



GRACE

HEALTH SERVICES

104 Grand Avenue
Copperhill, TN 37317
(p) 423-548-1000
(f) 423-548-1002

PATIENT INFORMATION

PATIENT'S NAME (PLEASE PRINT)	SS#	MARITAL STATUS Single Married Widowed Divorced Separated	DATE OF BIRTH	AGE SEX- Male / Female
STREET ADDRESS	CITY AND STATE	ZIP CODE	HOME TELEPHONE NUMBER /CELL NUMBER	
PATIENT DRUG ALLERGIES		SPOUSE OR PARENT'S NAME	SPOUSE DATE OF BIRTH	
HAS ANY MEMBER OF YOUR FAMILY BEEN TREATED BY OUR PHYSICIAN BEFORE? INCLUDE PHYSICIAN AND FAMILY MEMBER	PREVIOUS PHYSICIAN	PERMISSION TO RELEASE INFORMATION TO:		
HOW DID YOU HEAR ABOUT OUR PRACTICE? <input type="checkbox"/> NEWSPAPER <input type="checkbox"/> INSURANCE COMPANY <input type="checkbox"/> YELLOW PAGES <input type="checkbox"/> FRIEND <input type="checkbox"/> OTHER		EMAIL		

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

NAME OF POLICY HOLDER _____ POLICY HOLDER DATE OF BIRTH _____

INSURANCE ID _____ POLICY NUMBER _____

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE/OTHER INSURANCE COMPANY BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO GRACE HEALTH SERVICES FOR ANY SERVICES FURNISHED ME BY THAT PARTY WHO ACCEPTS ASSIGNMENT/PHYSICIAN. REGULATIONS PERTAINING TO MEDICARE ASSIGNMENT BENEFITS APPLY. I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND CENTERS FOR MEDICARE AND MEDICAID SERVICES OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM/OTHER INSURANCE COMPANY CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT. I UNDERSTAND THAT IT IS MANDATORY TO NOTIFY THE HEALTH CARE PROVIDER OF ANY OTHER PARTY WHO MAY BE RESPONSIBLE FOR PAYING FOR MY TREATMENT (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.)

X _____

SIGNATURE OF POLICY HOLDER

DATE

NOTICE OF PRIVACY PRACTICES

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received / read a copy of Grace Health Services Notice of Privacy Practices.

YOU ARE ULTIMATELY RESPONSIBLE FOR YOUR BILL

FINANCIAL POLICY

We strongly feel all patients deserve the very best medical care that we can provide. Everyone benefits when financial arrangements are agreed upon. Our professional services are rendered to you, not the insurance company. Payment for treatment is ultimately your responsibility.

I hereby authorize the release of any information necessary to process insurance claims and request payment of benefits to be made for services rendered to my dependents or myself.

I understand I am responsible at the time of service for paying any required copay and/or deductible.

I understand that if I have no insurance coverage and am considered self-pay, I understand that I am responsible for payment of services rendered to myself or dependents at the time of the service.

I understand if I fail to pay amounts owed, the clinic has the right to secure an outside collection agency and/or attorney to collect the unpaid debt and to report the unpaid debt to a credit reporting agency. I further understand that I will be responsible for any additional charges or fees necessitated by securing the collection agency or attorney, including reasonable attorney's fees.

There will be a \$35.00 charge on all returned checks.

I HAVE READ AND UNDERSTAND THE PAYMENT POLICY OF THIS OFFICE AND AGREE TO ABIDE BY THE SAID POLICY.

X _____

PATIENT / GUARANTOR (for minors) SIGNATURE

ACKNOWLEDGEMENT OF INSURANCE AUTHORIZATION, NOTICE OF PRIVACY PRACTICES, RESPONSIBILITY FOR BILL By signing on the above line, I acknowledge consent to all (3) three sections listed above.



104 Grand Avenue
Copperhill, TN 37317
(423) 548-1000 FAX (423) 548-1002

AUTHORIZATION FOR AND CONSENT TO RELEASE INFORMATION

Patient Name: _____ Date of Birth: _____

SSN: _____ Phone #: _____

Release information from: _____ Phone #: _____

Fax #: _____

Release information to: _____ Phone #: _____

Fax #: _____

I, the undersigned patient/guardian, hereby authorize the Dr. releasing records listed above, to release information listed below, from the records of patient listed above.

*****MEDICAL RECORDS ACCEPTED BY FAX OR MAIL ONLY. NO CD'S.*****

Please release the following information- check all that apply

Progress Notes

Labs

x-rays

Hospital

Immunizations

Other- _____

By signing this release, I agree to pay any fees that pertain to the release of my medical records. I understand this authorization includes release of all medical records including HIV records, Psychiatric Mental illness, Drug / Alcohol abuse records, Venereal Disease and any other statutory protected diseases. This authorization and consent will expire ninety days following the date signed. I understand that I may revoke this authorization and consent at any time except to the extent that action has previously taken in reliance thereof.

Signature of Patient / Guardian

Date

Relationship to Patient

Signature of Witness

Protected Health Information (PHI) / HIPAA

Patient Name (Print)

Date 06/13/2018

Due to recent implemented Federal Regulations the following public notice by Grace Health Services PLLC is effective as of November 1, 2011.

The Grace Health Services PLLC is required to:

1. Maintain the privacy of your health information.
2. Provide you with this notice as to what our legal duties and privacy practices are with respect to information we collect and maintain about you.
3. Abide by the terms of this practice.
4. Notify you if we are unable to agree to a requested restriction, and accommodate any reasonable request you may have to communicate health alternative means or alternative locations.
5. We will not use or disclose your health information without your authorization, except as described in this notice.
6. We will use and disclose your PHI in order to bill and collect payment for the services and items you may have received from us. For example, we will contact your insurer to certify that you are eligible for benefits and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment.

WE ARE PERMITTED TO USE, AND MAY BE REQUIRED, TO DISCLOSE YOUR PHI UNDER SPECIAL CIRCUMSTANCES:

1. **Disclose Required By Law:** Our practice will use and disclose your PHI when we are required to do so by federal, state, or local law, including health oversight activities, court or administrative orders or similar legal proceedings.
2. **Public Health Risk:** Our practice may disclose your PHI to public health authorities who are authorized to collect information for such purposes as maintaining vital records, preventing or controlling disease, injury, or disability; or notifying a person regarding potential exposure to a communicable disease.
3. **Serious Threats to Health of Safety:** Our practice may disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public.
4. **Deceased Patients:** Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.
5. **Organ Donor:** Our practice may release PHI to a medical facility for tissue procurement of transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.
6. **Worker's Compensation:** Our practice may release your PHI for workers' compensation and similar programs.

Our practice may contact you or your authorized representatives (see authorization form attached) to

provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The practice might routinely contact patients via telephone at home and /or work, via mail at home, and unless otherwise requested, may leave messages on the appropriate voice mail or answering service regarding appointments and billing questions.

All requests for medical records should be hand written and should contain:

Full Name

Date of Birth

Mailing Address

Phone Number

Written Signature

An additional fee might be asked for generating a copy or mailing all medical records as per the rules practiced by the clinic.

At no time will any person, including your spouse, be able to obtain information from your medical record without prior written authorization. Only parents or legal guardian of a child under the age of 18 will be allowed to access medical record information, with proof of child's social security number and date of birth.

Patient Rights

1. **Confidential Communications:** You have the right to request that our practice communicate with you about health and related issues in a particular manner or at a certain location. Our practice will accommodate reasonable request.
2. **Requesting Restrictions:** You have the right to request restriction on our use of disclosure of you PHI for treatment, payment, or health care operations. We are not required to agree to your request; however if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. **Inspection and Copies:** You have the right to request and obtain a copy of your PHI. Our practice will charge a fee for the cost of copying, mailing, labor, and supplies associated with your request. Our practice may deny your request to inspect and/or copy limited circumstances. However, you may request a review of our denial.
4. **Amendment:** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for this practice. Your request must provide us with the reason that supports your request for amendment. Your request may be denied if you ask us to amend information that is in our opinion: a) accurate and complete; b) not part of the PHI kept by or for the practice; c) not part of the PHI that you would be permitted to inspect and copy; or d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
5. **Rights to a paper Copy of This Notice:** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time.
6. **Rights to File a Complaint:** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

If you have any questions regarding this notice or would like to exercise any of your rights under this notice, you may contact:

Grace Health Services PLLC
104 Grand Avenue
Copperhill TN37317

Phone 423-548-1000

Grace Health Services PLLC

****Complete and return to Receptionist****

ACKNOWLEDGEMENT

I acknowledge that I have received the Notice of Privacy Practices from Grace Health Services PLLC and understand that if I have questions regarding this Notice I may contact the office at 104 Grand Avenue, TN 37317 423-548-1000.

Indicated below are names of any Person(s) to whom I would like Grace Health Services PLLC to allow disclosure of Individually Identifiable Health Information (IIHI). (Please, specify the type of information that may be disclosed, such as lab test, appointment information, prescription information, etc. You may indicate "All" if appropriate).

Name	Relation to Patient	Allowed Disclosure <input type="checkbox"/>

Patient Name

Patient Signature

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

- Are you under a physician's care now? Yes No If yes, please explain: _____
- Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
- Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
- Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____
- Do you take, or have you taken, Phen-Fen or Redux? Yes No _____
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No _____
- Are you on a special diet? Yes No _____
- Do you use tobacco? Yes No _____
- Do you use controlled substances? Yes No _____

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa drugs

Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	<input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine	<input type="radio"/> Yes <input type="radio"/> No	Hemophilia	<input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments	<input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis A	<input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss	<input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis	<input type="radio"/> Yes <input type="radio"/> No	Drug Addiction	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C	<input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Easily Winded	<input type="radio"/> Yes <input type="radio"/> No	Herpes	<input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever	<input type="radio"/> Yes <input type="radio"/> No
Angina	<input type="radio"/> Yes <input type="radio"/> No	Emphysema	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Rheumatism	<input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout	<input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures	<input type="radio"/> Yes <input type="radio"/> No	High Cholesterol	<input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever	<input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve	<input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding	<input type="radio"/> Yes <input type="radio"/> No	Hives or Rash	<input type="radio"/> Yes <input type="radio"/> No	Shingles	<input type="radio"/> Yes <input type="radio"/> No
Artificial Joint	<input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst	<input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia	<input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness	<input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat	<input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble	<input type="radio"/> Yes <input type="radio"/> No
Blood Disease	<input type="radio"/> Yes <input type="radio"/> No	Frequent Cough	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Spina Bifida	<input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion	<input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea	<input type="radio"/> Yes <input type="radio"/> No	Leukemia	<input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease	<input type="radio"/> Yes <input type="radio"/> No
Breathing Problem	<input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches	<input type="radio"/> Yes <input type="radio"/> No	Liver Disease	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No
Bruise Easily	<input type="radio"/> Yes <input type="radio"/> No	Genital Herpes	<input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Lung Disease	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No	Hay Fever	<input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No	Tonsillitis	<input type="radio"/> Yes <input type="radio"/> No
Chest Pains	<input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters	<input type="radio"/> Yes <input type="radio"/> No	Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints	<input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths	<input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder	<input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease	<input type="radio"/> Yes <input type="radio"/> No	Ulcers	<input type="radio"/> Yes <input type="radio"/> No
Convulsions	<input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease	<input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care	<input type="radio"/> Yes <input type="radio"/> No	Venereal Disease	<input type="radio"/> Yes <input type="radio"/> No
						Yellow Jaundice	<input type="radio"/> Yes <input type="radio"/> No

Have you ever had any serious illness not listed above? Yes No

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____