Medical Direct Care
Total Health and Wellness Family Medical Clinic

Copay $ _____

New Patient Registration Form

General Information (please print)

Name: _____ DOB _____ Sex: __M __F
Social sec # _____ Marital status: Single__ Married__ Divorced __Widowed __
Primary address _____
City _____ State _____ Zip _____
Home phone _____Work phone _____ Cell phone _____
Emergency contact _____ Relationship _____Phone _____
E-mail _____ Authorize E-mail? __Y __N
Pharmacy name _____ Phone _____ Fax _____
Employment status: ___employed ___not employed ___retired ___student
Employer: _____ Occupation _____

Patient Phone Message Consent

It is our policy to notify you of test results ordered by this office and to call you to confirm appointments. This is to acknowledge that you authorize us to:

- Leave a detailed message on voice mail/machine/cell YES _____ NO _____ (initial yes or no)
- Leave a detailed message with individual answering the phone YES _____ NO _____ (initial yes or no)

Sharing of Medical Information

I give the physician and office staff of **MEDICAL DIRECT CARE** permission to discuss my medical condition with the following individuals:
Name:_____ Relationship:_____
Name:_____ Relationship:_____
Name:_____ Relationship:_____

Doctor Information

Referring Physician _____ Specialty _____
Primary Care Physician _____ Phone _____

Primary Insurance

Insurance name _____ Subscriber's name _____
Insurance ID#: _____
Social Sec # _____ DOB _____ Relationship to insured _____

Secondary Insurance

Insurance name _____ Subscriber's name _____
Insurance ID#: _____
Social Sec # _____ DOB _____ Relationship to insured _____

Patient Authorization for ePRESCRIBE

ePrecribing is a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the practice. ePrescribing greatly reduces medication errors and enhances patient safety. Understanding all of the above, I hereby authorize the physician and/or staff of **MEDICAL DIRECT CARE** to enroll me in the ePrescribe Program.

Patient signature _____ Date _____

Patient Authorization for PHARMACY BENEFITS MANAGER

I authorize the physician and/or staff of **MEDICAL DIRECT CARE** to request and obtain my prescription medication history from other healthcare providers, the pharmacy benefit manager and/or any third-party pharmacy payors for treatment purposes.

Patient signature _____ Date _____

Patient Authorization for MEDICARE PATIENTS

I authorize the physician and/or staff of **MEDICAL DIRECT CARE** to release to the social security administration, Health Care Financing Administration or its intermediaries or carriers any information needed for this or any Medicare claim. I permit a copy of this Authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who may cause Medicare payment information to cross over automatically to my supplement insurer. I understand that I am financially responsible for any services deemed non-covered by Medicare.

Patient signature _____ Date _____

Patient Authorization for PPO and HMO PATIENTS

I authorize the physician and/or staff of **MEDICAL DIRECT CARE** to release to my insurance company or its representative any information including the diagnosis and records of any treatment or examination rendered to me during medical or surgical care. I authorize and request my above named insurance company to pay directly MEDICAL DIRECT CARE the amount due for medical or surgical services. I understand that I am financially responsible for any services deemed non-covered by my insurance company.

Patient signature _____ Date _____

Patient Authorization for ALL PATIENTS

I understand that I am financially responsible for services in the office and that refunds from services charged on a credit card will be returned to the same credit card. Furthermore, I also understand that any account balance that is not paid may be sent to a collection agency. Should any delinquent account balance be referred to a collection agency, I understand that I will be financially responsible for any and all cost and fees relating to the collection of my debt. I also authorize my physician and **MEDICAL DIRECT CARE** to photograph me for medically related documentation purposes.

Patient signature _____ Date _____

Special Accommodations

If a patient requires an accommodation for their appointment, the individual or his/her representative must notify **MEDICAL DIRECT CARE** of the needed accommodation one week prior to the first new patient appointment. Subsequent appointments also require one week's notice. Under the American with Disabilities Act, "Providers are responsible for incurring all costs of providing reasonable aid and cannot pass that charge onto the patient or to his/her insurance company." If a patient who has requested accommodations does not provide a minimum of 24 hours' notice to cancel the appointment or does not show to the scheduled appointment, all charges incurred by **MEDICAL DIRECT CARE** is the patient's responsibilities.

Patient signature _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

Notice to patients: We are required to provide you with a copy of our Notice of Privacy Practices which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice. You may refuse to sign the acknowledgement, if you wish. ***I acknowledge that I have received a copy of the*** **MEDICAL DIRECT CARE** ***Notice of Privacy Practices.***

Patient signature _____ Date _____

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the named health care provider to release the information or records specified upon this request, in person or by mail to the location specified at the time of the request.

Provider: (name and address)	**Patient:** **SS#:** **DOB:**

RECORDS AUTHORIZED TO BE RELEASED:

- ☐ **Admission history and physical**
- ☐ **Discharge summary**
- ☐ **Complete hospital chart**
- ☐ **Office notes**
- ☐ **Outpatient records**
- ☐ **Psychiatric and other mental health records**
- ☐ **Lab Reports**
- ☐ **Radiological images**
- ☐ **Consultation notes or reports**
- ☐ **Complaints or grievances filed, with responses or dispositions**
- ☐ **Records relating to drug or alcohol abuse** (must specify the extent or nature of the records to be released)
- ☐ **Medication administration logs, dietary logs, staff contact or service logs, and other records that may not be part of my individual medical record, but which contain information relating to me** (These records should be redacted to protect information pertaining to other patients.)
- ☐ **Other (specify):**

Extent or nature of records to be released:
(example, specific hospitalization or visit)

This information will be used for the purpose of:

- ☐ **Investigating an allegation of abuse**
- ☐ **Providing advocacy services**
- ☐ **Other activities at the request of the individual**
- ☐ **Verifying my eligibility for services offered by the _____**
- ☐ **Legal representation**

This authorization will expire one year from the date of the signature below. I understand that I can revoke this authorization at any time by writing to the Health Care Provider or to the Office Manager, but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

I also 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.**
- **Federal privacy regulations will no longer apply to the information disclosed, and that my redisclose the information.**
- **I am entitled to receive a copy of this authorization.**
- **A copy of this authorization may be utilized with the same effectiveness as an original.**

_____
Patient or Representative **Date**

_____
Name of Representative (print)

_____
Relationship to Patient

190 Hatcher Lane, Ste. B – Clarksville, TN 37043
Phone: (931) 221-0902 Fax: (931) 221-0602
www.medicaldirectcare.com

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Full Name: _____

Date of Birth: _____

Today's Date: _____

Past Medical History Form

Please fill out as much of the information as honestly and completely as possible.

Preferred Pharmacy:		
List Current Medications or circle: NONE	**Dose**	**Frequency**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

List Allergies or circle: NONE			
Allergy	**Reaction**	**Allergy**	**Reaction**
1.		4.	
2.		5.	
3.		6.	

Do you have a history of: (circle all that apply) or NONE

((PLACE DATE OF WHEN YOU WERE DIAGNOSED NEXT TO ANY THAT APPLY))

Allergy/Immun.
Seasonal Allergies
Rheumatoid Arthritis
Autoimmune Dis.

ENT
Sinusitis
Tonsillitis
Fx of Nasal Bone
Laryngeal Cancer

Hemat./Lymphatic
Leukemia
Lymphoma
Anemia

Skin
Dermatitis
Eczema
Psoriasis
Cellulitis
Acne
Impetigo

Cardiovascular
Hypertension
Atrial Fibrillation
Hyperlipidemia
CHF
Tachycardia
PVD

Eye
Cataracts
Glaucoma
Macular Degen.
Diabetic Retinopathy

Musculoskeletal
Arthritis
Gout
Osteoarthritis
Osteoporosis
Degenerative Discs
Spinal Stenosis
Fibromyalgia

Central Nervous System
Neuropathy
Seizure
Stroke
Vertigo
Alzheimer's
Dementia

Genitourinary
Nephrotic Synd.
Urinary Incontinence
BPH
Erectile Dysfunction
Uterine Fibroids
Endometriosis

Psychiatric
Depression
Anxiety
Bipolar Disorder
OCD
Anorexia Nervosa
PTSD

Endocrine
Diabetes
Hyperthyroidism
Hypothyroidism

GI
Pancreatitis
Hemorrhoids
Diverticulitis
GERD
Peptic Ulcer Disease

Pulmonary
Asthma
COPD

Other:
_____
_____
_____
_____
_____

Have you ever been hospitalized? ☐ Yes ☐ No If so, why? _____

_____

_____

Surgical History (circle all that apply) or NONE

((PLACE DATE OF SURGERY NEXT TO ANY THAT APPLY))

ENT Surgery
Tonsillectomy
Adenoidectomy

Eye Surgery
Left / Right Cataract Ext.
Bilateral Cataract Ext.

Cardiac Surgery
CABG (Bypass)
Angioplasty w/Stent
Pacemaker
Aortic / Pulm. / Mitral / Tricusp. Valve Repair / Replace

Respiratory Surgery
Laryngectomy

Ortho Surgery
Shoulder
Arthroscopy
Hip Replacement

GI Surgery
Colonoscopy
EGD
Appendectomy
Cholecystectomy
Hemorrhoidectomy
Umb. / Ing. / Hiatal Hernia Repar
Lap-Band Proc.
Gastrectomy

GU Surgery
TURP
Hydrocholectomy
Bladder Tumor Resect

OB/GYN Surgery
C-section
Tubal Ligation
Hysterectomy

Endo Surgery
Thyroidectomy

Other:
_____
_____
_____
_____
_____
_____

Illness/Condition:	Family Members										Describe:
	Father	Mother	Brother(s)	Sister(s)	Son(s)	Daughter(s)	Paternal Grandfather	Paternal Grandmother	Maternal Grandfather	Maternal Grandmother	
Cancer (describe the type)											
Stroke											
CHF											
Hypertension											
Diabetes											
Depression											
Anemia											
Obesity											
Osteoarthritis											
Osteoporosis											
Other:											
Other:											

Social History

Marital Status: ☐ Single ☐ Married ☐ Divorced
Work: ☐ Employed (Full-time / Part-time) ☐ Unemployed ☐ Homemaker ☐ Retired ☐ Disabled
Children (ages) & (in home / away): _____
Education (highest level received): _____

Habits:

Alcohol: ☐ None ☐ Yes: How many drinks/day _____ frequency/week _____
Tobacco: ☐ None ☐ Yes: Chew or Smoke? _____ How many/day _____ Since _____
Recreational Drugs: ☐ None ☐ Yes: What kind _____ How many/day _____
Hobbies/Interests: _____
Sports: _____
Pets: _____
Other: _____
_____

iPatient Care HIPAA Consent Form (08/2017 vs 1)

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the users and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date that I revoke this consent is not affected.

_____ _____

(Print Patient Name) (Date)

_____ _____

(Sign Patient Name) (Relationship to Patient)

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Medical Direct Care No-Show Policy

Effective 1/11/2018

We appreciate the opportunity to serve your medical needs. We respect your time and we vow to see you as promptly as possible. We ask that you respect our time by calling to cancel your appointments as soon as possible when you realize that you will be unable to keep it. By calling at least two (2) hours in advance to cancel your appointment when you are unable to keep it, you allow us to book another patient who needs to be seen.

We realize that sometimes things happen beyond your control and we appreciate when you call to cancel appointments when necessary. If you fail to call to cancel your appointment at least 2 hours prior to your appointment and you fail to show-up for that appointment within ten minutes of your appointment time, it will be considered a "no-show."

It is our policy when you commit "no-show" on your New patient (initial) clinic visit **or** commit a second "no-show" and all subsequent "no-shows", you will be charged **$55.00**. If you accumulate three (3) "no-shows" within a two (2) year period, we may no longer be able to serve you and meet your healthcare needs by providing you with appointments within our facility. If you accumulate three (3) "no-shows" we will contact you and send you a letter informing you to seek medical treatment at another medical clinic.

Print Name: _____

Sign Name: _____ Date: _____

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