Patient Information

Please Print

Date: _____
Primary Care Provider: _____
Local Pharmacy: _____ Mail order: _____
PMB Consent: I consent to have my prescriptions list electronically pulled from my pharmacy: No□ Yes□
Last Name: _____ First Name: _____ MI: _____
DOB: _____ SSN: _____ Driver's License #: _____
Language: Spanish□ English□ Other□
Mailing Address: _____ City: _____
State: _____ Zip: _____ Primary Phone #: _____ Home□ Cell□
Employer: _____ Employer Phone #: _____
Employer Address: _____ City: _____
State: _____ Zip: _____ Disability Status: No, I am NOT disabled□ Yes, I am disabled□

Mother's Name (***if minor***): _____ DOB: _____ SSN: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Father's Name (***if minor***): _____ DOB: _____ SSN: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____

Marital Status: Separated□ Widowed□ Divorced□ Single□ Married□
Race: Declined□ Other□ Native Hawaiian/Pacific Islander□ Caucasian/White□ Native American□ Asian□ American Indian/Alaskan Native□ African American/Black□
Sexual Orientation: Straight or heterosexual □ Lesbian or gay □ Bisexual □ Pansexual and/or questioning □ Something else; please specify: _____ Unsure □ Decline to answer □
Gender Identity: Male □ Female □ Transgender (man/transman/female to male) □ Transgender (woman/transwoman/ male to female) □ Gender nonconforming (neither exclusively male nor female) □ Additional gender category (or other) please specify: _____ Decline to answer □
Ethnicity: Not Hispanic/Latino□ Hispanic/Latino□

Person Responsible For Bill: _____
Primary Ins: _____ Subscriber ID: _____ Group ID: _____
Name of Subscriber: _____ DOB: _____
Secondary Ins: _____ Subscriber ID: _____ Group ID: _____
Name of Subscriber: _____ DOB: _____

Do you have a living will or POA? No□ Yes□
Is this visit accident related? Yes□ No□ If yes, accident details: _____

Assignment of Insurance Benefits and Authorization to Obtain or Release Patient Information

I hereby authorize the physician's office to release such information as may be necessary for claims to the insurance companies listed above. I also hereby authorize payment directly to the physician for any benefits otherwise payable directly to me, but not to exceed the regular charges for this period. I am financially responsible to the physicians for charges not covered by the assignment. Patients not covered by insurance are responsible at the time of service for charges incurred or arrangements for payment must be made with the business office. I authorize the physician's office to release or obtain such information as may be necessary to assist in my medical treatment, including available prescription history from external sources.

I understand concealment of insurance is considered fraud and will be grounds for instant dismissal from practice as well as possible criminal penalties. I agree to notify WTH-HC & WTMG immediately of any change in insurance status.

Patient Signature Print Name Date

Patient Portal

The Patient Portal is a convenient and secure way for patients to access their health records, pay bills, and ask questions. You may sign up for this service by providing us with your email address. If you opt in for this service, you will be sent an invitation and temporary password.

□**YES, I would like to participate in using the Patient Portal.**

Print Name: _____ DOB: _____

Email Address: _____ *(You may update your email at any time)*

Is the patient a minor child or adult for whom you are the legal guardian authorized to make healthcare decisions? Yes□ No□

Name of primary email account holder: _____
Relationship to Patient: _____

I understand that the patient's protected health information (PHI) is protected by federal and state law. To safeguard this information, I understand that all PHI transmitted from medical record to my patient portal complies with federal and state regulations for the secure transmission of PHI.

I further understand that the correct operation of a patient portal requires me to maintain a valid email address and to update that address with my provider as needed. Access to my secure portal is an optional service, and I or my provider may discontinue participation in this service at any time. Participation in the patient portal is NOT necessary to receive medical care from HCMC Physicians Clinics.

I agree that it is my responsibility to safeguard the login information for the email address that I have provided, and that other individuals who have access to this email address may be able to use it to access my patient portal.

□**NO, I would not like to participate in using the Patient Portal. I understand that I may change my mind at any time.**

If you need your provider to discuss treatment information with other providers, a current Release of Information Form is required.

I hereby authorize West Tennessee Healthcare Henry County or West Tennessee Medical Group practices to send electronic communications and health records to me and their authorized vendor (MyHealthRecord), electronically via a patient portal. I understand that communication about the patient portal will be sent to me at the email address that I provided above.

Patient Signature Print Name Date

West Tennessee Medical Group

Discrimination is Against the Law

Title VI of the Civil Rights Act of 1964 requires that federally assisted programs be free of discrimination. The Tennessee Department of Health also requires that its services be offered to all eligible persons. Jackson-Madison County General Hospital District ("the District") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)). The District does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The District:

- ✓ Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats).

- ✓ Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact Interpreter Services at (731)541-4676 or page them at (731)935-5690. They are available from 8:00 a.m. to 4:30 p.m., Monday – Friday. After hours and weekends, please call the operator at (731)541-5000.

If you believe that the District has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person or by mail, fax, or email with the Civil Rights Coordinator: Amy Garner, VP/Chief Compliance Officer

Jackson-Madison County General Hospital District

620 Skyline Drive, Jackson, TN 38301

Telephone: (731)541-2970 Fax: (731)541-9404 Email: Amy.Garner@WTH.org

If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services

200 Independence Ave., SW Room 509F, HHH Building Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

This notice is available at WTH's website: wth.org.

Patient/representative signature: _____

Date:_____

Consent for Treatment and Financial Responsibility

Patient Authorization for treatment and financial responsibility at a West Tennessee Medical Group ("WTMG") facility:

1. I consent to West Tennessee Healthcare ("WTHC"), West Tennessee Medical Group ("WTMG"), and WTHC and WTMG providers (collectively "Provider") to provide the treatment necessary for the care of @@PatientFullName@@.
2. I authorize the release of all medical records to the referring provider, my primary care provider, and my insurance company, if applicable.
3. I allow fax or another appropriate electronic method to transmit my medical records.
4. I understand that payment is due for charges at the time of service unless other definite financial arrangements have been made before treatment.
5. If the charges are not paid in full when due, I agree to be responsible for and to pay in addition to the charges for services and treatment received. If I fail to pay those charges, I agree that I am will also pay all costs associated with such collection activity, including, but not limited to, reasonable collection agency fees, attorneys fees, and court costs.
6. I consent to Provider or its agents communicating with me by phone or email. By giving this consent, I understand that Provider may call, text, or email me by any method for any account-related purpose and to request my participation in patient satisfaction surveys. I understand that standard text and data rates may apply to the calls or texts.
7. I have been made aware and understand the medical practices and offices may use an electronic prescription system that allows prescriptions and related information to be electronically sent between my providers and my pharmacy. Further, I have been informed and understand that my providers using the electronic prescribing system will see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.
8. I have been made aware of and understand that Provider may provide certain treatments via telehealth. I further understand and acknowledge that I may refuse telehealth services and instead request an in-person visit. I understand that if I refuse to participate in telehealth services, such refusal will not affect my right to future care or treatment. I acknowledge that if I participate in telehealth services I am consenting to the use of telehealth.
9. I further authorize and request that insurance payments be made directly to Provider.
10. I agree to take full financial responsibility for services rendered by Provider.
11. I have read and fully understand the above consent for treatment and financial responsibility, release of medical information, and insurance authorization.

_____ _____ _____ _____

Patient (or Guardian) Signature Date Witness Date

Acknowledgment of Receipt of Notice of Privacy Practices

By signing this document, I acknowledge that I have received a copy of The Clinic's Joint Notice of Privacy Practices.

_____ _____ _____

Name (Print) Signature (Relation, if other than patient) Date

☐ Patient unable to sign/ No family available
☐ Patient refused to sign
☐ Other:

☐ Employee
Signature:_____
The Clinic's Use Only (Do not write below this line)

Date acknowledgment mailed: _____
Date acknowledgment received: _____

Advanced Directives:

Do you have a living will or durable power of attorney? ☐ No ☐ Yes

If you do have a durable power of attorney, please identify:

_____

Would you like us to give you a packet of information regarding advance directives:
☐ No ☐ Yes (Packet distributed)

_____ _____ _____ _____

Patient Signature Date Witness Date

West Tennessee Medical Group

Clinical Intake Form

Patient Name: _____ DOB: _____

Chief Complaint: _____ **Date Onset:** _____

Have you ever been treated for this condition in the past? Yes ☐ No ☐ If yes, please explain _____

_____

Other Concerns: _____

Sexual Orientation: *Straight or heterosexual ☐ Lesbian or gay ☐ Bisexual ☐ Pansexual and/or questioning ☐ Something else; please specify:* _____ *Unsure ☐ Decline to answer ☐*

Gender Identity: *Male ☐ Female ☐ Transgender (man/transman/female to male) ☐ Transgender (woman/transwoman/ male to female) ☐ Gender nonconforming (neither exclusively male nor female) ☐ Additional gender category (or other) please specify:* _____ *Decline to answer ☐*

What sex was originally listed on your birth certificate? *Male ☐ Female ☐ Decline to answer ☐*

Tobacco Use: Yes ☐ No ☐ Former smoker ☐ If yes, how many years? _____ How much? _____
Age Start: _____ Age Stop: _____ Cigs ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew ☐

Alcohol Use: Yes ☐ No ☐ Former alcoholic ☐ Number of drinks per week: _____ Age start: ____ Age Stop: ____
Beer ☐ Wine ☐ Liquor ☐

Recreational Drugs: Yes ☐ No ☐ Have you ever used needles to inject drugs? Yes ☐ No ☐ Age Start: _____
Age Stop: _____ Marijuana ☐ Barbiturates ☐ Amphetamines ☐ Methamphetamine ☐ Opiates ☐ Cocaine ☐

Sexually Active? Yes ☐ No ☐ If yes, what contraceptive (condoms, pill, diaphragm, etc)? _____

Exercise Regularly? Yes ☐ No ☐ How often? _____ How would you rate your diet? Good ☐ Fair ☐ Poor ☐
Uses Seatbelt Regularly? Yes ☐ No ☐ **Hand Dominance?** Right ☐ Left ☐

Current Medications (please list ALL medications including over the counter, inhalers, eye drops, herbs)

Medications	Dosage

Allergies **No Known Drug Allergies** ☐

Medications	*Reaction*	**Food**	*Reaction*	**Environmental**	*Reaction*

Surgical History **No Surgical History** ☐

Surgical Procedure	**Yes**	**Surgical Procedure**	**Yes**
Abdominal Surgery		Hip (Left) (Right) (Total)	
Amputation: _____		Hysterectomy (total, including ovaries)	
Aneurysm (AAA)		Hysterectomy (partial, ovaries left)	
Appendectomy		Kidney	
Biopsy (location) _____		Knee Scope (Left) (Right)	
Carpal Tunnel Release (Left) (Right)		Knee Total (Left) (Right)	
Cataract		Mastectomy (Left) (Right) (Total)	
Colonoscopy		Neck	
Coronary Bypass		Ovary Ligation (Tubal)	
Coronary Stent		Ovary Removal	
EGD (Stomach Endoscopy)		Sinus	
Foot (Left) (Right)		Shoulder Scope (Left) (Right)	
Gallbladder		Shoulder Total (Left) (Right)	
Heart Cath		Spine	
Heart Bypass		Tonsils/Adenoids	
Heart Surgery (other than coronary bypass)		Vasectomy	

Other surgeries not listed: _____

_____

Personal Medical History (Currently have or have had in the past) **No Medical History to Report** ☐

Condition	Yes	Comments	Conditions	Yes	Comments
Adrenal gland disease			High Cholesterol		
Alcohol Abuse			HIV/AIDS		
Allergy			Hyperthyroidism		
Anemia			Hypothyroidism		
Arthritis			Irritable Bowel Syndrome		
Asthma			Kidney Disease/Failure		
Back or neck problems			Kidney Stones		
Bladder/Kidney problems			Liver Disease		
Bleeding Tendency			Lupus		
Blood Clot/DVT (Leg) (Lung)			Migraine Headaches		
Blood Transfusion			Mitral Valve Prolapse		
Cancer			MRSA		
Cataracts			Multiple Sclerosis		
Colon Polyps			Myasthenia Gravis		
Congestive Heart Failure (CHF)			Osteoporosis		
(Cont.) Condition	**Yes**	**Comments**	**Conditions**	**Yes**	**Comments**
Coronary Heart Disease			Paralysis		
Depression/Anxiety			Pneumonia		
Diabetes (adult onset) (childhood onset)			Poor Circulation		
Dialysis			Prostate Nodules		
Diverticulosis			Psoriasis		
Eczema			Rash of Skin		
Emphysema/COPD			Reflux/GERD		
Enlarged Prostate			Rhythm Disturbance/AFIB		
Epilepsy/Seizures			Sickle Cell		
Fibromyalgia			Sleep Apnea		
Gallbladder Disease			Stomach Ulcer		
Glaucoma			Thyroid Nodules		
Gout			Tuberculosis		
Heart Attack			Ulcer-Gastric		
Heart Disease			Valve Disease		
Hepatitis (Type A) (Type B) (Type C)			VRE		
Hernia			Wound Infection		
High Blood Pressure					

Other medical issues not listed: _____

_____

_____

West Tennessee Medical Group

Family Medical History **Unknown ☐** **Adopted ☐**

Condition	Yes	Family Members/Comments
Alcoholism		
Alzheimer's		
Asthma or Lung Disease		
Autoimmune Disease		
Cancer		
Coronary Artery Disease (Heart Attack, Angina)		
Diabetes		
Emphysema (COPD)		
Genetic Disorder (Explain)		
Heart Disease/Heart Problems		
High Blood pressure		
Kidney Disease		
Liver Disease		
Tuberculosis		
Cancer of:_____		

Significant medical history not listed: _____

_____

_____

Is there anything else you would like us to know? _____

_____

_____

_____

_____

IMMUNIZATIONS

Check the box if you don't know the information ☐

Check off any vaccinations you have had (add year, if known).

Tetanus (Td):	With Pertussis (Tdap):	
Varicella (chicken pox) shot or illness:	Pneumovax (pneumonia):	
Influenza (flu shot):	MMR:	
Hepatitis A:	Meningitis:	
Zostavax (Shingles):	HPV:	
Covid #1:	Covid #2:	Covid Booster:

HEALTH MAINTENANCE SCREENING TESTS:

Date of last Colonoscopy or Sigmoidoscopy? _____Polyp? ☐ No ☐ Yes

Date of last Lipid? _____ Abnormal? ☐ No ☐ Yes

WOMEN ONLY:

Date of last Mammo: _____Abnormal? ☐ No ☐ Yes

Date of last Pap Smear:_____Abnormal? ☐ No ☐ Yes

Total number of pregnancies: _____Abnormal? ☐ No ☐ Yes

Date (month/day if known) of last menstrual period if you are still menstruating: _____

Age at beginning of period (menstruation): _____

Age at end of periods (menopause): _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance and any collection fees or court costs incurred as a result of my failure to make satisfactory payments. I also authorize West Tennessee Healthcare, West Tennessee Medical Group, or my insurance company to release any information required to process my claims.

_____ _____

Patient Signature Date

Authorization to Treat Minor in Absence of Parent/Guardian

Under most circumstances, a parent or legal guardian should make every effort to be present for any of a minor's medical visits. However, we understand that there are occasions where a parent or legal guardian is unavailable to be physically present for a medical visit. This form allows a parent/guardian to specify how such visits will be handled.

Minor Patient Name: _____

Consent

I, the parent/guardian for this minor child, request and authorize West Tennessee Medical Group and its staff ("WTMG") to deliver routine medical care to this child as may be deemed necessary or advisable in his or her diagnosis or treatment even when I am not present. Routine medical care may include, but is not limited to: medical evaluation, physical exam, routine immunizations, injections, x-rays, lab work (e.g., throat or nasal swabs, blood draws, wart treatment with liquid nitrogen, minor burns, minor suturing).

If non-routine medical care is deemed necessary or advisable when I am not present, WTMG may communicate with me by home phone, cell phone, or email. If WTMG cannot communicate with me for timely decision-making, I authorize the following individuals to serve as surrogate decision-makers and authorize any of them to make decisions and consent to any medical treatment which the provider deems in the best interest of the health and welfare of my child:

_____ _____

Name Relationship to Patient

_____ _____

Name Relationship to Patient

_____ _____

Name Relationship to Patient

HIPAA Release

I authorize WTMG to discuss my child's medical care with any of the above-named individuals who accompany him/her to a medical visit. I understand that I may revoke this release in writing at any time, but if I do so, it will not have any effect on any actions taken by WTMG releasing the information prior to WTMG receiving my written revocation.

Financial Responsibility

I understand that I remain financially responsible for the cost of the minor child's treatment even if I am not present for the visit. To the extent any amount or co-pay is due on the day of treatment and I am not present, the adult accompanying the minor child will be required to make the payment on my behalf.

I release and indemnify WTMG from any claims or liability for complying with this Authorization to Treat and HIPAA Release.

I have read, understand, and give my consent as stipulated above. My signature means that I have read this form and/or have had it read to me and explained in the language that I can understand.

Parent or Guardian Name (please print) : _____

Signature: _____ **Date:** _____

This authorization will remain in effect until revoked or changed by a parent or legal guardian or until _____/_____/_____(leave blank if you would like this authorization to remain in effect indefinitely).

Consent to Contact

We will need to contact you from time to time about your care at West Tennessee Healthcare Henry County or West Tennessee Medical Group practices. To do so in the most effective manner, we ask that you provide us with your preferred phone number, workplace phone number, emergency contact and a number where they can be reached in case the need arises. We would also like you to include your email and preferred method of contact. Please help us update our records by providing the information below. Thank you.

Primary Phone Number: _____ Home □ Cell □
Secondary Phone Number: _____ Home □ Cell □
Work Phone Number: _____
Emergency Contact Name & Phone Number: _____
How is this person related to you? _____
Emergency Contact Name & Phone Number: _____
How is this person related to you? _____

I give permission to WTMG practices to disclose my Protected Health Information to the person I have listed above as my emergency contact. I understand that I may revoke or change this authorization at any time by filling out another "Consent to Contact" form.

***No*□ *Yes*□

Preferred Communications: Email □ Telephone □ Text □
Email: _____

I, _____, acknowledge and agree that West Tennessee Healthcare Henry County or West Tennessee Medical Group practices may contact me or my guardian via text (SMS) or voice communications at the telephone number(s) I have listed as my primary and secondary phone numbers for purposes of confirming or rescheduling appointments, for reporting the results of laboratory or diagnostic results, or for responding to or initiating communications related to my health care. I understand that messages may be left on an answering service or sent via email or SMS to a number or address I have provided in regards to my recent or upcoming visit(s), and automated messages communicating normal laboratory results may be delivered to any party answering the number(s) I have provided. I understand I have the right to request to opt-out of automated calls at any time.

I further acknowledge and agree that West Tennessee Healthcare Henry County or West Tennessee Medical Group practices or vendor thereof, including collection or billing companies, may contact me or my guardian by telephone or text message to any telephone number I have provided to you, and any other telephone number associated with my account, including wireless or mobile telephone numbers. I further agree that you may use any method of contact to these numbers I have provided, such as an Automated Telephone Dialing System (ATDS) or prerecorded message. I also agree that I will notify West Tennessee Healthcare Henry County or West Tennessee Medical Group practices if I have given up ownership or control of any such phone number that I have listed above.

Patient Signature Print Name Date