Armadillo Medical Services P.C.
420 College St., Ste A, Lafayette, TN 37083
Office: 615-688-5383 Fax: 833-984-3473

Phillip Hunt, MD
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Authorization to Release Healthcare Information

Patient's Name: _____

Date of Birth: _____

I authorize my previous provider: _____
(Name of Doctor/Clinic)

to release my medical records to: ARMADILLO MEDICAL SERVICES, P.C.
420 College S., Ste A, Lafayette, TN 37083
Office: 615-688-5383 Fax: 833-984-3473

RECORDS TO BE RELEASED:

☐ Entire Medical Records

☐ Healthcare Information related to the following treatment, condition, or dates:

_____

☐ Other:

_____

☐ Yes ☐ No

I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s)listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No

I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

PATIENT DEMOGRAPHICS

Date of Birth: __@PDOB____ Today's Date: ____/____/_____

Patient Name: _____ Preferred Name: _____
Last First Middle

Address: _____ City: _____ State: _____ Zip_____

Cell Phone: ( )_____ Home Phone: ( )_____ Other Phone: ( )_____

Would you like to receive text message reminders for appointments? _____Yes _____ No

S.S. #_____ **Circle One:** Male Female **Circle One:** Single Married Divorced Widowed

e-mail: _____ * You will receive an invitation to sign up for our **Patient Portal** where you can view your office visit notes, get appointment information, request refills and communicate with your provider. ***Please sign up for the valuable service!***

Emergency Contacts:

Name: _____ Relationship: _____ Emergency Phone #: ( )_____

Name: _____ Relationship: _____ Emergency Phone #: ( )_____

Race (*check one*)
___ White
___ Black/African American
___ Amer. Indian/Native Alaskan
___ Asian
___ Decline to answer

Ethnicity (*check one*)
___ Hispanic or Latino
___ Not Hispanic or Latino
___ Decline to answer

Preferred Language (*check one*)
___ English
___ Spanish
Other_____

Preference for Reminders
___ Phone Call
___ Email
___ Text Message

PAYMENT OR INSURANCE INFORMATION

Self- pay: _____ (Skip to the next section.)

Medical insurance: _____

Primary Insurance: _____ I.D. #: _____ Tricare Sponsor (if applicable) SSN #: ____/____/_____

Subscriber Name: _____ Date of Birth: ____/____/_____ Relationship to Patient: _____

Secondary Insurance: _____ I.D. #: _____ Tricare Sponsor (if applicable) SSN #: ____/____/_____

Subscriber Name: _____ Date of Birth: ____/____/_____ Relationship to Patient: _____

* ***Please provider copies of all insurance cards for us to scan.***

GUARANTOR INFORMATION (FOR PATIENTS UNDER 18)

Name: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip_____

Cell Phone: ( )_____ Home Phone: ( )_____ Other Phone: ( )_____

***** I verify that the information I have given above is accurate and I understand that it is my responsibility to update any of this information as it changes. *****

_____ ____/____/_____
Patient / Guardian of Patient Date

* ***Please provide a photo ID for us to scan.***

____ I hereby authorize the release of information necessary to process an insurance claim for services rendered.

____ I understand I must pay my co-payment/deductible ON THE DAY OF SERVICE.

____ I understand if I fail to pay the amount owed, Armadillo Medical Services has the right to secure and outside agency or attorney to collect the debt and to report the unpaid amount to collections.

____ If I am a self-pay patient, I understand that I am responsible for payment of services rendered. I further understand that payment will be due ON THE DAY OF SERVICE.

____ I understand there will be a $30.00 service charge for any returned checks.

____ I have read and understand the payment policy of this office and agree to abide by this said policy.

Patient/Guardian Signature: _____ Relationship to Patient: _____

Patient Name: _____ Date: _____

Narcotic Agreement

This narcotic agreement is in the best interest of both patient and provider. I understand Armadillo Medical Services, is not a pain management clinic. I understand that the clinic will not provide prescriptions for treatment of chronic pain management, including but not limited to narcotic pain relievers, muscle relaxers, or benzodiazepines (sleeping pills, etc.). I also understand that I may be randomly drug tested by urine or blood to ensure that I am properly taking my medications as prescribed by my provider. I understand that it is unethical and illegal to take prescription medications that have not been prescribed to me. I also understand that it is unethical and illegal to give or sell my prescription medications to someone else. If at any time I have failed a drug screen, I am aware that I will be notified by my provider. I also understand that this compromises my patient/doctor agreement and could possible result in termination of said patient/doctor agreement. I understand and am fully aware of the policy that has been set forth by Armadillo Medical Services and agree to abide by it.

Patient Printed Name: _____

Patient/Guardian Signature: _____ Relationship to Patient: _____

Witness Signature: _____ Date: _____

HIPPA Rights and Responsibilities (Check One)

___ I authorize Armadillo to leave messages on my answering machine or voicemail concerning my health.

___ I do not authorize Armadillo to leave message on my answering machine or voicemail concerning my health.

I authorize the persons listed below to have full disclosure of my medical information. I understand it is my responsibility to let the staff know if I need to make a change to this list. I understand I will only list individuals that I trust and that may have full disclosure of my personal health information.

Name: _____ Telephone#_____ Relationship:_____

Name: _____ Telephone#_____ Relationship:_____

Name: _____ Telephone#_____ Relationship:_____

Personal Medical History

Check if you now have or have had any of the following conditions:

Cardiovascular: (Check all that apply)

__Stroke __Heart Disease __High Blood Pressure __Mitral Valve Disorder __Pacemaker __High Cholesterol

Do you see a Cardiologists? Yes / No Name of Doctor: _____

Kidney/Urinary Problems: (Check all that apply)

__Kidney Failure __Kidney Stones __Prostate Problems __Bladder Problems

Do you see a Urologists? Yes / No Name of Doctor: _____

For men only: __Erectile Dysfunction __Testicular Cancer

Date of last prostate exam:_____ Date of last PSA:_____

Endocrine Problems: (Check all that apply)

__Diabetes __Diabetic Neuropathy __Diabetic Retinopathy __Diabetic Ulcers __Thyroid Disorders

Do you see an Endocrinologist? Yes / No Name of Doctor:_____

Have you had a diabetic foot exam? Yes / No Date:_____ Name of Doctor:_____

Gastrointestinal Problems: (Check all that apply)

__Rectal Bleeding __Irritable Bowel Syndrome __Constipation __Hernia __Hemorrhoids __Diarrhea

Do you see a GI Doctor? Yes / No Name of Doctor:_____

Have you had a colonoscopy? Yes / No Date:_____ Have you had and EGD? Yes or No Date:_____

Respiratory/Lung Problems: (Check all that apply)

__Asthma __Emphysema __COPD __Allergies __Tuberculosis __Nose Bleed __Dentures __Missing Teeth

Do you see a pulmonologist? Yes / No Name of Doctor:_____

Do you see a dentist? Yes / No Name of Doctor:_____

Eye/Vision Problems: (Check all that apply)

__Glaucoma __Wear Glasses __Wear Contacts __Wear Glasses & Contacts (both)

Do you see an eye doctor? Yes / No Name of Doctor:_____

Other Problems:

__HIV
__Bleeding Disorders
__Reaction to Anesthesia
__Hearing Aids
__Depression
__Hepatitis
__Headaches
__Blood Transfusion
__Ulcers
__Chicken Pox
__Seizures
__Arthritis
__Measles
__Drug Abuse
__Sexual Problems
__Epilepsy
__Lupus
__Mumps
__Blood Clots
__Whooping Cough
__Alcohol Abuse
__Rheumatic Fever
__STD
__Cancer / Type:_____

Do you see any other Providers? Yes or No If so please list _____

Name: _____ Telephone#_____ Relationship:_____

Personal Medical History, continued.....

Do you have any metal plates or pins in your body? Yes or No, If Yes, Where: _____

Are you claustrophobic? Yes or No

Please list and allergies to MEDICATION: _____

Please list other allergies: _____

What Pharmacy do you use? _____

Prescription Medication:

Medication Strength: Ex: Tylenol 100mg	Directions: Ex: Twice a day	Prescribed by:	Reason for taking:

If you are taking more than 5 medications, you may list the rest on the back of this sheet. If you have a list already written out, we can get a copy of it and just write "see list" on the table above.

Please list any Non-Prescription medications/Vitamins you take on a regular basis:

_____

Surgical History:

(Please the type of surgery you had done and the year)

Family History

Family History: Please check the box if one of these relatives has been diagnosed with any of the following problems.								
Diagnosis:	Father	Mother	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Cancer, Breast								
Cancer, Colon								
Cancer, Ovary								
Cancer, Prostate								
Cancer, Other								
Heart Disease								
High Blood Pressure								
Stroke								
Diabetes								
Bleeding Disorders								
Mental Disorders								

Female Patients Only:

Do you see an OB Gyn? Yes or No If so, Name of Doctor: _____

Date of last menstrual period:_____ Date of last Pap Smear:_____ No. of sexual partners_____

Have you ever had an abnormal Pap Smear? _____, If so, please provide the date: _____

Current type of Birth Control being used, if any:_____

Have you had the following?

Tubal Litigation? Yes or No, Date: _____ Hysterectomy? Yes or No, Date: _____

Are you under any Hormone Replacement Therapy? Yes or No Are you postmenopausal? Yes or No

Have you ever had a mammogram? Yes or No If so, date of last exam:_____ Do you do self breast exam?_____ If yes, how often_____

Vaccine History

Vaccine:	Date Given:	Place vaccine was administered:

Social History

Do you use tobacco products? Yes or No

What type of tobacco product? Cigarettes, Cigars, Chewing Tobacco, Snuff *If you have quit, when _____

Do you drink Alcohol? *If so, how much? _____Do you use street/recreational drugs? ___If so, what_____

Do you exercise regularly? Yes or No

Advanced Directives for Healthcare (18 years above only) Examples: Living Will, Durable Power of Attorney, Organ Donor, or DNR orders Do you have any finalized advanced health directives? Yes or No If yes, please provide a copy to keep in your chart.

I agree that all the information in this form is true to my knowledge. I understand that it is my responsibility to inform my provider of any changes in the above information:

Patient/Guardian Signature: _____ Date: _____

FOR OFFICE USE ONLY:

Provider Notes:

I have reviewed the following information on this patient's history form with the patient and/or guardian:

Provider's Signature:_____ Date: _____

NO SHOW/MISSED APPOINTMENT POLICY

We, at Armadillo Medical Services, understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least a 24-hour notice). You can cancel appointments by calling the following number: 615-688-5383

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder call to you is made/attempted one (1) business day prior to your scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time.

PLEASE REVIEW THE FOLLOWING POLICY:

1. Please cancel your appointment with at least a 24 hours' notice: There is a waiting list to see the providers at Armadillo Medical Services and whenever possible, we like to fill cancelled spaces to shorten the waiting period for our patients.
2. If less than a 24-hour cancellation is given this will be documented as a "No-Show" appointment.
3. If you do not present to the office for your appointment, this will be documented as a "No-Show" appointment.
4. After the first "No-Show/Missed" appointment, you will receive a phone call or letter warning that you have broken our "No-Show" policy. Armadillo Medical Services will assist you to reschedule this appointment if needed.
5. If you have 2 "No-Show/Missed" appointments within a one-year time period, you will receive a warning letter from our office and will be assessed a $25.00 no show fee.
6. If you have 3 "No-Show/Missed" appointments within a one-year time, you will receive a second $25 no show fee assessment. Dismissal from the practice will be considered.
   ***You will be notified by letter if the dismissal was approved.**

I have read and understand Armadillo Medical Services No Show/Missed Appointment Policy and understand my responsibility to plan appointments accordingly and notify Armadillo Medical Services appropriately if I have difficulty keeping my scheduled appointments.

Patient Name _____ Date of Birth _____ Date _____

Patient Signature or Parent/Guardian if minor _____ Relationship to Patient _____

Staff Signature _____ Date _____