DATE:____________

**PATIENT**

**PATIENT** NAME: SEX: M F SOCIAL SECURITY #:

MAILING ADDRESS: DATE OF BIRTH: / / MARITAL STATUS: S M W D

STREET ADDRESS:

CITY: STATE: ZIP: HOME TELEPHONE #: ( )

EMPLOYER: ADDRESS:

CITY: STATE: ZIP: WORK TELEPHONE #: ( )

**SPOUSE'S** NAME: SPOUSE'S SOCIAL SECURITY #: DATE OF BIRTH: / /

SPOUSE'S EMPLOYER/ADDRESS:

IF AN EMERGENCY, CONTACT: ____________ TELEPHONE #: RELATIONSHIP:

REFERRED BY:____________PRIMARY CARE PHYSICIAN:____________

**INSURANCE**

PRIMARY INSURANCE: POLICY HOLDER: DATE OF BIRTH: / /

POLICY NUMBER: GROUP #: EFFECTIVE DATE:

MAIL CLAIMS TO :

SECONDARY INSURANCE: POLICY HOLDER: DATE OF BIRTH: / /

POLICY NUMBER: GROUP #: EFFECTIVE DATE:

MAIL CLAIMS TO:

**WORKERS' COMPENSATION PATIENTS:** WILL THIS BE COVERED UNDER WORKERS' COMPENSATION? ____YES ____NO

IF YES, NAME/ADDRESS OF COMPANY:____________

PHONE #:____________TREATMENT AUTHORIZED BY:____________ DATE OF INJURY:____________

**GUARANTOR**

**RESPONSIBLE PARTY**

NAME ADDRESS CITY STATE ZIP CODE

( )
DAY TIME TELEPHONE RELATIONSHIP TO PATIENT OCCUPATION

EMPLOYER ADDRESS TELEPHONE

HAS ANY MEMBER OF YOUR IMMEDIATE FAMILY BEEN TREATED BY ANY OF OUR PHYSICIANS? ____YES ____NO

IF YES, NAME OF PHYSICIAN(S) AND FAMILY MEMBER(S):____________

I have completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. **I understand that even though I have some type of insurance coverage, I am responsible for payment of services**. I understand if collection action is taken on my account, I will be assessed an additional fee. I agree that the clinic may apply money received on my account to any unpaid balance that I may owe. I have read and understand the payment policy of The Greenville Clinic.

SIGNATURE DATE

PREFERRED METHOD OF PAYMENT: ____CASH ____CHECK ____CREDIT CARD (VISA OR MASTERCARD)

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Please answer the following questions:

What is your main heart problem now ?

| Do you experience chest pain or angina ? | Yes \| No |
|---|---|
| If yes - circle appropriate responses | |
| how often ? | constantly \| once a day \| several times a day \| weekly \| monthly |
| when does the pain come on ? | at rest \| with exercise \| when upset \| anytime |
| how long does it last ? | seconds \| minutes \| hours \| days |
| how does it feel ? | aching \| burning \| squeezing \| sharp \| pressure \| tightness \| other |
| does it radiate to your ? | back \| right arm \| left arm \| both arms \| neck \| abdomen |
| do you also feel with the pain | shortness of breath \| dizziness \| nausea \| weak |
| is it worse ? | after eating \| at night |
| can your relieve the pain ? | by resting \| taking nitroglycerin \| lying down |

Have your had any heart attacks ? **Yes** **No**

If yes - indicate when and what hospitals:

| Indicate if your have had: | No | Yes | If YES - indicate | | | Comments |
|---|---|---|---|---|---|---|
| | | | Year | Hospital | Doctor | |
| EKG | | | | | | |
| Holter monitor | | | | | | |
| Treadmill Test | | | | | | |
| Echocardiogram | | | | | | |
| Heart cath | | | | | | |
| Angioplasty / stent | | | | | | |
| Heart bypass surgery | | | | | | |
| Heart valve surgery | | | | | | |
| Pacemaker / Defibrillator | | | | | | |

Circle if you have an of the following:

| High blood pressure | Diabetes | High cholesterol | Smoked in past 5 yrs | Family members with heart attacks under 55 |
|---|---|---|---|---|

| Shortness of breath | Swelling of feet | Swelling of abdomen | Palpitations | Dizziness | Blackouts | Rheumatic fever | Heart murmur as a child | Congenital heart defects |
|---|---|---|---|---|---|---|---|---|

List current medications and doses: *See flow sheet* *See medication reconciliation order sheet* ☐**None**

List your ALLERGIES: ☐**None**

Previous surgery with date / year : ☐**None**

What other illness / conditions are you currently being treated for ? ☐**None**

List major injuries / accidents with date / year: ☐**None**

| Tobacco use (circle): | Never | Chew tobacco | Smoke cigarettes | Quit when? | # packs per day: |
|---|---|---|---|---|---|

Alcohol use: No | Yes -- then How much per week ---

| Name / Signature: | Date / Time: |
|---|---|

**Please mark YES to symptoms that you are currently having or had had in the recent past:**

| | | Yes | No |
|---|---|---|---|
| General | Dizziness | | |
| | Fever / chills | | |
| | Night sweats | | |
| | Weight change | | |
| | Heat / cold intolerance | | |
| | Thyroid trouble | | |
| Head | Blindness | | |
| | Drainage from ears | | |
| | Loss of hearing | | |
| | Pain in ears | | |
| | Sinus trouble | | |
| | Visual disturbance | | |
| Skin | Itching | | |
| | Moles | | |
| | Rash | | |
| Joints | Joint pain | | |
| | Joint stiffness | | |
| | Joint swelling | | |
| Blood | Anemia | | |
| | Blood clots | | |
| | Eating dirt or clay | | |
| | Excessive bleeding | | |
| Heart | Blackouts | | |
| | Chest pain/discomfort | | |
| | Easy fatiguability | | |
| | Heart murmur | | |
| | High cholesterol levels | | |
| | Palpitations | | |
| | Shortness of breath | | |
| | Swelling of feet | | |

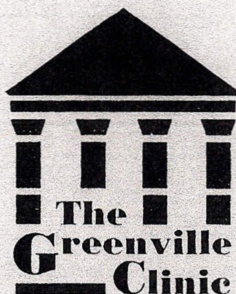
| | | Yes | No |
|---|---|---|---|
| Lungs | Cough | | |
| | Coughing up blood | | |
| | Positive TB skin test | | |
| | Shortness of breath | | |
| | Wheezing | | |
| Gastrointestinal System | Abdominal pain | | |
| | Abdominal swelling | | |
| | Blood in bowel | | |
| | Constipation | | |
| | Dark bowel movements | | |
| | Diarrhea | | |
| | Heartburn | | |
| | Indigestion | | |
| | Jaundice | | |
| | Nausea | | |
| | Trouble swallowing | | |
| | Vomiting | | |
| | Vomiting blood | | |
| Kidneys and Urinary Tract | Blood in urine | | |
| | Burning with urination | | |
| | Difficulty voiding | | |
| | Flank pain | | |
| | Frequent urination | | |
| | Impotence | | |
| | Kidney stones | | |
| | Lesions on penis | | |
| | Testicular pain | | |
| | Urethral discharge | | |
| | Voiding at night | | |

| | | Yes | No |
|---|---|---|---|
| Nervous System | Headaches | | |
| | Muscle cramps | | |
| | Pain / sensory abnormality | | |
| | Seizures | | |
| | Sleep disturbance | | |
| | Weakness | | |
| Psychiatric | Anxiety | | |
| | Nervousness | | |
| | Depression | | |
| | Loss of control | | |
| | Violence | | |
| | Mental retardation | | |
| Breast | Breast lump | | |
| | Breast pain | | |
| | Nipple discharge | | |
| Women Only | Abnormal vaginal bleeding | | |
| | Irregular periods | | |
| | Pelvic pain | | |
| | Vaginal discharge | | |
| | Are you pregnant ? | | |

Please list any other ongoing symptoms we should know about:

Please list any illnesses that run in the family:

| Name / Signature: | Date/Time: |
|---|---|
| | |




1502 South Colorado St.
Greenville, MS 38703
(662) 332-9872

# AUTHORIZATION AND ASSIGNMENT OF BENEFITS

## PAYMENT POLICY

Patients are expected to make payment in full for office services at the time of the visit. For your convenience, we accept cash, checks, VISA, and MasterCard. We understand that circumstances sometimes do not make it possible for you to pay in full. When this happens, payment arrangements will be made with one of our Patient Accounting Representatives. Patients who have insurances contracted with us are responsible for any co-payment or deductible at the time of service. Any balance remaining on one of these accounts after insurance payments have been received will become the responsibility of the patient. Accounts with delinquent balances could be reported to the credit bureau or turned over to our collection agency if little or no effort has been made by the patient to settle the amount owed.

**PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE**: I authorize above office to use my medical information for treatment, payment, and healthcare operations, including submitting information to my insurance company for the purpose of processing claims. I permit the following to be used in place of this document for all federal, state, and private commercial health insurance claims:

(1) Photocopy or other facsimile reproduction of this authorization, or
(2) Use of computer to indicate my signature is on file at above office, and/or
(3) Use of a computer to transmit my insurance claim by phone for processing.

▶Print Name ▶Signature ▶Date

**CERTIFICATION/AUTHORIZATION OF INSURED**: I certify that the insurance information I have provided above office to be true and correct to the best of my knowledge. I authorize payment for services rendered to the doctors associated with the above office. I understand that the doctor(s) cannot accept responsibility for collecting my insurance claim or for negotiating a settlement on a disputed claim. I am responsible for payment of my account in full within the terms of the above payment policy. If I am under 18, the parent/guardian requesting treatment assumes responsibility. I understand that if my account should ever require action by a collection agency in order to collect the balance owed, fees charged by this agency may be added to the balance due on my account.

I authorize the doctors and CFNP(s) of above office and its designees to provide treatment. I further authorize labs, radiology centers, Pathologists and Radiologists who may interpret and report on diagnostic tests, and Anesthesiologists who will administer anesthesia during a scheduled procedure, to provide such treatment, if such tests/procedures are ordered by my doctor(s). I authorize above office to release all or part of my records to

(1) Physicians to whom I am being referred, and/or
(2) Any in- or out-patient facility where I am scheduled to receive treatment.

▶Print Name ▶Signature ▶Date

HIPAA 4/11/03

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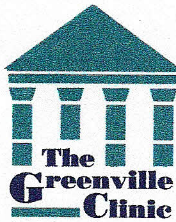


# Notice of Privacy Practices

Effective Date April 14, 2003

**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.**

The Greenville Clinic creates a record of the care and services you receive from us. We call this record your health information. We are required by law to keep your health information private. We are also required to provide you with this notice so that you will know how we use and release your health information. This notice also lists the rights you have regarding your health information. We will abide by the terms of this notice. This notice covers all healthcare providers who are affiliated with The Greenville Clinic and who may provide you with care.

We reserve the right to change the terms of this notice and our privacy practices at any time. Any changes will apply to the health information we already have. When we make changes to our privacy practices, we will post an updated notice in the places where you may get treatment from The Greenville Clinic. You can also request a copy of this notice at any time.

## HOW THE GREENVILLE CLINIC MAY USE AND RELEASE YOUR HEALTH INFORMATION

### Uses and Releases Relating to Treatment or Payment

**For Treatment**. For example, a doctor treating you for chest pain may need to know if you have any existing heart problems so that he/she can make an informed decision concerning your treatment. Additionally, we will/may contact you to (1) remind you of your appointment by calling or mailing a notice; or (2) discuss treatment alternatives or other health related benefits that may be of interest to you as a patient.
**To Obtain Payment for Treatment**. For example, we will release some of your health information to your health insurance company in order to receive payment for your treatment.
**For Health Care Operations**. For example, administrative personnel reviewing the quality and appropriateness of the care you receive may use your health information.

### Uses and Releases That Do Not Require Your Permission

**Emergencies**. We may use or release your health information in an emergency treatment situation.
**Food and Drug Administration**. We may use and release your health information to a person or company required by the Food and Drug Administration to track adverse events and as otherwise required.
**Workman's Compensation**. We may use and release your health information as necessary to comply with workman's compensation laws and other similar legally-established programs.
**Federal, State or Local Law**. We may use and release your health information when required by law.
**Government Agencies and Law Enforcement**. We may release your health information to government agencies and law enforcement.
**Ordered by a Court, Tribunal or Other Judicial Proceeding**. We may release your health information when ordered by a court, tribunal or other Judicial proceeding.
**Public Health Reasons**. We may use or release your health information for public health reasons.
**Coroners, Medical Examiners and Funeral Home Directors**. We may release your health information to a coroner, medical examiner or funeral home director.
**Health Oversight Reasons**
**Organ and Tissue Donation**. We may release your health information for organ and tissue donation.
**Research Reasons**. We may release your health information for reviews to prepare a research study and when approved by an institutional review board.
**Disaster Relief Reasons**. We may release your health information for the reason of coordinating disaster relief efforts.
**Specialized Government Functions**. We may release the health information of military personnel and veterans in certain situations to the government. We may also release your health information for national security reasons.
**Avert a Serious Threat to Health or Safety**. We may release your health information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person, such as instances of child and/or elderly abuse or neglect.

### Uses and Releases to Which You Have the Opportunity to Object.

**People Who Help Take Care of You**. We may provide your health information to a family member, friend or other person, if they help take care of you, or if they are responsible for paying for your care, unless you tell us not to. In emergencies, you will not be given the chance to tell us not to provide information to those who take care of you.

**Other Uses and Releases Require Your Prior Written Permission**

Other uses and releases will be made, of your health information, only with your written permission. You may take back permission once you have given it and your refusal to provide permission will not be held against you; however, it may prevent us from completing a task you have requested, such as enrollment in a research study or to create a report for your attorney. The request to take back the permission must be made to The Greenville Clinic in writing. You cannot take back permission if The Greenville Clinic has already acted in reliance of the permission and as needed to maintain the integrity of a research study.

**YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION**

**You have the right to see and to get copies of your health information**. With only a few exceptions, you have the right to look at, or get copies of your health information that we have. You must make the request in writing. If we do not have your health information, but we know who does, we will tell you how to get it. We will respond to you within 30 to 90 days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed. If you request copies of your health information, we may charge you a fee based on our cost. Instead of providing the health information you requested, we may provide you with a summary or explanation of the health information as long as you agree to accept a summary and to the cost in advance.

**You have the right to request a correction to your health information**. If you believe that your health information is incorrect or information is missing, you may request that the information be changed or added. You must make the request in writing. You must also give us a reason for your request. We will let you know if we accept your request within 60 days of receiving your request. Under certain circumstances, we may deny the request. If we deny your request, we will let you know why. We will also explain your right to file a written statement of disagreement with the denial. If we approve your request, we will make the change to your information. We will let you know when the change is made. We will also let concerned parties know when the change is made.

**You have the right to request a listing of releases we have made of your health information**. You have the right to an accounting of all entities that obtained information unrelated to treatment or payment without your permission, except as otherwise required by law. We will respond within 60 days of receiving your request. Your request must state the time period desired for the accounting, which must be less than a six-year period and starting after April 14, 2003. The list will contain the date of the release, the name of the recipient and address, if known, a description of the information released, and the reason for the release. If you make more than one request in the same year, you will be charged a fee based on cost for each additional request.

**You have the right to request limits on uses and releases of your health information**. You have the right to request a limit on the health information we use or release about you for treatment or payments. We will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them, except in some situations, such as during emergencies. You may not limit the uses and releases that we are legally required or allowed to make.

**You have the right to choose how we communicate with you**. You have the right to request that we communicate with you in a certain way. For example, you may request that we contact you by phone rather than by mail. We will agree to the request as long as we can easily provide it in the format you requested. We require that you make requests for confidential communications in writing.

If you would like more information on accessing, obtaining a copy or obtaining a list of the releases that we have made of your health information, you may call The Greenville Clinic at (662) 332-9872.

**You have the right to complain to The Greenville Clinic and/or US DHH**. You have the right to complain to The Greenville Clinic and/or to the U.S. Department of Health and Human Services, if you believe that The Greenville Clinic has violated your privacy rights. To complain, please call:

Administrator (662) 332-9872

I have received and had an opportunity to ask questions concerning the Practice's Notice of Privacy Practices for Protected Health Information.

________________________________________

Patient or Patient's Representative

________________________________________

Date