Today's Date ____/____/____

# PATIENT REGISTRATION FORM

## PATIENT INFORMATION

| Patient Name Last | First | Middle | ☐ Mr ☐ Mrs ☐ Miss ☐ Ms | Marital Status (circle) Single/ Married / Divorced /Sep/ Widow |
|---|---|---|---|---|
| Is this your legal name? ☐ YES ☐ NO | If not, what is your legal name? | | Birthdate / / | Age Sex ☐ M ☐ F ☐ T |
| Street or Mailing Address (circle one) | City | State | Zip Code | Home Phone Number ( ) |
| Cell Phone Number ( ) | E-Mail Address (To be used for appointment reminders) | | | Social Security - - |
| Occupation | Employer | | Employer Phone Number | |

**Employment Status:** ☐1 – Full-Time ☐2 – Part-Time ☐3 – Not Employed ☐4 – Self-Employed ☐5 – Retired ☐6 – Active Military
**Student Status:** ☐F – Full-Time Student ☐P – Part-Time Student ☐N – Not a Student

**Race:** ☐American Indian/Alaska Native ☐Asian ☐Native Hawaiian/Pacific Islander ☐Black/African American ☐White ☐Hispanic ☐Other ☐Declined

**Ethnicity:** ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Declined

**Language:** ☐English ☐Spanish ☐Indian ☐Japanese ☐Chinese ☐Korean ☐French ☐German ☐Russian ☐Other _____

**Pharmacy:** Do you have a living will? ☐ YES ☐ NO

Referred By ( Please check one box)
☐ Dr. _____ ☐ Insurance ☐ Hospital ☐ Family ☐ Friend ☐Yellow Pages ☐ Other _____

Other Family Members Seen Here

PCP Name Phone #

## RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Responsible Party: ☐Another Patient ☐Guarantor ☐Self ☐Check here if information is same as patient

| Name | Address | Home Phone Number |
|---|---|---|
| Birth Date / / | E-Mail Address | ( ) |
| Occupation | Employer | Employer Address | Employer Phone Number ( ) |

## INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Is this visit for one of the following? ☐ WORKERS COMPENSATION (WC)
☐ OCCUPATIONAL MEDICINE (OM) ☐ MOTOR VEHICLE ACCIDENT (MVA) ☐ ACCIDENT DATE _____

| Does the patient have healthcare coverage? ☐ YES ☐ NO | Insurance Name | | | | |
|---|---|---|---|---|---|
| Name of Insured | Social Security Number - - | Birth Date / / | Effective Date / / | Group ID | Subscriber ID (Policy Number) |

Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other _____

| Name of Secondary Insurance | Name of Insured | Date of Birth / / | Group ID | Subscriber ID (Policy Number) |
|---|---|---|---|---|

Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other _____

## EMERGENCY CONTACT

| Name (Last, First) | Relationship to Patient | Home Phone Number ( ) | Other Phone Number ( ) |
|---|---|---|---|

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge. I consent to receive text messages and/or email messages from the practice to any cell number and/or email provided which may include appointment reminders, bills, payment receipts, or marketing materials. I understand that a patient's care is directed by his/her physician(s) and I consent to any services that are appropriate for my care and as ordered by my physician(s).

_____ _____

Patient/ Guardian Signature Date

# HIGHPOINT SURGICAL ASSOCIATES

HIGHPOINT HEALTH PARTNERS

Patient's Name: _____

Address: _____

City, State. Zip: _____

Date of Birth: _____ Telephone No. : (_____)_____

SS # _____

## Release of Information to Highpoint Surgical

☐ I authorize the release of information from:

_____

Name of Physician, Institution, Etc.

_____

Address

_____

City, State, Zip

**Please Send information requested below to:**

**Dr.Brain Reed M.D.**

**Highpoint Surgical Associates**

**P (615)-328-3730 F (615)-328-3731**

## Release Of Information From Highpoint Surgical

☐ I authorize Highpoint Surgical Associates to release copies my medical records as listed below. The information should be sent to:

_____

Name pf Physician, Institution, Etc.

_____

Address

_____

City, State, Zip

(___)_____ (_____)_____

Telephone Number Fax Number

**DATE(S) OF TREATMENT:** _____

The information that is to be released should be detailed to specific dates of service, treatment, etc. A meaningful description of the information to be disclosed should be provided.

***Please note that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Highpoint Surgical Associates*.**

**Information to be Released:**

| | |
|---|---|
| ☐ Discharge Summary | ☐ EKG |
| ☐ History & Physical | ☐ EGD |
| ☐ Clinic Visits | ☐ Colonoscopy |
| ☐ ER Records | ☐ Operative Report: _____ |
| ☐ Physician Orders | ☐ Radiology Imaging:_____ |
| ☐ Complete Medical Records | ☐ Other: _____ |

I have read, or have had to me, the above statements, and understand them as they apply to me. I further understand that I may revoke this authorization at any time except to the extent that action has already been taken in accord with this authorization. Revocation by the patient or legal representative is allowed only in the event that release of information has not already occurred.

Specific exceptions to revoke an authorization exists, as detailed by federal law, such as:

- Highpoint Surgical Associates has taken action in reliance thereon
- The authorization was obtained as a condition of obtaining insurance coverage, whereby another law providers the insurer with the right to contact a claim under the policy.

In order to revoke an authorization, a written document stating the intent of the patient to revoke such authorization must be either presented in person to or delivered by certified mail to the privacy officer or Highpoint Surgical Associates. This revocation document must contain signature of the patient or patient's legal representative. I understand that treatment, payment, enrollment, or eligibility for benefits may be conditioned on obtaining this authorization.

X_____ X_____

Signature of Patient or Appropriate Legal Representative Date

_____If applicable, relationship to patient photo ID was Provided YES or NO if no, the form of patient identification must be so stated and a copy provided with authorization. In order to be valid, the signature on the authorization must be after the date of service that is being requested for release.

_____ _____

Witness Date

HIGHPOINT
SURGICAL ASSOCIATES
HIGHPOINT HEALTH PARTNERS

## CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than **24 hours notice.** This will enable another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24 hours notice, we are unable to offer that slot to other people. **Procedure cancellations require 48 hours advance notice, without notification they may be subject to a $100.00 cancellation fee.** Patients who do not show up for their appointment without a call to cancel an office appointment or procedure appointment will be considered as NO SHOW. Patients who No-Show two (2) or more times in a 12 month period, will be required to obtain a new referral from their Primary Care Physician. **Patients may also be subject to a $25.00 fee for office appointment No Shows. The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.** We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval. Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. **Please note that it is the patients responsibility to call and reschedule a follow-up appointment in the event of a No Show or Cancellation to insure that you are able to obtain proper care for your illness.** Questions about cancellation and no show fees should be directed to the Billing Department (615-328-5253). Please sign that you have read, understand and agree to this Cancellation and No show Policy.

Patient Name (Please Print) _____

Signature of Patient or Patient Representative _____

Date of birth _____

HIGHPOINT
SURGICAL ASSOCIATES
HIGHPOINT HEALTH PARTNERS

## HIPAA ACKNOWLEDGEMENT, PATIENT CONSENT AND FINANCIAL POLICY

I. **CONSENT FOR TREATMENT:** I hereby consent to the performance of such diagnostic procedures and/or medical treatment as deemed necessary or advisable by my physician(s). I hereby consent to the performance of all nursing and technical procedures and tests as directed by my physician(s). I understand that my medical care may require the collection of samples, including fluids or tissues, from my body. This may include having blood drawn or tissues removed during tests, treatment, or surgery. Further, I understand that should any medical personnel or other person(s) be exposed or report an exposure to my blood or body fluids, my blood will be tested for blood borne infections including Hepatitis Band C as well as HIV/AIDS. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examination. I have the right to refuse tests or treatment (as far as the law allows) and to be told what might happen if I do. I have the right not to have any photos or videos taken of me unless I agree to this, except as needed to treat me. I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force until revoked in writing.

II. **NOTICE OF PRIVACY PRACTICES:** Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Acknowledgement. The terms of our Notice may change; if we change our notice, you may request a revised copy by contacting our office or you will receive a new notice the next time you are treated at our office. The Clinic provides this form to comply with the Health Information Portability and Accountability Act of 1996 (HIPAA).

_____
Patient Initials

The patient understands that:

- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice reserves the right to change the notice of privacy practices.

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings, and care decisions to the individuals listed below. Please note that this does not allow these individuals to obtain copies of my medical records without a complete and valid authorization from me.

| NAME | RELATIONSHIP | CONTACT NUMBER |
|---|---|---|
| | | |
| | | |
| | | |

III. **ELECTION TO ELECTRONICALLY TRANSMIT MEDICAL INFORMATION:** I authorize Clinic to provide a copy of the medical record of my treatment, and a summary of care record to my primary care physician(s), specialty care physician(s), and/or any health care provider(s) or facility(ies) to facilitate my treatment and continuity of care. I understand that information

disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence,, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. The summary of care record consists of information from my medical record, including among other things, information concerning procedures and lab tests performed during this episode of care, my care plan, a list of my current and historical problems, and my current medication list. I understand that I may, by placing my request in writing to the Clinic, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire automatically one year after the date on which my current treatment episode comes to an end.

IV. **PARTICIPATION IN HEALTH INFORMATION EXCHANGE(S):** Federal and state laws may permit this Clinic to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I hereby authorize Clinic to provide a copy of my medical record or portions thereof to any health information exchange or network with which Clinic participates and to any other participant in such health information exchange or network for purposes of treatment, payment, health care operations, and the purposes discussed above, and in accordance with the terms of the participation agreement for that health information exchange or network. A full list of health information exchanges and/or networks with which Clinic participates may be found in the Notice of Privacy Practices, which is available on the Clinic website, and this list may be updated from time to time if and when Clinic participates with new health information exchanges or networks. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. I understand that I may, by placing my request in writing to the Privacy Officer, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire upon revocation.

V. **EMAIL AND TEXT COMMUNICATIONS:** If at any time I provide an email or text address at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify the Clinic to the contrary in writing. In this section, calls and text messages include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer-assisted technology, or by electronic mail, text messaging, or by any other form of electronic communication from Clinic, its affiliates, contractors, servicers, Clinical providers, attorneys, or agents, including collection agencies. Practice may contact me via email and/or text messaging to remind me of an appointment, to obtain feedback on my experience with the Practice's healthcare team, and to provide general health reminders/information.

VI. **FINANCIAL POLICY:** The undersigned, in consideration of the services to be rendered to the patient, is obligated to pay the medical practice in accordance with its regular rates and terms, and if the account is referred to an attorney or agency for collections, to pay reasonable

attorney's fees and collection expenses. The undersigned hereby assigns to the medical practice all insurance benefits for services provided.

- The Clinic will file your insurance as a courtesy to you; however, you are responsible for the entire bill. **All co-payments, unmet deductibles, and other patient-responsible services must be paid at the time of the visit.** If your insurance carrier applies the billed charges to your deductible, denies the services, or considers the services non-covered, you are responsible for payment of the service. **If you do not have insurance, payment in full will be expected at the time of the visit.**

- In the event your insurance company does not pay the claim within a reasonable amount of time (45-60 days), then you may become responsible for the bill. If payment is not received within a reasonable amount of time from the guarantor, or if we receive returned mail as undeliverable, we will place your account with an outside collection agency.

- If your insurance plan requires a referral or prior authorization, you must present this along with your insurance ID at each visit. If you do not have the referral when you arrive for your appointment, payment for the visit becomes your responsibility.

- Returned checks will be subject to a returned check fee. A fee may be charged for missed appointments.

**VII. PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUESTS:** If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate State agency for payment of a Medicaid claim. I certify the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I request that payment of assignment benefits be made on my behalf.

I acknowledge receipt of the HIPAA Acknowledgement and Consent Form. I further acknowledge that I have been given the opportunity to ask questions.

_____ _____

Printed Name of Patient or Representative Signature of Patient or Representative

_____

Date

Relationship to Patient (if other than patient) _____

**CLINIC STAFF USE ONLY**

☐ Check if patient refused to take a copy of the Notice of Privacy Practices

State reason for refusal, if known:

_____ _____

Witness (Staff) Signature Witness (Staff) Printed Name

_____

Date

HIGHPOINT
SURGICAL ASSOCIATES
HIGHPOINT HEALTH PARTNERS

Date: _____

Name: _____ D.O.B._____

Reason for Appointment: _____

Primary Care Doctor: _____ Office Number: _____

Visit Type: (Please Circle One) New Patient Hospital Follow-up Established (Follow-Up Care)

**Medical History**: (Please Circle All That Applies)

Heart Disease Heart Attack Heart Problems Stroke High Blood Pressure High Cholesterol

Diabetes Asthma COPD Seizures Liver Disease Hepatitis C Hepatitis B Acid Reflex

Back Pain Thyroid Problems Liver Disease Fibromyalgia Migraines Anxiety Depression Kidney Disease

Cancer (List Type):_____Other Medical History: _____

**Surgical History:** (If Applicable, Please list along with year)

**Has patient ever had any problems with anesthesia from previous surgeries?** Yes or No If 'Yes' Please list: _____

| Name of Surgery/Procedure | Date |
|---|---|
| | |
| | |
| | |
| | |

**Hospitalizations: Has patient been hospitalized in the last 90days**? Yes or No If 'yes' please

Date: _____ Name of Hospital: _____

**Allergies**: (Please Circle If Applicable)

No Known Allergies Sulfa Penicillin Cholesterol Medications (statins) Codeine Latex

Other Allergies: _____

**Social History:** (Please Circle, If Applicable)

| Social History | Currently Use | | Type/Amount/Frequency | If stopped, When? (Year) |
|---|---|---|---|---|
| Tobacco Use? | Yes | No | | |
| Alcohol Use? | Yes | No | | |
| Recreational Drugs? | Yes | No | | |

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HIGHPOINT HEALTH PARTNERS

**Family History:** (Please check all that apply)

| Problem | Mother | Father | Grandparents (Mat. Or Pat.) | Bro/Sister |
|---|---|---|---|---|
| Hypertension | | | | |
| Heart Disease | | | | |
| Abnormal Cholesterol | | | | |
| Diabetes | | | | |
| Colon Cancer | | | | |
| Liver Disease | | | | |
| Cancer (List Type) | | | | |
| Thyroid Problem | | | | |

Patient's Mother: Living or Deceased

Patient's Father: Living or Deceased

## Current Medications:

| Medication Name | Strength | Frequency (How often taken) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Blood Thinners:** Is the patient on any blood thinner medication (Plavix, Xarelto, Warfarin, Etc.) Yes or No If 'Yes' please list below.

**Medication:** _____ **Prescribing Physician:** _____

_____ _____

Signature Date

HIGHPOINT
SURGICAL ASSOCIATES
HIGHPOINT HEALTH PARTNERS

Date: _____

Patient Name: _____ DOB: _____

**General**
Weight Change O Yes O No
*Circle: Gain or loss*
Fatigue O Yes O No
Fever O Yes O No
Night Sweats O Yes O No

**Ophthalmologic**
Dry eye O Yes O No
Pain O Yes O No

**ENT**
Hoarseness O Yes O No
Mouth Sores O Yes O No
Sinus Problems O Yes O No
Sore Throat O Yes O No
Swollen Glands O Yes O No

**Endocrine**
Cold Intolerance O Yes O No
Heart Intolerance O Yes O No

**Respiratory**
Cough O Yes O No
Hemoptysis O Yes O No
Shortness of breath O Yes O No
Wheezing O Yes O No

**Breast (female)**
Breast Lump O Yes O No
Breast Pain O Yes O No
Nipple Discharge O Yes O No

**Gastrointestinal**
Nausea O Yes O No
Vomiting O Yes O No
Abdominal Pain O Yes O No
Change in bowl habits O Yes O No
Hemorrhoids O Yes O No

**Cardiovascular**
Chest Pain O Yes O No
Irregular Heartbeat O Yes O No
Swelling of Extremities O Yes O No
Poor Circulation O Yes O No
Previous Heart Attack O Yes O No

**Hematology**
Blood Clotting Problems O Yes O No
Prolonged Bleeding O Yes O No
Anemia O Yes O No

**Genitourinary**
Blood in Urine O Yes O No
Painful Urination O Yes O No

**Musculoskeletal**
Back Pain O Yes O No
Muscle aches O Yes O No
Arthritis O Yes O No

**Neurologic**
Gait Abnormality O Yes O No
Tingling/Numbness O Yes O No

**Skin**
Itching O Yes O No
Rash O Yes O No
Skin Lesion(s) O Yes O No

**Psychiatric**
Anxiety O Yes O No
Depressed Mood O Yes O No
Substance Abuse O Yes O No