GRACE
HEALTH SERVICES

340 MAIN STREET
Copperhill, TN 37317
(p) 423-548-1000
(f) 423-548-1002

PATIENT INFORMATION

PATIENT'S NAME (PLEASE PRINT)	SS# MARITAL STATUS DATE OF BIRTH Single Married Widowed Divorced Separated	AGE SEX- Male / Female
MAILING ADDRESS	CITY AND STATE	ZIP CODE	HOME TELEPHONE NUMBER
CELL NUMBER	SPOUSE OR PARENT'S NAME	SPOUSE DATE OF BIRTH
HOW DID YOU HEAR ABOUT US? NEWSPAPER, WORD OF MOUTH, SOCIAL MEDIA?	PREVIOUS PHYSICIAN	PERMISSION TO RELEASE INFORMATION TO:
PREFERRED PHARMACY **NAME**_____**PHONE**_____	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 ASSIGNEMENT. 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 **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
340 Main Street 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_____year
□ Appendectomy_____year
□ Arthroscopy _____year
□ Bariatric Surgery _____year

GRACE
HEALTH SERVICES
340 Main Street Copperhill, TN 37317
Phone: (423) 548-1000 Fax: (423) 548-1002

□ Bladder Surgery___year

□ Bowel/Stomach Resection____year

□ Cardiac Stents ____year

□ Cataracts___year

□ Coronary Bypass (How Many? _____)

□ C-Section____year

□ Gall Bladder_____year

□ Heart Valve____year

□ Hemorrhoidectomy____year

□ Hernia Repair____year

□ Hysterectomy (Partial or Complete?)

□ Joint Replacement: _____

□ LASIK____year

□ Pacemaker____year

□ Prostate Surgery/Resection___year

□ Rotator Cuff Repair ___year

□ Spinal Surgery _____year

□ Thyroidectomy___year

□ Tonsillectomy___year

□ Tubal Ligation___year

□ 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
340 Main Street 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 Heartbeat
- 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
340 Main Street 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 medical issues? _____

Mother medical issues? _____

Siblings medical issues? _____

_____

Grandparents medical issues? _____

GRACE HEALTH SERVICES

AUTHORIZATION FOR CONSENT TO RELEASE INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: _____

PHONE: _____

RELEASE INFORMATION FROM : _____PHONE:_____

FAX: _____

RELEASE INFORMATION TO: GRACE HEALTH SERVICES PHONE: _____

FAX: _____

I, THE UNDERSIGED 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 ONLY NO CD'S PLEASE*****

PLESAE RELEASE FOLLOWING INFORMATION:
__ PROGRESS NOTES
__ LABS
__ X-RAYS
__ HOSPITAL RECORDS
__ 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 Date

NOTICE OF PRIVACY PRACTICES AKNOWLEDGEMENT PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers whom may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand, your Notice of Privacy Practices containing a more complete description of their uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations.
I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Due to HIPPA (Health Insurance Privacy & Accountability Act) Regulations, mention above, we must ask you the following questions regarding you PHI (Protected Health Information).

DOES OUR OFFICE HAVE PERMISSON TO?

- Leave a message on your answering machine at home? YES NO
- Contact you by cell phone (text messaging or phone call)? YES NO
- Discuss your medical condition or dental treatment such as Appointment time, Pre-medications or other prescriptions with any member of your household? YES NO
- If yes, whom: _____Relationship_____
- Leave message or try to contact you at your place of employment? YES NO

Patient Name_____
If Patient is a minor, relationship to patient_____
Signature_____
Date_____

_____

OFFICE USE ONLY I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below
DATE: _____INITIALS: _____REASON: _____