

NOLENSVILLE FAMILY MEDICINE
JOHN R. THOMPSON, M.D.

HIPAA RELEASE FORM DOCUMENT

I (please print) _____ have received and read the Nolensville Family Medicine Notice of Privacy Practices.

Patient Name (please print) _____ Date of Birth _____

Patient Signature or Parent / Legal Guardian if under 18 years old

Witness Signature

Date

I authorize this organization to discuss my medical condition and information with the following:

	Yes	No	Name	Phone Numbers
Emergency Contact				
Spouse				
Parents				
Children				
Friends				
Relative				

CAN A MESSAGE REGARDING YOUR MEDICAL INFORMATION BE LEFT ON AN ANSWERING MACHINE? CIRCLE ONE: NUMBER

HOME	YES	NO	_____
CELL	YES	NO	_____
WORK	YES	NO	_____

Nolensville Family Medicine

John R. Thompson M.D. PLLC

We would like to take this opportunity to thank you for choosing Nolensville Family Medicine for your medical care. While our primary concern is treating you and your family's healthcare needs, we understand that you may have concerns regarding your insurance and financial obligations.

We ask that you understand your benefits and services that are covered or not covered by your insurance. Although we accept most commercial insurances, not all insurances have the same benefits. Benefits can vary from patient to patient depending on the plan you are covered on.

Below is a summary of our financial policy. Please initial beside each statement to indicate your understanding of the statement.

1. You will be asked to pay your Co-Pay, Co-Insurance, and/or Deductible at the time of each visit. Initial _____
2. At every visit you will be asked for your insurance information, if you fail to supply the correct or current insurance information at the time of your visit, the balance will be forwarded to you for payment. We do not refile insurance claims. You will be responsible for the balance. We will provide you the information you need to file the insurance on your own. Initial _____
3. The payment received varies by insurance company. It is the responsibility of the patient to pay any outstanding balance that remains. We will send you a statement after your insurance has paid. Initial _____
4. Covered and Non-Covered services differ from plan to plan. We ask that you review and understand your benefits and policies regarding what services are covered and what services are not covered. If a procedure or service is not covered, you will be billed for that amount directly. Initial _____
5. Some insurance companies require that lab work be sent to a specific laboratory. It is your responsibility to know where your labs should be sent for correct billing. Initial _____
6. Accounts that are delinquent and are sent out to our collection agency will be assessed a 20% collection fee. You will be responsible for all attorney fees and court cost associated with these collections. Nolensville Family Medicine uses Nashville Adjustment Bureau for all delinquent accounts. Please be aware that if your account is turned out to our collection agency this will negatively affect your credit rating. Initial _____
7. If you make an appointment and fail to show for that appointment, there will be a \$35.00 charge added to your account. You will be asked for that balance before your next appointment. Initial _____
8. If you have a returned check, you will incur a \$25.00 returned check charge on the account. You will no longer be able to write a check at our office if this occurs. Initial _____

Please remember it is your responsibility to understand your insurance benefits and we will be glad to work with you and your insurance company to ensure appropriate payment for your medical charges.

I have read the above and understand my obligations. This will be a one time authorization, and will be kept on file.

Patient Name (Please print)

Signature of Patient (Guarantor if under the age of 18)

Date

Witness

Date

Nolensville Family Medicine Patient History (age 12+)

Name _____	Date of Birth _____	Date _____
Past Medical History:		
List all allergies and meds you cannot take with reaction to each.	List all fractures and other pertinent injuries, with dates.	
_____	Date _____	
_____	Date _____	
_____	Date _____	
_____	Date _____	
_____	Date _____	
List all of your medications with dosage of each. Please include any over-the-counter medications.	List all surgeries and other hospitalizations with diagnoses and date of each. Include births (vaginal or C-Section).	
_____	Date _____	
_____	Date _____	
_____	Date _____	
_____	Date _____	
_____	Date _____	
_____	Date _____	

Chicken Pox Yes	Date _____	Migraine Headaches Yes	Year of Onset _____
Pneumonia Yes	Date(s) _____	Stroke Yes	Date(s) _____
Infectious Mono Yes	Date _____	Gout Yes	Year of Onset _____
Positive TB Test Yes	Year of Onset _____	Arthritis Yes	Type _____ Year of Onset _____
AIDS or HIV+ Yes	Year of Onset _____	Osteoporosis Yes	Year of Onset _____
Rheumatic Fever Yes	Date _____	Glaucoma Yes	Year of Onset _____
Heart Attack Yes	Date(s) _____	Chronic Back Trouble Yes	Year of Onset _____
Congestive Heart Failure Yes	Year of Onset _____	Prostate Infections Yes	Date(s) _____
High Blood Pressure Yes	Year of Onset _____	Enlarged Prostate Yes	Year of Onset _____
Other Heart Disease Yes	Type _____ Year of Onset _____	Recurrent UTI's Yes	Year of Onset _____
High Cholesterol Yes	Year of Onset _____	Kidney Stones Yes	Date(s) _____
Mitral Valve Prolapse Yes	Year of Onset _____	Other Kidney Disease Yes	Type _____ Date _____
Diabetes Mellitus Yes	Type _____ Year of Onset _____	Stomach Ulcer or H.Pylori Yes	Date(s) _____
Thyroid Disease Yes	Type _____ Year of Onset _____	Viral Hepatitis Yes	Type(s) _____ Date _____
Tuberculosis Yes	Date _____	Colon Polyp(s) Yes	Date(s) _____
Asthma Yes	Year of Onset _____	Venereal Disease Yes	Type(s) _____ Date(s) _____
Breast Cancer Yes	Year of Onset _____	Mental Illness Yes	Type _____ Date _____
Colon Cancer Yes	Year of Onset _____	Anxiety Yes	Year of Onset _____
Prostate Cancer Yes	Year of Onset _____	Depression Yes	Year of Onset _____
Skin Cancer Yes	Type(s) _____ Date(s) _____	Alcohol Problem Yes	Year of Onset _____
Other Type Cancer Yes	Type _____ Date _____	Drug Problem Yes	Drug(s) _____ Year of Onset _____
Anemia Yes	Type _____ Date _____	Epilepsy Yes	Year of Onset _____
Bleeding Tendency Yes	Year of Onset _____	Other Significant History _____	

Family Medical History: Please include family member, for example, Father, Maternal Grandfather, Paternal Grandmother, etc.
Please include type of illness when applicable, for example, Type I or Type II Diabetes, Colon Cancer, etc.

High Cholesterol _____	Tuberculosis _____
Heart Disease _____	Allergies _____
Heart Attack _____	Asthma _____
High Blood Pressure _____	Chronic Lung Disease _____
Diabetes Mellitus _____	Osteoporosis _____
Thyroid Disease _____	Gout _____
Obesity _____	Stroke _____
Cancer _____	Migraine Headaches _____
Anemia _____	Mental Illness _____
Bleeding Tendency _____	Depression _____
Ulcer _____	Anxiety _____
Gallstones _____	Alcohol Problem _____
Kidney Disease _____	Drug Problem _____
Glaucoma _____	Other _____

Social History:

Occupation _____ Retired? _____ Unemployed? _____	Education Level _____
Religious Affiliation _____	Hobbies _____
Name of Church/Synagogue _____	Types of Pets _____
Alcohol Use? Yes # of drinks per week _____	Lived Out of Country? Yes Locations _____
Tobacco Use? Yes # packs per day _____ Age Started _____	Comments _____

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Patient Name _____ DOB: _____ Today's Date _____

In the past 12 months, have you experienced any of the following?

	Yes	No		Physician Comments
1			Significant Weight Changes	
2			Frequent Dizziness	
3			Visual Changes	
4			Hearing Changes	
5			Ringing in Ears	
6			Frequent Difficulty Sleeping	
7			Frequent Use of Over the Counter Sleep Aids	
8			Frequent Headaches	
9			Allergy Symptoms of Nose, Eyes or Ears	
10			Difficulty Chewing or Swallowing Food	
11			Frequent Indigestion	
12			Frequent Use of Over the Counter Antacids	
13			Frequent Use of Over the Counter Pain Relievers	
14			Change in Usual Bowel Habits	
15			Black Tarry Stools	
16			Blood in Stool	
17			Chalky White Stools	
18			Unexplained Abdominal Pain	
19			Unexplained Chest Pain	
20			Recurring Flutters in Chest (Palpitations)	
21			Unexplained Shortness of Breath	
22			Recurrent Joint Pain or Swelling	
23			Frequent Swelling of Hands or Legs	
24			Focal Weakness or Numbness	
25			Loss of Consciousness	
26			Frequent Difficulty Passing Urine	
27			Regularly Wake up at Night to Void Urine	
28			How Many Times?	
29			Worrisome Skin Lesions	
32			**MEN ONLY**	
33			Difficulty with Sexual Function	
36			**WOMEN ONLY**	
37			Heavy/Frequent or Irregular Vaginal Bleeding	
38			Abnormal Vaginal Discharge	
39			Vaginal Itching or Burning	
40			Do you Perform Self Breast Exams?	
41			Any Change in Self Breast Exam?	
42			Date of Last PAP Smear:	
43			Ever Had an Abnormal PAP Smear?	
44			Date of Last Mammogram:	
45			Total Number of Pregnancies:	
46			Total Number of Miscarriages/Abortions	
47			Total Number of Children:	
48			Did you Breastfeed your Children?	
49			Your Age at First Pregnancy:	
50			Age When Started Periods:	