town Med will refer to 11-1-52, Mississippi Code of 1972 which states.

- Maximum copy charge is $20.00 for up to 20 pages
- $1.00 per page for the next 80 pages
- $.50 per page for all pages thereafter
- 10 percent of the total charge will be added for postage and handling
- Actual cost of re-producing x-rays or other special records

Collections and Legal Fees

If total balance is not paid within 90 days, your account may be placed in an outside collection agency. You are responsible for all collections and legal fees that may accumulate after this action is taken.

Ole Town Med realizes that medical care can often become very expensive. If you have concerns about your ability to pay for services, we recommend that you contact us for assistance in management of your account. Should you have any questions in regard to our financial policy then we encourage you to ask. It is our goal, not only to provide the best quality medical care, but to help you by answering any questions you may have. If payment is made with a check, there will be a returned fee of $25.00 if the check is not authorized.

I hereby acknowledge and agree to all information provided on this page by signing, whether electronically or manually.

Signature of Patient or Guardian: _____ ***Date:*** _____

Signature of Clinic Representative: _____ ***Date:*** _____

OLE TOWN MED 2580 Jackson Avenue West Suite 44, Oxford, MS 38655
oletownmed@gmail.com 662.234.9112

PATIENT INFORMATION

Date: _____

Last Name: _____ First: _____ Middle Initial: _____

Social Security#: _____ DOB: _____ Age: _____ Sex: _____

Mailing Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Phone # Home: (___) _____ Cell: (___) _____ Work: (___) _____

Email: _____ Race:_____ Ethnicity:_____

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

Marital Status: Single___ Married___ Divorced___ Widowed___ Separated___

Employment: Full-time___ Part-time ___Retired___ Other_____

Employer_____ Occupation_____

Student: Full-time ___ Part-time___ School Name_____

Emergency Contact Information:

Name: _____ Relationship: _____

Phone #: _____

Is this accident related?

_____ MVA: _____ Worker's Compensation: ___ Other: _____

Date of accident: _____

Description of accident: _____

RELEASE OF PERSONAL HEALTH INFORMATION

Who may we discuss your health information with? _____

_____

Phone #: (___) _____ Can we leave a message on your phone/cell? _____

Person Responsible for Bill:

Name:_____ Date of Birth:_____

Social Security Number:_____ Address:_____ Phone Number:_____

_____

Everything stated above is true and complete to the best of my knowledge and I agree to notify you of any changes

PHARMACY NAME: _____ City: _____ State: _____

PRIMARY CARE PHYSICIAN NAME: _____ City: _____ State: _____

I hereby acknowledge and agree to all information provided on this page by signing, whether electronically or manually.

Signature of patient or guardian: _____ ***Date:*** _____

Talk to receptionist about how to access your account online at www.YourHealthFile.com