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)

Greenville Printing Center • Ref. # 1583

The Greenville Clinic, P.A. New Patient History

Reason for visit:

What other illnesses / conditions are you currently being treated for?

List current medications and doses:
1)
2)
3)
4)
5)
6)
7)
8)
9)
10)
11)
12)

Previous surgery:	Date:

Previous non-surgical hospitalizations:	Date:

List major injuries / accidents:	Date:

LIST ALLERGIES:

Tests and Immunizations:	Yes	Year done	Not sure	Never
Breast mammography				
PAP smear				
Pneumonia vaccine				
Sigmoidoscopy / colonoscopy				
PSA (prostate specific antigen)				
Tetanus shot				
Treadmill test				

Have you ever been diagnosed with the following?	Yes	No
Diabetes		
High blood pressure		
Cancer		
Heart attack(s)		
High cholesterol levels		
Stroke		

List diseases other family members have had:
Father
Mother
Brothers
Sisters
Children

Tobacco use:	Yes	No
Chew tobacco?	Yes	No
Smoke cigarettes?		
❑ Never		
❑ Not now - quit how long ago		
❑ Used to smoke - packs per day		
❑ Yes - how many packs per day		

Do you drink alcoholic beverages?
If yes - how much per week?

Patient / signature:	Date:

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The Greenville Clinic **Patient Systems Review**

	YES	NO
Constitutional ○		
Fever		
Chills		
Fatigue		
Night Sweating		
Appetite		
Fluid Intake		
Recent Weight gain (Lbs)		
Recent Weight loss (Lbs)		
Eyes ○		
Eye Pain ○		
Vision changes ○		
Discharge from Eyes ○		
Corrective lens		
Ophthalmology Exam		
ENT ○		
Earache ○		
Loss Of Hearing ○		
Ear Discharge ○		
Tinnitus ○		
Vertigo		
Allergies		
Epistaxis ○		
Nasal Discharge		
Nasal Congestion		
Sinus Pain		
Sinus Pressure		
Facial Pain		
Sore Throat ○		
Hoarseness		
Mouth pain		
Tonsillar Pain		
Bleeding Gums ○		
Tooth Pain ○		
Oral Lesions		
Dysphagia ○		
Dysphasia		
Dental Exam		
Neck ○		
Neck Pain ○		
Neck Stiffness		
Swollen Glands in neck ○		
Lump or swelling in neck		
Cardiovascular ○		
Chest Pain		
Palpitations ○		
Fatigue ○		
Leg Claudication ○		
Respiratory ○		
Shortness Of Breath		
Wheezing ○		
Dyspnea on Exertion		
Cough ○		
Sputum		
Hemoptysis ○		

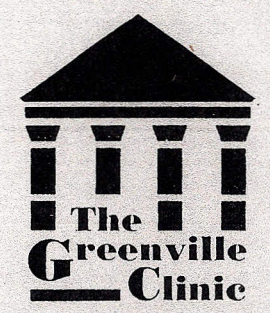
	YES	NO
Gastrointestinal		
Abdominal Pain		
Vomiting ○		
Nausea ○		
Constipation ○		
Diarrhea ○		
Heartburn ○		
Rectal Bleeding ○		
Hematemesis ○		
Colonoscopy		
FOBT		
Musculoskeletal		
Joint Pain		
Joint Swelling		
Joint Stiffness		
Range of Motion		
Muscle Aches		
Muscle Weakness		
Limb Pain		
Limb Swelling		
Deformity		
Injury		
Body Aches		
Integumentary ○		
Skin Lesions		
Skin Rash		
Itching (Pruritus)		
Excessive Dry Skin ○		
Skin Bruising		
Skin Ulceration		
Diabetic Foot Exam		
Neurological ○		
Confused		
Convulsions		
Headache		
Dizziness		
Lethargy		
Difficulty Walking		
Weakness (Paresis)		
Numbness (Hypesthesia)		
Tingling (Paresthesia)		
Psychiatric		
Memory Deficits		
Change in Personality		
Emotional Problems		
Anxiety		
Depression		
Sleep disturbances		
Suicidal		
Homicidal Thoughts		
Substance Use/Abuse		

	YES	NO
Heme/Lymph ○		
Easy bleeding ○		
Easy Bruising ○		
Polyphagia		
Polydypsia ○		
Polyuria		
Cold Intolerance		
Heat Intolerance		
Hot Flashes		
Proptosis		
Deepening Of Voice		
Breast		
Breast Pain ○		
Breast Lump		
Nipple Discharge		
Breast Rash		
Breast Swelling		
Breast Trauma		
Monthly SBE		
Last Mammogram:		
Genitourinary ○		
Dysuria ○		
Urinary Frequency ○		
Urinary Urgency		
Urinary Hesitancy ○		
Hematuria		
Nocturia ○		
Hemorrhoids ○		
Incontinence		
Incomplete Bladder emptying		
Perineal Itching		
Perineal Lesions		
Vaginal Discharge		
Testicular Pain		
STE		
Menses Abnormal		
Dysmenorrhea		
Abnormal Vaginal Bleeding		
Pelvic Pain ○		
Penile Discharge		
Birth Control Method:		
Last Pap Smear:		
Last Menses:		
Last DRE:		

Other Symptoms: _____

_____

_____



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
Greenville Printing Center • Ref. #1349

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