GRACE
HEALTH SERVICES
104 Grand Ave, Copperhill, TN 37317
Phone: (423) 548-1000 Fax: (423) 548-1002

HEALTH HISTORY

Patient Information

Patient Name: Date of Birth:

Mailing Address:

State/Zip: Preferred Phone:

SSN: email:

Marital Status: Single__ Married___ Divorced___ Widowed___ Partner___

Education Grade_____ High School_____ College_____ Degree_____ Graduate School_____

Spouse or parent's name: Spouse date of birth:

Sex Male____ Female____ Occupation:

Preferred Pharmacy Name:

Pharmacy phone:

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 MY BY THAT PARTY WHO ACCEPTS ASSIGNMENT/PHYSICIAN. REGULATIONS PERTAINING TO MEDICARE ASSIGNMENT BENEFITS APPLY. I AUTHORIZE ANY HOLDER OF MEDICAL OR ANY 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 11288 of the Social Security Act and 31 U.S.C 3801-3812 provides penalties for withholding this information.)

Signature **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.

24 Hour Cancellation & "No Show" Fee Policy Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care.

Therefore, Grace Health Services reserves the right to charge a fee of $20.00 for all missed appointments ("no shows") and appointments which, absent a compelling reason, are not cancelled with a 24-hour advance notice. "No Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple "no shows" in any 12-month period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

X_____

PATIENT / GUARANTOR (for minors) SIGNATURE

ACKNOWLEDGEMENT OF INSURANCE AUTHORIZATION, NOTICE OF PRIVICY PRACTICES, RESPONSIBILITY FOR BILL, CANCELLATION POLICY By signing on the above line, I acknowledge consent to all (4) four sections listed above.

GRACE
HEALTH SERVICES
104 Grand Ave. Copperhill, TN 37317
Phone: (423) 548-1000 Fax: (423) 548-1002

Past Medical History: (Circle) any condition you have been Diagnosed with)

Angina
Anxiety
Arthritis
Asthma
Atrial Fibrillation
Bipolar Disorder
Breast Disease
Cancer (type)
_____
Chronic Kidney Disease (Stage ___)
Congestive Heart Failure
COPD (Emphysema, Bronchitis)
Coronary Disease
Depression
Diabetes (Type 1 or Type 2)
DVT (leg clots)
Erectile Dysfunction
Fibromyalgia
Glaucoma
Gout
Headaches (Migraine/Tension)
Hearing Loss
Heart Burn, Reflux
Hepatitis (A, B, C)
High Blood Pressure
High Cholesterol
HIV / AIDS
Hyperthyroidism
Hypothyroidism
Incontinence
Kidney Stones
Lupus
Macular Degeneration
MI/Heart Attack
Osteoporosis
PCOS
Pneumonia
Prostate Disease
PTSD
Pulm Emboli (lung clots)
Seizures
Stomach Ulcers
Stroke
Urinary Tract Infections
Valve Disorder
Other_____

Surgical History: (Please write the year next to any surgery you have had) □ None

□ Adenoidectomy
□ Appendectomy
□ Arthroscopy
□ Bariatric Surgery _____

GRACE
HEALTH SERVICES
104 Grand Ave. Copperhill, TN 37317
Phone: (423) 548-1000 Fax: (423) 548-1002

□ Bladder Surgery
□ Bowel/Stomach Resection
□ Cardiac Stents _____
□ Cataracts
□ Coronary Bypass (How Many? _____)
□ C-Section
□ Gall Bladder
□ Heart Valve
□ Hemorrhoidectomy
□ Hernia Repair
□ Hysterectomy (Partial or Complete?)
□ Joint Replacement: _____
□ LASIK
□ Pacemaker
□ Prostate Surgery/Resection
□ Rotator Cuff Repair
□ Spinal Surgery _____
□ Thyroidectomy
□ Tonsillectomy
□ Tubal Ligation
□ Other_____

Preventative Health History (please write year):

Procedures: Physical Exam: _____ Colonoscopy _____ Endoscopy _____
Labs _____ Last Chest X-ray _____ Dental Exam _____ **Eye Exam** _____
Immunizations: Tdap_____ Zostavax/Shingrix_____ Prevnar _____
Pneumovax_____ Influenza_____ COVID-19 _____

Women: Last Pap Test _____ Mammogram _____ Bone Density _____
Men: PSA Screening _____ Advance Directive _____ Living Will/Power of Attorney _____
(If yes can we get a copy for your file)

Social History:

Alcohol: □ None □ Yes: How many drinks/day _____ Occasionally? _____ Type? _____
Tobacco: □ None □ Former: Quit? _____ □ Yes: Chew/Smoke/Vape? _____ How many/day _____since_____
Caffeine: □ None □ Yes: What kind_____ How many/day _____
Other Recreational Drugs: □ None □ Yes: What kind_____ How many/day _____
Work: □ Employed □ Unemployed □ Retired □ Disabled
Current Occupation _____Former Occupation _____

GRACE
HEALTH SERVICES
104 Grand Ave. Copperhill, TN 37317
Phone: (423) 548-1000 Fax: (423) 548-1002

Review of Systems (Circle any symptoms you have)

General
- Fever
- Chills
- Weakness/Fatigue
- Weight Loss
- Weight Gain
- Snoring
- Cold or Heat Intolerance
- Unusual Hair Loss
- Hot Flashes

HEENT
- Sore Throat
- Sinus Drainage
- Sinus Headache
- Nasal Congestion
- Nose Bleeds
- Earache
- Hearing Loss
- Ringing in Ears
- Blurred Vision
- Itchy/Watery Eyes

Cardiac
- Chest Pain
- Palpitation
- Irregular Heartburn
- Leg Swelling

Respiratory
- Cough
- Shortness of Breath
- Wheezing
- Coughing up Blood
- Cannot Breathe Laying Flat

Skin
- Rash/Hives
- Skin Discoloration/Easy Bruising
- Lesions/Warts/Moles
- Itching

Musculoskeletal
- Joint Pain
- Joint Swelling
- Muscle Weakness
- Back Pain (Upper or Lower)
- Muscle Cramps/Spasms
- Falling

Neurological
- Frequent Headaches
- Seizures
- Passing Out
- Limb Weakness
- Limb Numbness
- Dizziness
- Balance Issues
- Tremors

Psych
- Depression
- Agitation/Irritability
- Insomnia
- Anxiety
- Frequent Crying Spells
- Mood Swings

Gastrointestinal
- Nausea/Vomiting
- Difficulty Swallowing
- Hemorrhoids
- Diarrhea
- Constipation
- Abdominal Pain
- Heartburn/Indigestion

Urinary
- Painful/Burning Urination
- Urinary Frequency
- Blood in Urine
- Incontinence

GRACE
HEALTH SERVICES
104 Grand Ave. Copperhill, TN 37317
Phone: (423) 548-1000 Fax: (423) 548-1002

Health History Intake Form

Patient Name: _____ Date of Birth: _____

Previous Primary Care Physician (if any): _____
Phone: _____ Mailing Address: _____

Other Physicians involved in your care: _____

_____

Reason for visit today: _____

_____

Allergies (Medication/Food, indicate reaction): □ None

_____

Medication List: (Please list name/dose/frequency if known) □ None

Name	Dose	Frequency

Family History: (please indicate deceased or alive and medical issues) □ None

Adopted □ Yes □ No

Father: _____

Mother: _____

Siblings: _____

_____

Grandparents: _____

GRACE
HEALTH SERVICES

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: Grace Health Services Phone #: 423-548-1000

Fax #: 423-548-1002

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**

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 CIRCUSTANCES:

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

Patient Name

Patient Signature