



# GRACE

HEALTH SERVICES

340 MAIN STREET

Copperhill, TN 37317

(p) 423-548-1000

(f) 423-548-1002

*Email: [mygracehealthservices@gmail.com](mailto:mygracehealthservices@gmail.com)*

## PATIENT INFORMATION

PATIENT'S NAME (PLEASE PRINT)	SS#	MARITAL STATUS Single Married Widowed Divorced Separated	DATE OF BIRTH	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 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

\_\_\_\_\_

DATE



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? Deceased or alive \_\_\_\_\_

Mother medical issues? Deceased or alive \_\_\_\_\_

Siblings medical issues? \_\_\_\_\_

Grandparents medical issues? \_\_\_\_\_



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

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

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

- |   |   |
|---|---|
| <input type="checkbox"/> Adenoidectomy _____ year | <input type="checkbox"/> Arthroscopy _____ year       |
| <input type="checkbox"/> Appendectomy _____ year  | <input type="checkbox"/> Bariatric Surgery _____ year |

- |  |  |
|--|--|
| <input type="checkbox"/> Bladder Surgery ___year           | <input type="checkbox"/> Hysterectomy (Partial or Complete?) |
| <input type="checkbox"/> Bowel/Stomach Resection ___year   | <input type="checkbox"/> Joint Replacement: _____            |
| <input type="checkbox"/> Cardiac Stents ___year            | <input type="checkbox"/> LASIK ___year                       |
| <input type="checkbox"/> Cataracts ___year                 | <input type="checkbox"/> Pacemaker ___year                   |
| <input type="checkbox"/> Coronary Bypass (How Many? _____) | <input type="checkbox"/> Prostate Surgery/Resection ___year  |
| <input type="checkbox"/> C-Section ___year                 | <input type="checkbox"/> Rotator Cuff Repair ___year         |
| <input type="checkbox"/> Gall Bladder ___year              | <input type="checkbox"/> Spinal Surgery ___year              |
| <input type="checkbox"/> Heart Valve ___year               | <input type="checkbox"/> Thyroidectomy ___year               |
| <input type="checkbox"/> Hemorrhoidectomy ___year          | <input type="checkbox"/> Tonsillectomy ___year               |
| <input type="checkbox"/> Hernia Repair ___year             | <input type="checkbox"/> Tubal Ligation ___year              |
| <input type="checkbox"/> 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 \_\_\_\_\_ Normal \_\_\_ abnormal\_\_\_ Mammogram \_\_\_\_\_ Normal \_\_\_ abnormal \_\_\_

Bone Density \_\_\_\_\_ Hysterectomy Partial or complete why was it done? \_\_\_\_\_

**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 \_\_\_\_\_

**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  
DUCKTOWN, TN 37326

423-548-1000

423-548-1002 fax

AUTHORIZATION FOR CONSENT TO RELEASE INFORMATION

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

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 ONLY NO CD'S PLEASE\*\*\*\*

PLEASE 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

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## **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.

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## **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 PRIVACY PRACTICES, RESPONSIBILITY FOR BILL, CANCELLATION POLICY** By signing on the above line, I acknowledge consent to all (4) four sections listed above.

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: \_\_\_\_\_