AMEN CLINIC, P. C.

Date

Please answer the following questions prior to your first examination. It will help your physician to know about your health.

Name	Male Female	Date of Birth	Age	Religion
Occupation	Shift Worked Day Night Both		How Long	Education (Highest level attained)
Reason for visit?				Address Change Since Last Year Yes No

Personal Medical History (Check all that apply)

___Anemia	___Digestive Problems/Ulcers	___High Blood Pressure
___Arthritis/Gout	___Dizzy/Fainting Spells	___Bladder Problem
___Asthma/Pneumonia	___Frequent Urinary Infections	___Kidney/Prostrate Problems
___Back Problem	___Glaucoma/Cataracts	___Shortness of Breath
___Cancer	___Headaches	___STD's (Sexual Transmitted Diseases)
___Chest Pain/Pressure	___Heart Attack/Disease	___Stroke
___Depression	___Hemorrhoids	___Thyroid Problem
___Diabetes	___Hepatitis	___TB/Lung Disorders

Surgery History (Mark ones you have had and year)

___Amputation _____	___Gallbladder_____	___Stomach _____	___Ear Tubes _____
___Appendix_____	___Hernia _____	___Thyroid _____	___C Section _____
___Back _____	___Hemorrhoid _____	___Tonsils _____	_____ _____
___Breast _____	___Hysterectomy _____	___Tubal Ligation _____	
___Cataract _____	___Prostate _____	___Vasectomy _____	
___Heart Surg/Angioplasty _____	___Removal of Ovaries _____	___Other _____	

Women Only

___Abnormal PAP Smears	___Painful Intercourse	Menapause Yes No
___Bleeding Between Periods	___Vaginal Discharge	Start Date of Last Period _____
___Breast Lump	Age Periods Began_____	PAP Smear
___Extreme Menstrual Pain	Usual Duration (Days)_____	Mammogram
___Hot Flashes	Periods Regular Yes No	Are You Pregnant Yes No
___Nipple Discharge	Is Menstrual Flow Heavy Mod Light	Number of Preg ____ Num Children _____

Immunizations (Dates if Available)		**Health Habits**
___DPT _____	___OVP (Polio) _____	Alcohol
___Flu _____	___Pneumonia _____	Caffeine
___Hepatitis _____	___PPD _____	Drugs
___HIB _____	___Tetanus _____	Tobacco
___MMR _____	___Other_____	Exercise

Family History

Relationship	Health Problem	If Deceased, Cause and Age
Father		
Mother		
Father's Parents		
Mother's Parents		
Brother/Sister		

Meds/OTCs/Alternatives Meds (List dosage, frequency, years of usage)	**Allergies** (List medications food, or substances)

	Initial and date each review and update					
Provider Signature	Int	Int	Int	Int	Int	Int
	Date	Date	Date	Date	Date	Date

PATIENT HEALTH HISTORY — Clinic Name Center

Date

Please answer the following questions prior to your first examination. It will help your physician to know about your health.

Name	Male Female	Date of Birth	Age	Religion
Occupation	Shift Worked Day Night Both		How Long	Education (Highest level attained)
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___Appendix_____	___Hernia _____	___Thyroid _____	___C Section _____
___Back _____	___Hemorrhoid _____	___Tonsils _____	_____ _____
___Breast _____	___Hysterectomy _____	___Tubal Ligation _____	
___Cataract _____	___Prostate _____	___Vasectomy _____	
___Heart Surg/Angioplasty _____	___Removal of Ovaries _____	___Other _____	

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___HIB _____	___Tetanus _____	Tobacco
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Relationship	Health Problem	If Deceased, Cause and Age
Father		
Mother		
Father's Parents		
Mother's Parents		
Brother/Sister		

Meds/OTCs/Alternatives Meds (List dosage, frequency, years of usage)	**Allergies** (List medications food, or substances)

	Initial and date each review and update					
Provider Signature	Int	Int	Int	Int	Int	Int
	Date	Date	Date	Date	Date	Date

AMEN CLINIC, P. C.

Patient Information Sheet **Welcome to our Practice**

Please complete and sign: (attach copy of **insurance ID** card {and **drivers license** as required})

PATIENT INFORMATION (Please print)

First Name_____ MI _____ Last Name _____

Address_____ Appt # _____ City _____ State_____ Zip _____

Home Phone _____Marital Status Single Married Divorced Widowed Separated

Social Security # _____ Sex M F Date of Birth ___/___/_____ Age _____

Employer _____ Work Phone _____

Employer's Address_____City _____ State_____ Zip _____

Mother's Maiden Name _____ Student Status Full-Time Part-Time

Emergency Contact: Name _____ Relationship_____

Home Phone _____ Work Phone _____

RESPONSIBLE PARTY INFORMATION

If you are the responsible party, mark "self" and move down to "Insurance Information".

Patient's relationship to responsible party: Self Spouse Dependent SSN_____

First Name _____ MI _____ Last Name _____

Address _____ City _____ State _____ Zip _____

Marital Status Single Married Divorced Widowed Separated Sex M F

Date of Birth _____/____/_____ Age _____ Work Phone_____

Employer _____ Job Title _____

Employer's Address _____ City _____ State____ Zip _____

INSURANCE INFORMATION (Attach copy of insurance card)

Primary Insurance_____ Telephone number _____

Group / Policy Number_____ Subscriber / I.D. Number_____

Name of Card Holder_____ Card Holder Date of Birth_____

Effective Date _____ Deductible $_____ Co-Pay $_____

Secondary Insurance_____ Telephone number _____

Group / Policy Number_____ Subscriber / I.D. Number_____

Name of Card Holder_____ Card Holder Date of Birth_____

Effective Date _____ Deductible $_____ Co-Pay $_____

Referred by _____ Signature_____ Date_____

Problem List

Dx #	Date	**CHRONIC** Problems

Dx #	Date	**Acute** Problems

List Surgeries and Dates	List Hospitalizations and Dates

Medicine List (including OTCs and Alternative Meds)

Mark through or yellow out discontinued medicines

Dx#	Start Date	**MEDICATION**/Dosage/ Schedule	Stop Date	Dx#	Date Refill	**REFILLS**: (Drug/Number ordered)	Init

				Pharmacy:		**Telephone #**	

Patient Name/Label

Allergies:	**Do not reorder:**

Medicine List (including OTCs and Alternative Meds)

Mark through or yellow out discontinued medicines

Dx #	Start Date	MEDICATION/Dosage/Schedule	Stop Date	DX #	Date Refill	REFILLS: (Drug/Number ordered)	Init

Patient Name/Label

Patient's Name:
Insurance # (HICN)

ADVANCE BENEFICIARY NOTICE (ABN) NOTE: You need to make a choice about receiving these health care items or services.

We expect that your insurance will pay for the items or services that are described below. Some insurance companies do not pay for all of your health care costs. Your insurance only pays for covered items and services when your insurance rules are met. The fact that your insurance may not pay for particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**

. Ask us to explain, if you don't understand why your insurance probably won't pay.
. Ask us how much these items or services will cost you in case you have to pay for them yourself or through other insurance.

Please choose one option. Check one box. Sign & date your choice.

Option 1. YES. I want to receive these items or services. I understand that my insurance will not decide whether to pay unless I receive these items or services. Please submit my claim to my insurance. I understand that you may bill me for items or services and that I may have to pay the bill while my insurance is making its decision. If my insurance does pay, you will refund to me any payments I made to you that are due to me. If insurance denies payment, I agree to be personally and fully responsible for payment. That is, will pay personally; wither out of pocket or through any other insurance that I have. I understand I can appeal my insurance decision.

Option 2. NO. **I have decided not to receive these items or services.** I will not receive these items or services. I understand that you will not be able to submit a claim to my insurance and that I will not be able to appeal your opinion that my insurance won't pay.

NAME_____
DATE_____

Signature of patient or person acting on patient's behalf

NOTE: your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to my insurance your health information on this form may be shared with my

insurance. Your health information which my insurance sees will be kept confidential by insurance.
OMB Approval NO. 0938-0566 Form No. CMS-R131-G (June 2002)

Amen Clinic, P.C.
Patient Authorization Form
Advance Directives

Patient Authorization:

1. I consent to treatment necessary for the care of the below named patient.
2. I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable.
3. I allow fax transmittal of my medical records, if necessary.
4. I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.
5. In the event the charges incurred are not paid-in-full when due and collection action is instituted whether by collection agency, or attorney, or both; I agree to be responsible for and to pay in addition to the charges for services and treatment received all costs associated with such collection activity including, but not limited to, reasonable collection agency fees, attorneys fees, and court costs.
6. I further authorize and request that insurance payments be made directly to the provider.
7. I have read and fully understand the above consent for treatment and financial responsibility, release of medical information, and insurance authorization.
8. I agree with all the above with the exception of number _____.
9. I acknowledge full financial responsibility for services rendered by Amen Clinic, P.C.

_____ _____
Patient (or Guardian) Signature Date

_____ _____
Witness Date

Advanced Directives:

Do you have a living will or durable power of attorney? ☐ Yes ☐ No

If you do have a durable power of attorney, please identify: _____

Would you like a packet of information on Advance Directives: **(Please check yes or no)**

☐ Yes (Packet distributed) ☐ No

_____ _____
Patient Signature Date

_____ _____

Witness Date

PATIENT NAME:	Birth Date:	SS No. (optional)	
	Other Names Known By:		

INFORMATION BEING RELEASED BY: Amen Clinic, P.C.

Release Records To:	Address:	City:	
	Telephone #:	State:	Zip:

Purpose of Disclosure: **Medical Care** **Insurance** **At the Request of the Patient**
Other, Please Explain:

DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED:

Dates of Treatment:	**Place of Treatment:** Inpatient Emergency Room Outpatient Clinic Other (specify):

I understand that:

1. ~~**I may revoke this authorization in writing at any time, but if I do so, it will not have any effect on any actions taken**~~ **by the facility releasing the information (hereafter referred to as "the facility") prior to the facility's receiving the revocation. Further details regarding the manner in which this authorization may be revoked may be found in the facility's Notice of Privacy Practices.**
2. **This authorization allows the facility to release the above indicated documents in my medical record, including those copies from other health care facilities and providers as requested. The released information may no longer be protected by federal privacy regulations and may be redisclosed.**
3. **Any disclosure of records concerning diagnosis and/or treatment of alcohol and/or drug abuse is covered by Title 42 CFR, and if there is any such information, I hereby authorize the release of information. This authorization also includes any information related to diagnosis and/or treatment of any psychiatric or mental illness or any state of infection with the HIV (AIDS) virus.**
4. The facility is hereby released from any liability and the undersigned will hold the facility harmless for complying with this authorization.
5. The facility will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization, except for research related purposes and as otherwise permitted under applicable law.
6. The authorization will expire in ninety (90) days unless I provide an alternate expiration date or event. This authorization will not apply to any dates of service that occur after the date this authorization is signed.
7. If the facility will use or disclose my protected health information for marketing purposes, the facility will not receive remuneration or compensation for such use or disclosure for marketing purposes unless The Family Clinic Privacy Coordinator completes and signs the following statement:

I, _____ (signature of **Amen Clinic, P.C.** Privacy Coordinator) hereby certify that the facility will receive remuneration or compensation for the use or disclosure of this patient's protected health information from _____ (fill in source of remuneration or compensation).

~~I have read and understood this authorization. I hereby authorize the release, use, and disclosure of the above~~ requested protected health information about me.

_____ _____

Signature of Patient **Signature of Patient's Authorized Representative**

Date

Telephone # _____

_____

Description of Representative's Authority to Act for Patient

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION **FROM** ANOTHER FACILITY

PATIENT NAME:	**Birth Date:**	**SS No. (optional)**	
	Other Names Known By:		
Person/Organization Authorized to Disclose Protected Health Information:			
Release Records To: Amen Clinic P.C. Attention: _____	**Address: 150 Murray Guard Dr**	**City: Jackson**	
	Telephone #: 731-300-3168 **Fax #: 731-300-3169**	**State: TN**	**Zip: 38305**
Purpose of Disclosure:	**Medical Care Insurance At the Request of the Patient** **Media, Public Relations, Marketing, Advertising, Posting, or Radio Broadcasting** **Other, Please Explain:**		
Description of Information to be Used or Disclosed:			
Dates of Treatment:	Place of Treatment**:**		

Choose From the Following:

All Dictated Reports & Physical	Lab (may include AIDS/HIV information)		History
Radiology Reports	Pertinent Summary	Discharge Summary	
Pathology Reports			
ER Record	Consultation	Anesthesia Record	Billing Record
Operative/Procedure Report	Entire Chart	Photographs/Images	Other (specify):

I understand that:

1. **I may revoke this authorization in writing at any time by notifying in writing the person/organization providing or disclosing the information. However, if I revoke this authorization, it will not have any effect on any actions taken by the person/organization providing, disclosing, or receiving the information prior to receiving the revocation, nor shall it be valid to the extent that the disclosing person/organization or receiving organization has taken action in reliance on this authorization.**
2. This authorization allows **Amen Clinic, P.C.** to obtain any and all documents in my medical record including those copies from other health care facilities and providers. I understand that the information that is released or provided may be re-disclosed and no longer protected by federal privacy regulations.
3. Any disclosure of records concerning diagnosis and/or treatment of alcohol and/or drug abuse is covered by Title 42 CFR, and if there is any such information, I hereby authorize the release of information. This authorization also includes any information related to diagnosis and/or treatment of any psychiatric or mental illness or any state of infection with the HIV (AIDS) virus.
4. **Amen Clinic, P.C.** is hereby released from any liability and the undersigned will hold **Amen Clinic, P.C.** harmless for requesting or seeking my protected health information.
5. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal will affect my ability to obtain treatment, receive payment, or eligibility for benefits.
6. The authorization will expire in ninety (90) days unless I provide an alternate date or event. This authorization will not apply to any dates of service that occur after the date this authorization is signed.
7. A facsimile of this authorization or a copy of this authorization shall be valid and binding with the same force as an original signature, and the person/organization releasing the information shall be entitled to rely on the same.

I have read and understood this authorization. I hereby authorize the release of the above-requested medical information about me to **Amen Clinic, P.C.** from the facility named above.

_____

_____

Signature of Patient **Signature of Patient's Authorized Representative**

_____ _____ _____

_____

Telephone Number to Act for Patient **Date** **Description of Representative's Authority**

Amen Clinic, P.C.

Acknowledgment of Receipt of Notice of Privacy Practices

By signing this document, I acknowledge that I have received a copy of Clinic's Joint Notice of Privacy Practices.

_____

Name (Print)

_____ _____

Signature (Relation, if other than patient) Date

Patient unable to sign/ No family available

Patient refused to sign

Other: _____

Employee Signature: _____

Clinic Name Use Only (Do not write below this line)

Date acknowledgment mailed: _____

Date acknowledgment received: _____