

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

Pediatric Medical History

[For ages under 12]

Child's Name _____

Birth date _____

Past Medical History: Has your child ever had:

Mumps, Measles	Yes	No	Croup	Yes	No
Chicken Pox	Yes	No	TB/ Lung Disease	Yes	No
Eczema/ Skin Problems	Yes	No	High Blood Pressure	Yes	No
Pneumonia	Yes	No	Kidney/ Bladder Problems	Yes	No
Asthma/ Wheezing	Yes	No	Sexually Transmitted Disease	Yes	No
Cancer	Yes	No	High Cholesterol	Yes	No
Hepatitis	Yes	No	Handicaps/ Disabilities	Yes	No
HIV/ AIDS	Yes	No	Diabetes	Yes	No
Hemophilia	Yes	No	Rheumatic Fever	Yes	No
Abnormal Bleeding	Yes	No	Congenital Heart Defect	Yes	No
Allergies	Yes	No	Heart Murmur	Yes	No
Frequent Ear Infections	Yes	No	Convulsions/ Epilepsy	Yes	No
Frequent Colds or Sore Throats	Yes	No	Emotional Disorders or Suicide Attempts	Yes	No

Please list any hospitalizations, surgeries, trauma, and serious or unusual illnesses which your child has experienced.

Date **Hospitalization/Surgery/Trauma/Illness** **Hospital/ Physician's Name** **City, State**

List all food/drug/insect allergies with reaction to each.

List all current medications with dosage of each

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 _____
 Heart Disease _____
 Heart Attack _____
 High Blood Pressure _____
 Diabetes Mellitus _____
 Thyroid Disease _____
 Obesity _____
 Cancer _____
 Anemia _____
 Bleeding Tendency _____
 Ulcer _____
 Gallstones _____
 Kidney Disease _____
 Glaucoma _____

Tuberculosis _____
 Allergies _____
 Asthma _____
 Chronic Lung Disease _____
 Osteoporosis _____
 Gout _____
 Stroke _____
 Migraine Headaches _____
 Mental Illness _____
 Depression _____
 Anxiety _____
 Alcohol Problem _____
 Drug Problem _____
 Other _____

Social History:

Child's Education Level _____
 Religious Affiliation _____
 Name of Church/Synagogue _____
 Comments _____

Hobbies _____
 Types of Pets _____
 Lived Out of Country?... Yes Locations _____

Signature of Parent or Guardian

Date

Nolensville Family Medicine
Pediatric Review of Systems
[For ages under 12]

Child's Name _____

Birth date _____

Review of Systems: Please circle any problems your child currently has or ever has had.

Thumb Sucking	Yes	No	Toilet Training Problems	Yes	No
Diarrhea or Constipation	Yes	No	Dental Problems	Yes	No
Irritable/ Temper Problems	Yes	No	Bed Wetting	Yes	No
Nightmare/ Sleep Problems	Yes	No	Eye Problems	Yes	No
Developmental Problems	Yes	No	Speech Problems	Yes	No
Has your child ever eaten dirt, paint, or plaster?	Yes	No	Hearing Problems	Yes	No
Does your child take vitamins, fluoride, iron or other supplements?	Yes	No	Was your child born more than two weeks late or two weeks early?	Yes	No
Feeding or Eating Problems	Yes	No	Child's Weight at Birth:	Lbs.	oz.
# of Meals each Day:			Type of Delivery:	Vaginal	C-Section
# of Snacks each Day:			Was/ is child breast-fed? Age Discontinued:	Yes	No
Does your child get along with other children?	Yes	No	Did the mother use any cigarettes, alcohol, drugs, or medication during pregnancy?	Yes	No
Is your child doing well in school/ daycare?	Yes	No	Emotional Problems	Yes	No
Discipline Problems	Yes	No	Alcohol/ Drug Abuse	Yes	No