PREMIER
PRIMARY CARE
Where Passion for Care is Primary

702 Sherrill St., Suite B Union
City, TN 38261
731-885-8884
Fax 731-599-9713
www.premierunioncity.com

First: _____ Middle: _____ Last: _____

Date of Birth: ___ / _____ / _____ Gender: ◯ Male ◯ Female Marital Status: _____

Social Security#: _____ Email Address: _____

***Social Security Numbers are required for lab work and insurance. ***

Address: _____ City: _____ Zip Code: _____

Phone#: (_____) _____ Cell#:(_____) _____

Preferred Method of Contact: ◯ email ◯ home phone ◯ cell phone ◯ text

Employer: _____ Employer#: (_____) _____

Spouse's Name: _____ Spouse's DOB: ____ / ____ / _____ Spouse's#: (_____) _____

Emergency Contact: Name: _____ Relationship: _____

Phone#: (_____) _____ Cell# or Work#: (_____) _____

How did you hear about us? (friend, doctor, facebook, instagrarn,etc.) _____

Who may we thank for referring you? _____

Do you have a Living Will or Advanced Directive? ◯ yes ◯ no

Would you like us to retain a copy of your Living Will or Advanced Directive? ◯ yes ◯ no

Primary Insurance: _____ Subscriber Name/ DOB: _____

Secondary Insurance: _____ Subscriber Name/ DOB: _____

The above inormation is true to the best of my knowledge. By signing below, I give my consent to all medical care, examinations, and tests determined by Premier Primary Care that are 'necessary for me.

Type your name here

Patient / Guardian Signature: _____ Date: _____

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Name: _____ Age _____ Date of Birth _____ Today's Date _____

Current pharmacy (Name and Location):_____

Current Medications

Please list all medications you are now taking, including those you buy without a prescription (such as cold medicine or aspirin.) Please list name, dosage, and how many times per day they are taken.

1. _____ 5. _____ 9._____
2. _____ 6. _____ 10._____
3. _____ 7. _____ 11._____
4. _____ 8. _____ 12._____

Allergies: _____

Current Medical Problems

Please list the medical problems for which you came to see your provider for today. About when did they begin?

1. _____
2. _____
3. _____

Please list any previous illnesses or chronic conditions:

_____

_____

Immunizations:

Last tetanus? _____ Zostavax (shingles)? _____ Hepatitis B? _____ Gardasil? _____

Last Tuberculin (TB) skin test? _____ Was it ☐ positive ☐ negative

Have you had the chicken pox? ☐ NO ☐ YES At what age? ___ Have you received the Varicella vaccine? ☐ What age? ___

Social:

How many cigarettes do you smoke per day? _____ How many years have you smoked?_____

Are you ready to quit? ☐ YES ☐ NO Do you use illegal drugs? _____ What kind? _____

How much alcohol do you consume per day? ____ Per week? ____ Per month? ____

Do you exercise regularly? ☐ YES ☐ NO If yes, how many times per week? ____

What type of work/school do you do? _____

Who lives in the home with you? _____

Please list all past surgeries (List by date with age.) _____

_____

_____

Premier Primary Care

Name: _____ Date: _____

Family History Use ✔ to indicate positive history									
	Self	Father	Mother	Sister	Brothers	Aunts	Uncles	Daughters	Sons
Deceased									
Hypertension									
Heart Disease									
Stroke									
Kidney Desease									
Obesity									
Genetic Disorder									
Alcoholism									
Liver Disease									
Depressive/ Maniac Depressive Disorder									
Colon/ Rectal Cancer									
Other cancer									
Diabetes									
Thyroid									

Other Physicians and Providers of Care		
Name and Specialty Provider Type	Type of Care	Date Discontinued

Past Tests and Procedures		
Test	Date Test Was Performed	Provider Who Performed the Test
Pap smear (Women)		
Mammogram (Women)		
PSA (Men)		
Digital Rectal Exam		
Colonoscopy		

Do you receive a flu shot yearly? ( )Yes ( )No

When was your last flu shot? _____

Have you ever received a pneumonia shot? ( )Yes ( )No

If yes, when was your last pneumonia shot? _____

New Patient Symptom Survey

Type your name here

Signature: _____ Date: _____

COMMON SYMPTOMS: Circle the number according to severity: 0 = NONE, 1 = MILD, 5 = VERY SEVERE

Abdominal Gas or Cramping	1	2	3	4	5	Hives	1	2	3	4	5
Arthritis or muscle pain	1	2	3	4	5	Hyperactivity	1	2	3	4	5
Asthma	1	2	3	4	5	Itching	1	2	3	4	5
Cough	1	2	3	4	5	Nasal Congestion	1	2	3	4	5
Eczema	1	2	3	4	5	Poor memory or concentration	1	2	3	4	5
Fatigue	1	2	3	4	5	Sneezing	1	2	3	4	5
Frequent colds or sore throat	1	2	3	4	5	Trouble breathing while sleeping	1	2	3	4	5
Frequent sinus or ear infection	1	2	3	4	5	Watery, red, itchy eyes	1	2	3	4	5
Headache	1	2	3	4	5	Wheezing	1	2	3	4	5

SYMPTOM SCORE: _____ List any other current symptoms: _____

HISTORY

Are there any foods that cause you any problems? _____ How? _____

Do you have a history of allergies? ( ) Yes ( ) No If yes, how long have you had allergies? _____

What season(s) do your allergies usually flair up"? ( ) Spring ( ) Summer ( ) Fall ( ) Winter ( ) All Year

Have you been allergy tested before? ( ) Yes ( ) No If yes, when, _____

Does any medication give you relief of your allergy symptoms? ( ) Yes ( ) No Comment: _____

Do you have pets at home? ( ) Yes ( ) No Type: _____ Do they cause symptoms? _____

Are you exposed to fumes or dust? ( ) Yes ( ) No Comment: _____

Do you smoke? ( ) Yes ( ) No How much? _____

Are you exposed to smoke in your environment? ( ) Yes ( ) No

Who else in your family has allergies/asthma? ( ) Mom ( ) Dad ( ) Sibling ( ) Children

Have you been diagnosed with asthma? ( ) Yes ( ) No If so when? _____ Severity: ( ) Mild ( ) Moderate ( ) High

Do you think your asthma is under control? ( ) Yes ( ) No

How often are you using your inhaler? _____

Are you taking any sleep aids?_____

CONTRAINDICATIONS

Do you suffer from uncontrolled asthma or reduced lung function? ( ) Yes ( ) No

Ever had a severe allergic reaction? ( ) Yes ( ) No Ever hospitalized due to allergies? ( ) Yes ( ) No

Taking Beta Blockers to treat heart disease: ( ) Yes ( ) No Name of Medication: _____

Have you taken any allergy, antihistamine or cold medicine in the past 72 hours? ( ) Yes ( ) No

Are you pregnant? ( ) Yes ( ) NO ( ) N/A

CLINICAL USE ONLY

Is Patient Recommended for Allergy Test? ( ) Yes ( ) No Date of Allergy Test _____ Skin ( ) Blood ( )

Refer Patient to a specialist ( ) Yes ( ) No

Reviewed by: _____ Provider: _____ .Date: _____

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Premier Primary Care's Financial Policy Agreement

Thank you for choosing Premier Primary Care for your medical care. We are committed to providing you with quality personal health care, and appreciate your commitment to adhere to this Financial Policy Agreement. By understanding our policy, we can provide you with the best service. Agreement to this policy is required for all medical care.

Payment is required at the time services are provided. We accept cash, personal in-state checks and credit/debit cards. There is a $25.00 service charge for returned checks.

INSURANCE: We participate in most managed care plans and will bill your insurance plan as may be necessary. If we do not participate with your managed care plan, payment in full is required at the time of service, unless other arrangements have been made in advance, We may be able to bill your plan as a courtesy to you and credit your account if we receive additional payment. Knowing your insurance benefits, including eligibility, covered benefits, and medically necessary procedures is your responsibility; please contact customer service at your insurance company for questions you have regarding your coverage. **You are responsible for any charges not covered by your plan.**

• **Proof of Insurance:**All patients must complete and/or update their patient information at each office visit or via the patient portal prior to each visit. You must furnish up-to-date proof of insurance coverage and a copy of your driver's license If you provide false or expired insurance information, you will be responsible for the remainder of the claim. Please notify us of any changes in coverages prior to the time of service. Insurance denials for termination of coverage will be automatically billed to you.

• **Co-Pays and Deductibles:** All co-pays and unsatisfied deductibles must be paid at the time of service By contractual law, your insurance company requires us to charge for and you to pay for, all required copays, coinsurances, deductibles, and non-covered services.

• **Claim Submission:** We will submit your insurance claims and assist you in any way reasonable to help get the claim paid. Your insurance company may need you to supply information directly to them. It is your responsibility to copay with their request in a timely manner.

• **No Shows and Cancellations:** We make every effort to provide prompt medical care to all of our patients. If you are unable to keep a schedule appointment, please let us know 24 hours in advance. A **NO SHOW** is when a patient fails to keep a scheduled appointment. A **NO SHOW will generate a $30 fee** and three no shows may require that your seek your medical care elsewhere. In the event that you have a special circumstance regarding your missed appointment, please contact our office manager We understand that there may be issues beyond our control and want to be understanding of special circumstances.

I have read, understand, and agree to comply with the terms of Premier Primary Care's Financial Policy.

Signature: Type your name here _____ Date: _____

Printed Name: _____

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Authorization for Premier Primary Care To Disclose My Health Care Information

Patient Name: _____ Date of Birth: _____

You may disclose my health information to:

Name: _____ Relation: _____

Name: _____ Relation: _____

With this consent, Premier Primary Care my call my home or other alternative location and leave a message or voicemail or in person in reference to any items that assist the practice in carrying treatment, payment, and healthcare operations, such as appointment reminders, insurance items, availability of lab results, among other items.

"By suppling my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or any other healthcare related function I also authorize my healthcare provider to disclose to third parties, who may intercept these message.s, limited protected health information (PHI) regarding my health care events. I consent to the receiving multiple messages per day from my healthcare provider, when necessary, I consent to allowing detailed messages being left on my voice mail, answering system, or with another individual, if I am unavailable at the number provided by me."

_____ YES _____ NO

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, Premier Primary Care my decline to provide treatment to me.

Type your name here
Signature: _____ Date: _____

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Authorization to Release Medical Information

I authorize the named health care provider to **release or receive** information or records via secure fax, email or by mail.

Provider Name:	**Patient Name:**
Address:	**SSN:**
Phone:	**DOB:**

RECORDS AUTHORIZED TO BE RELEASED:

• **Adimission History and Physical**	• **Lab Reports**
• **Discharge Summaries**	• **Radiology Images and Reports**
• **Office Notes**	• **Psychiatric/ Mental Health Records**
• **Other**	

This authorization will expire one year from the date of the signature below. I understand that I may revoke this authorization at any time in writing to the healthcare provider, but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

I understand that:

• I am not required to sign this authorization and that my health care or payment for care will not be affected by my refusal.

• I am entitled to receive a copy of this authorization.

_____ _____

Patient or Representative Date

_____ _____

Printed Name of Representative Relationship to Patient

HIPAA Notice of Privacy Practices

Premier Primary Care
702 Sherrill St. Union City, TN 38261
731-885-8884

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment:
We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment:
Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay niay require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations:
We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our .office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by Jaw. You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) - Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information -This means you may ask us not to use or disclose any part of your protected health information and by law we must-comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.
You have the right to request to receive confidential communications -You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information -If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statemeni and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures -You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Notice of Privacy Practices Acknowledgment

Premier Primary Care

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have recelved or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

Patient Name or Legal Guardian (print) Date

Type your name here

_____

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date:_____ Attempt: _____

Staff Name:. _____