# Patient Medical History

Name: _____ Birthday: _____

Current Pharmacy: _____ Location: _____

| Medication Name | Dose | Times Taken Per Day |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## Medication Allergies & Reactions

| | | |
|---|---|---|
| | | |
| | | |

## Current/Previous Medical Conditions

| | | |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## Surgery/Hospitalization

| MO/YR | Procedure/Reason |
|---|---|
| | |
| | |
| | |
| | |
| | |

Continue on back →

# Patient Medical History

**Family Medical History**

Mother: Alive / Deceased Medical Conditions:_____

Father: Alive / Deceased Medical Conditions:_____

Other family medical conditions: _____

_____

Last Colon Cancer Screening (MO/YR):_____

Family Hx of Colon Cancer? **YES** **NO** Relationship:_____

**Females Only**

First Day of Your Last Period: _____

Menopause: **YES** **NO** Hysterectomy: **YES** **NO** If yes, **partial or complete**

Last Pap Smear (MO/YR): _____ Last Mammogram (MO/YR):_____

Family Hx of Breast Cancer: **YES** **NO** Relationship:_____

**Males Only**

Last Prostate Cancer Screening (MO/YR):_____

**Social History**

Are you now or have you ever been a smoker, including vapes?

**Never** **Former** **Current**

Have you consumed alcohol in the past year? **YES** **NO** How often:_____

Any current or past drug abuse? **YES** **NO**

**Current or Former Specialists**

| Provider/Office Name | Specialty | Phone Number |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**Any other information you would like your provider to know?**_____

_____

_____

Murfreesboro Family Medicine

# Patient Registration

Name:_____
LAST FIRST MI SUFFIX

Birthday:____/____/_____ SSN:_____-_____-_____

Address:_____
STREET CITY STATE ZIP

_____ EMAIL:_____
APT OR LOT #

Primary Phone:_____ Secondary:_____

Race:_____ Ethnicity:_____ Sex: **F** **M** Marital Status: **S M D W**

## MEDICAL INSURANCE INFORMATION

Primary Insurance:_____Policy #:_____Group #_____

Subscriber Name:_____Subscriber Phone: _____

Subscriber Address: :_____
STREET CITY STATE ZIP

Subscriber Birthday:____/____/_____ Subscriber SSN:_____-_____-_____

Relation: **Self** **Spouse** **Parent** **Other**:_____

Business Name:_____

Address:_____
STREET CITY STATE ZIP

Secondary Insurance:_____Policy #:_____Group #_____

Subscriber Name:_____Subscriber Phone: _____

Subscriber Address: :_____
STREET CITY STATE ZIP

Subscriber Birthday:____/____/_____ Subscriber SSN:_____-_____-_____

Relation: **Self** **Spouse** **Parent** **Other**:_____

Business Name:_____

Address:_____
STREET CITY STATE ZIP

## EMERGENCY CONTACT

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

I authorize the release of any medical information necessary to process insurance claims (which may include drug/alcohol, HIV status or psychiatric treatment). I further authorize the release of any pertinent medical records to any physicians and/or facility to which I may be referred. I give my consent for medical treatment of the above name and allow providers at Murfreesboro Family Medicine to review my external medication history. I hereby acknowledge that I was given the opportunity to read a copy of the **Notice of Privacy Practices** of Murfreesboro Family Medicine.

Name: _____ Signature: _____ Date:_____

Pharmacy: _____ Location: _____

# Authorization to Release Information

Name: _____

LAST FIRST MI

Birthday: _____

_____ I authorize Murfreesboro Family Medicine to release medical information (i.e., imaging results, lab results, etc.) to the following individuals: (for example: parents, siblings, spouse, children, etc.)

1. Name:_____

   Phone:_____Relationship: _____

2. Name:_____

   Phone:_____ Relationship:_____

_____ I ***do not*** authorize my information to be released to anyone.

I understand I may revoke this authorization at any time upon written notice. I hereby agree to hold harmless, any person complying with this authorization request.

Print Patient Name: _____ Date: _____

Signature: _____

If patient is a minor, parent or guardian must sign authorization consent.

**MURFREESBORO FAMILY MEDICINE**

**NOTICE OF PRIVACY PRACTICES**

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please read carefully.

State and federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this notice. We must follow the privacy practices as described below. This notice will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided the law permits the changes. Before we make a significant change, this notice will be amended to reflect the changes, and we will make the new notice available on request. We reserve the right to make any changes in our privacy practices and the new terms of our notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Shannon Alvey. Information on contacting us can be found at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or services to you. These professionals will have a privacy and confidentiality policy like this one.

Payment: We may use and disclose your health information to seek payment for the services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If possible, we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated, we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other state and federal officials and/or if you are an inmate or otherwise under custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

PATIENT PRIVACY RIGHTS: Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian). There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request form. You may also request access by sending us a letter to the address at the end of this notice. We will charge you a reasonable cost-based fee for expenses such as aa copies and staff time.

Murfreesboro Family Medicine

2933 Medical Cener Pkwy Suite A

Murfreesboro, TN 37129

Print Name: _____

Patient Signature: _____ Date: _____

# GENERAL CONSENT TO TREATMENT

As the patient, you have the right to be informed about your conditions and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify appropriate treatment and/or procedure for any identified condition(s):

I request and authorize medical care as my provider, his assistant or designees (collectively called "the providers") may deem necessary or advisable. This care may include, but is not limited to, routine diagnostics, radiology and laboratory procedures, administration of routine drugs, biological and other therapeutics, and routine medical and nursing care. I authorize my provider(s) to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my (the patient) care is directed by my provider(s) and that other personnel render care and services to me (the patient) according to the provider(s) instructions.

I understand that I have the right and opportunity to discuss alternative plans of treatment with my provider and to ask and have answered to my satisfaction any questions or concerns.

In the event that a healthcare worker is exposed to my blood or bodily fluid in a way which may transmit HIV (human immunodeficiency virus), hepatitis B virus or hepatitis C, I consent to the testing of my blood and/or body fluids for these infections and the reporting of my test results to the healthcare worker who has been exposed. _____ (initial)

I HAVE READ OR HAD READ TO ME AND FULLY UNDERSTAND THIS CONSENT. I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS AND HAD THESE QUESTIONS ADDRESSED.

Name of patient: _____ Date: _____

Signature of patient or representative: _____

_____ Consent of Legal Guardian, Patient advocate or Nearest Relative if patient is unable to sign.

_____ Consent of caregiver if patient is unable to sign.

***Patients under the age of 18, patients with disabilities, patients with legal guardians or a POA, please complete the information below.***

Name of legal guardian, patient advocate or nearest relative if patient is unable to sign.

_____

Relationship: _____ Telephone: _____

Address: _____
STREET CITY STATE ZIP

Signature of the above: _____ Date: _____ Time: _____

Signature of Witness: _____ Date: _____

# Murfreesboro Family Medicine Office Policies

Patient:_____ Date:_____

Murfreesboro Family Medicine is committed to being your partner in health to promote wellness and handle all your healthcare needs. Your understanding of our policies will help us to achieve that goal. Please initial each policy so that we may be assured that you understand it. If you would like clarification of any of our policies, please ask the receptionist or physician.
Thank you.

_____ Co-payments, if due, are expected at the time of check-in. Inability or unwillingness to comply with co-payments may lead to cancellation of a scheduled visit.

_____ All deductibles and coinsurance amounts are patient responsibility and will be billed to you after insurance has processed the claim. This arrangement is part of the contract between you and your insurance company

_____ Self-pay payment is due at the time of service. Additional charges may apply for adding tests or procedures. The lab company is a separate entity and payments will be billed directly from that company.

_____ There is a $25 dollar charge for returned checks.

_____ Patients with a balance greater than ninety (90) days will be required to pay half the balance and sign a payment plan in order to continue being seen.

_____ Please be aware that some or all of the services provided to you during your visit may not be covered by your insurance company. Any non-covered charges are patient responsibility.

_____ Our office may use an automated reminder system to help remind patients of upcoming appointments. However, timely cancellation of appointments remains the responsibility of our patients. If an appointment is canceled with less than 24 hours notice, a $25 No Show/Late cancellation fee will be charged.

_____ A ten (10) minute grace period will be given for late patients. After 10 minutes, the patient may be required to reschedule.

_____ In order to ensure timely communication, we require that our patients maintain current address, phone number and insurance information on file with our office. We also request that you provide an additional contact name in case we have difficulty reaching you.

_____ Long term treatments with the use of opioids and/or benzodiazepines will not be prescribed together by the providers at Murfreesboro Family Medicine. Patients in need of both medications will need to be referred out to either pain management or a psychiatrist to continue medication management.

_____ For patients that are prescribed controlled medications, a urine drug screen will be required at a minimum of two (2) times a year. Additional tests may be required at the discretion of the provider.

_____ Medication refills need to be requested 5 days prior to the due date for refill in order to ensure patients do not miss medication doses. We cannot guarantee refills called in less than 72 hours prior to the due date will be filled on time.

_____ This is a private practice where we strive to create a pleasant environment for all patients and staff. We understand that there are times when patients may be frustrated, and we will make every attempt to assist you. However, this practice will not tolerate physical abuse, verbal abuse, or harassment of any kind, under any circumstance. **Abuse or harassment in any form is grounds for discharge from this practice.**

# Authorization To Release Medical Record Information

Patient Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

I authorize you to release records to:

**Murfreesboro Family Medicine**

**2933 Medical Center Parkway**

**Murfreesboro, TN 37219**

**P: (615) 257-5601 F: (615) 728-3260**

Physician/Office Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Information to be released:

☐ All Medical Records ☐ Surgical Reports ☐ Prescriptions

☐ Imaging Reports ☐ Pathology Reports ☐ Mental Health

☐ Lab Reports ☐ Hospital Records ☐ Other _____

_____

_____

This authorization will remain in effect for 1 year, at which time the consent will expire unless revoked earlier. This authorization can be revoked in writing by the patient at any time, but is NOT retroactive to release of information made in good faith.

Signature of patient or guardian: _____

Print Name: _____ Date: _____

Relationship to patient: _____