Speight Family Medical, LLC

PATIENT INFORMATION

Please complete all blanks

PATIENT

NAME: LAST	FIRST	M.I.	AGE	BIRTHDATE	SS#
ADDRESS			CITY		STATE / ZIP
HOME PHONE			CELL PHONE		EMAIL

PREFERRED METHOD OF CONTACT ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ By Mail

SEX: ☐ F ☐ M ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Partnered for ____ years

RACE: ☐ Declined ☐ Caucasian ☐ African American ☐ Asian ☐ Alaskan Native ☐ Pacific Islander ☐ Asian ☐ Other

ETHNICITY: ☐ Declined ☐ Hispanic ☐ Non-Hispanic

EMPLOYER (SCHOOL NAME IF MINOR)	CITY	OCCUPATION/GRADE

Spouse/Parent OR Legal Guardian Name (if Minor):			RELATIONSHIP
ADDRESS	CITY/STATE	ZIP	WORK PHONE #( )
SS#	BIRTHDATE	CELL PHONE #( )	HOME PHONE #( )
REFERRED BY	EMERGENCY CONTACT		

As responsible party are you currently a patient in our office: ☐ Yes ☐ No

INSURANCE POLICYHOLDER

Name:		Relationship to Patient:	
Mailing Address:	City:	State:	Zip:
SS#:	Birthdate:	DL # or State ID #:	
Employer:		Work Phone: ( )	
Employer Address:	City:	State:	Zip:

PRIMARY INSURANCE INFORMATION

Insurance Company:	Member ID #:	Effective Date:	
Insurance Company Address:	City:	State:	Zip:
Policyholder Name:	Relationship to Patient:	Birthdate:	
Policyholder Social Security #:	Policyholder Employer:		
Policyholder Home Ph: ( )	Cell Ph: ( )	Work Ph: ( )	

SECONDARY INSURANCE INFORMATION (IF APPLICABLE)

Insurance Company:	Member ID #:	Effective Date:	
Insurance Company Address:	City:	State:	Zip:
Policyholder Name:	Relationship to Patient:	Birthdate:	
Policyholder Social Security #:	Policyholder Employer:		
Policyholder Home Ph: ( )	Cell Ph: ( )	Work Ph: ( )	

Patient Medical History   Patient Name: ______________________________   DOB: ____________

ALLERGIES: Please list any known allergy to medications, foods or medical products like latex, betadine, tape...
CHECK HERE IF NONE ☐

_______________________ _______________________ _______________________

_______________________ _______________________ _______________________

Please list **ALL** medications you are currently taking:
CHECK HERE IF NONE ☐

Name of Medication	Strength/mg	How often do you take it?

Pharmacy Information:

Pharmacy Name: ______________________________________ City__________________

Phone (_____) ______________________

Personal Medical History: Please check illness or conditions the patient has or has had in the past

	Allergies		GI Problems/Reflux/Ulcer/ IBS		Herpes
	Migraines		Anemia		AIDS/HIV
	Vision Problems (Glaucoma)		Liver Problems		Hepatitis B
	Hearing Problems		Gallbladder Problems/Stones		Hepatitis C
	Congenital Anomalies		Bladder Leakage		Cancers: Please List All
	Overweight/Obesity		Endometriosis		
	Thyroid Disease		Ovarian Cysts		
	Breast Disease/FCD/Breast Biopsy		Polycystic Ovarian Syndrome		
	Asthma		Kidney Problems/Stones		Please list any other conditions:
	COPD		Recurrent Bladder Infections		
	High Blood Pressure		Diabetes Type I (need insulin)		
	High Cholesterol		Diabetes Type II		
	Stroke		Lupus		
	Heart Attack		Arthritis		Blood Transfusion (Dates):
	Previous blood clot (DVT or PE)		Rheumatoid Arthritis		
	Clotting Disorder		Fibromyalgia		Immunizations Date
	Heart Murmur/ Abnormal Rhythm		Osteopenia/Osteoporosis		Influenza
	Atrial Fibrillation		Gout		Pneumonia
	CHF		Seizures/Epilepsy		Tetanus
	Depression/Anxiety		ADD/ADHD		Shingles
	Tuberculosis		Anaphylactic Reaction		HPV (Gardasil)

List all operations and the correlating dates:
CHECK HERE IF NONE ☐

____
____
____
____

Please list any other Physicians seen in last 12 months:
CHECK HERE IF NONE ☐

____
____
____
____

Have you had any of the following? If yes, please provide the correlating dates:

Dexa (Bone Scan) YES / NO When? ___________ Mammography YES / NO When? ___________

Colonoscopy YES / NO When? ___________ Stress Test YES / NO When? ___________

Do you have any metal in your body? If yes, please explain ___________

Date of last eye exam: ___________ Where? ___________ Do you wear glasses/contacts? YES / NO

Following Questions for Women Only

Menstrual History: Age period started:_____ Age period stopped:_____ Hysterectomy: YES / NO Age:_____

Date of last pap smear: ___________ Where? ___________ History of abnormal pap smears? ___________

Are you currently on birth control pills? YES / NO Do you currently have an IUD? YES / NO

Following Questions for Men Only

Genito-urinary Problems: Prostate Problems? YES / NO Sexual Difficulties? YES / NO Impotence? YES / NO

Any other? If yes, please explain?___________

Family History Please check if members of your family have a history with any of the following:

	Mother	Father	Brother	Sister	Mom's Mother	Mom's Father	Dad's Mother	Dad's Father	Other Family Aunt, Uncle, etc.
Heart Disease/Attack									
High Blood Pressure									
Kidney Disease									
Diabetes									
Stroke									
Cancer___________									
Cancer___________									
Other___________									

Social History

Smoking: Currently smoke? YES / NO Packs per day: ___________ Total years smoking: ___________

Stopped smoking? YES / NO Date stopped: ___________ Total years smoking: ___________

Never smoked? ☐ If you are a minor do your parents smoke in the house? YES / NO

Alcohol consumption per week: ☐ Non Drinker ☐ Social Drinker ☐ Current Alcoholic ☐ Past Alcoholism

Beer: ________ Wine: ________ Hard Liquor: ________

Have you ever used recreational drugs? ☐Yes ☐No **What Type?**___________**When?**___________

Is there a history of mental illness? ☐ Yes ☐No

If yes, please explain: ___________

Advance Directive: Which of the following does the patient have? **Please select one**:

☐None ☐ Living Will ☐Power of Attorney ☐DNR ☐Organ Donation ☐Other

Speight Family Medical, LLC Office Policies

Please read the following information regarding the guidelines for our practice. Please keep in mind that some of the policies are dictated by your insurance company. If you have any questions regarding this information, please ask our office staff. If you understand this information, please sign below and return this form to out receptionist.

1. You as the patient are responsible for verifying whether we are "in-network" according to your insurance company. Please be sure to bring your Insurance card and a ***valid*** photo I.D. to ***every*** visit to prevent any delay of your appointment.
2. We are happy to refer you to a sub-specialist when your provider determines that it is clinically necessary. You are responsible for verifying that the sub-specialist to which you are referred is considered "in-network" by your insurance carrier. Your referral should be obtained prior to your visit to the sub-specialist.
3. You are responsible for knowing which hospital your insurance carrier allows us to utilize for your procedures, tests, and admissions.
4. Please allow us one week to contact you regarding lab/test results.
5. If you have questions for the nurse or provider, we will return your call as soon as possible, giving priority to emergencies and scheduled patients in the office. At the time of your call, please let us know if you will be unavailable at a certain time & what telephone # is best.
6. School/work excuses are written ***only*** for the day you are seen in our office and for any additional days that is suggested by the provider. We are unable to write excuses for illnesses not evaluated by our office.
7. We ask that you arrive fifteen minutes prior to your appointment time in order to complete and/or review required paperwork. You will be asked to update your information on a yearly basis.
8. In order for our providers to see our patients in a timely manner, you may be asked to reschedule your appointment if you arrive 15 minutes late.
9. We ask all patients that do not have insurance coverage to pay the $100 office visit before services are rendered and any charges incurred during your appointment will be paid, in full, on the date of service before leaving.
10. It is the policy of this office that the adult presenting the child for treatment is responsible for payment of the patient portion at the time of services (e.g., deductibles, copayments, and non-covered services. **I understand a parent/legal guardian must accompany the child to every appointment.**
11. Speight Family Medical, LLC does not do long term pain management and we will refer the patients that require long term pain management out to a pain clinic.
12. Speight Family Medical, LLC will not call in prescriptions after hours, on weekends or on holidays. It is the patient's responsibility to manage their prescriptions and allow 24 business hours for refill requests before running out. **(INITIAL)**________
13. Speight Family Medical, LLC will not refill pain medications that has been lost, stolen or run out early due to use other than prescribed. It is the patient's responsibility to keep up with their medications. We check on our patient's drug history on the state's control substance website regularly and abuse of prescriptions can result is dismissal from our practice. **(INITIAL)**________
14. Speight Family Medical, LLC reserves the right to randomly drug test patients at the cost of the patient, if insurance denies payment. Our goal is to uphold correct use of prescriptions prescribed. **(INITIAL)**________
15. **I fully understand that no services including medication refills, appointments, referrals or other will be rendered until all balances are paid in full. Speight Family Medical, LLC will not make payment arrangements. If you are a guarantor for a minor patient please know that balances pertaining to you and all family members must be paid in full at all times to receive further service as described above – no exceptions. (INITIAL)** ______

Your Insurance Company and Our Office:

What you need to know about getting your Healthcare services covered

Many of the services provided in this office are covered by your insurance company. We gladly file claims for you as a courtesy, so that you do not have the additional worry and effort of dealing wit this during a time of illness.

Unfortunately, not all services are covered by every insurance company. In cases where the services have not been covered, you will personally responsible for the balance. Before we bill you, we will make sure that all of the information sent to your insurance company is accurate, and clearly describes the services you received.

Your Financial Responsibility:

We will file your insurance claim, but you are ultimately responsible for paying the services received in this office. Please remember that insurance companies do not pay for all medical services, even many that are especially helpful to the patient.

When a service is not covered by your insurance policy, you will be responsible for paying the bill. We cannot change the information on an insurance claim simply so that the claim will be paid. If you are not sure whether a service is covered by you plan, we will be glad to call your insurance company in advance to see if you will likely be responsible. Non-covered services are the responsibility of adult patients or the "guarantor - responsible party" for minor patients as outlined on the patient paperwork.

Insurance Filing and the Law:

Recent federal laws addressing all insurance companies require that we submit every claim accurately, reporting the exact services performed and the exact reason for performing them. We are unable to change this information simply for purposes of getting the claim covered. Our practice is committed to abiding by these laws, and will submit all claims in the appropriate manner.

Along with examinations, your provider may suggest that some "screening" tests be performed to allow them to get a better picture of your health. These services may also be considered as non-covered by your insurance company. If so you will be expected to cover the costs. Even if the results of these test show a problem, we must submit these tests as "screening" to your insurance company, and cannot change this information simply to receive payment.

Assignment of Benefit Agreement

*I have read and do understand these policies. My permission is given for any medical treatment including, not limited to, examination, injections, diagnostic testing or medical procedures as may be deemed advisable by member of Speight Family Medical, LLC for today and all future appointments. I hereby authorize my insurance company, including Medicare, to make payments to Speight Family Medical, LLC for medical and/or surgical services or items rendered to me or my dependent(s). I understand that if I have medical coverage, my bill will be submitted to my insurance as a courtesy to me. I fully understand that I am financially responsible for any co-pays, deductible, percentages or denied claims that my insurance does not cover. Should my account become delinquent, I understand that Speight Family Medical, LLC may seek assistance from a collection agency to collect and I will be held responsible for a **$20.00 late fee** plus any collection agency fee, court cost, and/or attorney fees that may be incurred. I certify that the information provided by me is correct and complete to the best of my knowledge and withholding information is grounds for dismissal from Speight Family Medical, LLC. It is my responsibility to update and all person, health and insurance information.*

Please Note: You may receive a separate bill from the lab for lab services performed in this office. **(INITIAL)** __________

Please Note: There will be a $35 charge for returned checks and a $25 appointment "no show" fee. **(INITIAL)** __________

Patient Name **(PRINT)**: ______________________________

Is Patient a Minor? Yes No What is your relationship to the minor patient? ____________________

If minor, Guarantor Name **(PRINT)**: ______________________________

Patient Signature (**Guarantor, if minor**): ______________________________ Date: ______________

Updated May 2015

Protected Health Information Acknowledgment Short Form

Use or Disclosure of Your Health Information
Your protected health information will be used by Speight Family Medical, LLC or disclosed to others for the purposes of treatment, obtaining payment or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information
You may make requests on the use or disclosure of your protected health information. Speight Family Medical, LLC may or may not agree to restrict the use or disclosure of your protected health information. If Speight Family Medical, LLC agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the Federal Privacy Standards.

Revocation of Consent
You may revoke the consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Standards
Speight Family Medical, LLC reserves the right to modify the privacy practices outlined in the notice.

Communications with the patient should be directed to:

Patient Name: ____

Address: ______________________________ City, State, Zip Code: ____________________

Home Phone (____) ____________________ Work Phone (____) ____________________

Cell Phone (____) ____________________ Alternative Phone (____) ____________________

May the Speight Family Medical, LLC staff leave messages regarding your healthcare on your voicemail or answering machine? ***Please check one:*** Yes _____ No _____

Who else can Speight Family Medical, LLC discuss details of your healthcare or release prescriptions to on your behalf? *Example:* Mom, Dad, Legal Guardian, Grandparents, Siblings, Aunts, Uncles, etc.

Name: ______________________ Relationship: ______________ Phone: ______________

Name: ______________________ Relationship: ______________ Phone: ______________

Name: ______________________ Relationship: ______________ Phone: ______________

I have reviewed this form and give permission to Speight Family Medical, LLC to use and disclose my health information in accordance with it.

Patient Name **(PRINT)**: ____

Is Patient a Minor? ☐ Yes ☐ No What is your relationship to the minor patient? ____________________

If minor, Guarantor Name **(PRINT)**: ______________________________________

Patient Signature (Guarantor, if minor): ______________________________ **Date:** ______________

Authorization For Release Of Protected Health Information From Another Facility

Patient Name:	Birth Date:
	SS No.

Person/Organization Authorized to Disclose Protected Health Information:

Release Records to: **Speight Family Medical** **76 Tabb Dr. Suite E** **Munford TN 38058**	**Phone # 901-840-2102** **Fax # 901-840-1979**

Description of Information to be Used or Disclosed: Medical Records

Dates of Treatment:	Place of Treatment:

Choose From the Following:

Entire Chart	Labs (may include AIDS/HIV information)	Discharge Summary
Radiology Reports	History and Physical	Other (specify):
ER Record	Pathology Reports	
Operative/Procedure Report	Billing Record	

I understand that:

1. I may revoke this authorization in writing at any time by notifying in writing the person/organization providing or disclosing the information. However, if I revoke this authorization, it will not have any effect on any actions taken by the person/organization providing, disclosing, or receiving the information prior to receiving the revocation, nor shall it be valid to the extent that the disclosing person/organization or receiving organization has taken action in reliance on this authorization.
2. This authorization allows **Speight Family Medical** to obtain any and all documents in my medical record including those copies from other health care facilities and providers. I understand that the information that is released or provided may be re-disclosed and no longer protected by federal privacy regulations.
3. Any disclosure of records concerning diagnosis and/or treatment of alcohol and/or drug abuse is covered by Title 42 CFR, and if there is any such information, I herby authorize the release of information. This authorization also includes any information related to diagnosis and/or treatment of nay psychiatric or mental illness or any state of infection with the HIV (Aids) virus.
4. **Speight Family Medical** is herby released from any liability and the undersigned with hold **Speight Family Medical** harmless for requesting or seeking my protected health information.
5. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal will affect my ability to obtain treatment, receive payment, or eligibility for benefits.
6. The authorization will expire in one year unless I provide an alternate date or event. This authorization will not apply to any dates of service that occur after the date this authorization is signed.
7. A facsimile of this authorization or a copy of this authorization shall be valid and binding with the same force as an original signature, and the person/organization releasing the information shall be entitled to rely on the same.

I have read and understood this authorization. I herby authorize the release of the above-requested medical information about me to Speight Family Medical from the facility named above.

__________________________________ __________________

Signature of Patient or Authorized Representative Date

Speight Family Medical

CONTROLLED SUBSTANCE AGREEMENT

This is an agreement between the physician staff of Speight Family Medical, Dr. Deanna Speight, FNP, Dawn Stewart, FNP, Ruby Turner, FNP and the patient signed below regarding the use of controlled substances. These substances, such as narcotics and sedatives, have the potential for drug dependence and addiction. They require special considerations when being prescribed.

It is therefore necessary for the patient to acknowledge the following critical points by signing this agreement:

1. Narcotics (such as hydroquinone, oxycodone, morphine, and fentanyl) are addictive.
2. You must take these medications as prescribed. It is not permissible to increase the dose without your provider's consent.
3. You are responsible for the safekeeping of your medications. You must not allow other to use your medication. Keep it well secured at all times.
4. Loss, theft, the dog ate it, it fell in the toilet or other such stories are not acceptable as cause for early refill.
5. You cannot obtain prescriptions from other doctors or providers for controlled substances unless approved by your provider at Speight Family Medical.
6. You must not drink alcohol or engage in recreational drug use while taking prescriptions for controlled substances.
7. Refills are NOT given on Fridays or after regular business hours.
8. You agree to submit to urine drug screens at any time.
9. You agree to use one pharmacy for all prescriptions. You may change pharmacies if we are informed.
10. You are required to be seen in the office, with an appointment, for refills MONTHLY until the provider approves any scheduling changes. NO EXCEPTIONS!
11. All appointments for controlled substances must be made at least a week in advance for refills.

At all times during the course of treatment you are encouraged to ask questions regarding the use of addictive medications and their side effects. You may choose to discontinue them at anytime. Any evidence of prescription tampering, drug diversion, selling or misbehavior involving controlled substances will trigger immediate termination of all prescribing.

Signed____

My pharmacy name & location____________________________

My pharmacy number_________________________________

Speight Family Medical, LLC
76 Tabb DR STE E Munford, TN 38058
403 Henslee Dr Dickson, TN 37055

Privacy Notice Acknowledgement

Acknowledgment of Receipt of Privacy Notice

By signing this form, you acknowledge that you have been given an opportunity to review Speight Family Medical, LLC's Privacy Notice, which explains how your health information will be handled in various situations. We must try to have you sign this form on your first date of service with us.

If your first date of service with us was due to an emergency, we must try to give you this notice and get your signature acknowledging receipt of this notice as soon as we can after the emergency.

Patient Name	Date of Birth	Last 4 SS#
Patient Name	Date of Birth	Last 4 SS#
Patient Name	Date of Birth	Last 4 SS#
Patient Name	Date of Birth	Last 4 SS#

Check all that are true:

- ☐ I have received and been given an opportunity to review Speight Family Medical, LLC's Privacy Notice.
- ☐ SFM, LLC has given me the chance to discuss my concerns and questions about the privacy of my health information.

Signature: Parent/Legal Guardian/Patient if over 18

Print Name: Parent/Legal Guardian/Patient if over 18

Relationship to Patient | Date

STAFF ONLY to complete if this Acknowledgment Form is not signed:
Does patient have a copy of the Privacy Notice?

- ☐ Yes
- ☐ No

Comments: