ONE STOP FAMILY CLINIC LLC
2994 S. Church St., Murfreesboro, TN 37127 P: 615-900-4045 F: 615-900-4059
www.onestopfamilyclinic.com

Registration Form

Patient Information

Last: _____ First: _____ Preferred Name: _____ Middle: _____

Sex: □ Male □ Female Date of Birth: _____/_____/_____ SS#: _____/_____/_____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (H)_____(C)_____ (W)_____

Email address: _____ (*You will get an invitation for the patient portal*)

Contact Preference: □ Home Phone □ Mobile Phone □ Work Phone □ Email or patient portal

Language: □ English □ Spanish □ Other _____

Race: □ White/Caucasian □ Black/African American □ Native Hawaiian or other Pacific Island □ Asian

□ American Indian/Alaska Native □ Other _____

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Other _____

Marital Status: □ Married □ Single □ Divorced □ Widowed □ Legally Separated □ Other

Emergency Contact: _____ Relationship to Patient: _____

Phone: (H)_____(C)_____ (W)_____

***If under age 18*, list the Names of Child's Parents/Guardians Below:**

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Employer Information

Patients Employer: _____ Occupation: _____

Address: _____City: _____ State: _____ Zip: _____

Responsible Party Information: (If other than yourself) ****Statements will be addressed to the Responsible Party****

Responsible Party Name: Last: _____ First: _____ Middle: _____

Sex: □ Male □ Female Date of Birth: _____/_____/_____ SS#: _____/_____/_____

Address: _____ City: _____ State: ____ Zip: _____

Phone: (H)_____(C)_____ (W)_____

Primary Insurance: _____ Name of Subscriber: _____

Subscriber's date of birth: ____/_____/_____ SSN:_____ Relationship to Patient: _____

Secondary Insurance:_____ Name of Subscriber: _____

Subscriber's date of birth: ____/_____/_____ Relationship to Patient: _____

WOULD YOU LIKE TO SEE US TO ESTABLISH PRIMARY CARE? □ YES □ NO, JUST WALK-IN SERVICES

HOW DID YOU HEAR ABOUT US? □ Signage □ Mills Family Pharmacy customer □ Word of Mouth □ Facebook □Website

□ Advertising _____ □ Other _____

Preferred Pharmacy (Name & Street): _____

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CONSENTS AND CONDITONS

I authorize One Stop Family Clinic, LLC to furnish information to insurance carriers concerning my care. I agree to pay One Stop Family Clinic, LLC for all services rendered to my dependents or myself.

SELF-PAY PATIENTS will be required to pay for your office visit before you are seen. However, you are responsible for any additional cost related to the visit. Federal Law requires that we bill every patient the same amount. We are not allowed to change billing based on whether or not patients have insurance.

INSURANCE PATIENTS – IT IS YOUR RESPONSBILITY TO:

- Provide a Credit Card/Debit card for authorization.
- Provide us with updated and current insurance information at each visit.
- Provide us with updated contact information including phone numbers and address.
- Pay your deductible and/or copay at the time of service.
- Pay any services not covered by your insurance.
- Make sure you have a current referral if your insurance requires one.

As a courtesy to our patients we will file all claims with your insurance carrier and provide them with any information necessary to process the claim. Once we receive an EOB from your insurance company, we will bill your card for the remaining amount you owe up to the amount you authorized at the time of service. If the amount you authorized does not cover the total amount due, we will then send you a statement. **YOU ARE RESPONSBILE FOR ALL SERVICES RENDERED – IF (FOR ANY REASON) YOUR INSURANCE DOES NOT PAY- THE BALANCE IS YOUR RESPONSIBILITY.**

If the insurance company denies your claim, stating you are not eligible or your coverage has terminated, your credit card/debit card that was authorized at the time of service will be charged for the authorized amount. If you have new insurance, we will file your claim to your new insurance company. However, no refunds will be issued until payment is received by the insurance company.

UNPAID BILLS – A collection agency will be chosen to manage delinquent accounts. Once referred to collections, no assistance will be provided by our office. If your account is placed with a collection agency, you will be responsible for all collections and attorney's fees necessary to collect this debt.

MEDICARE PATIENT CERTIFICATION AND ASSIGMENT OF BENEFIT. I certify that any information I provide in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I authorized payment of authorized benefits to be made on my behalf to all treating and consulting providers at One Stop Family Clinic, LLC by the Medicare or Medicaid program.

I authorize One Stop Family Clinic, LLC practitioners to provide treatment that they may deem advisable for my dependents and me. I understand that these services are voluntary and I have the right to refuse these services. In the event of a life-threatening emergency, I consent for the provider to administer emergency treatment. I authorize One Stop Family Clinic, LLC to conduct urine drug screens as part of my assessment per the office policy. I authorize One Stop Family Clinic, LLC to obtain any previous medical records, for my dependents or myself, including lab and imaging results, if my providers feel it is necessary for the care of my dependents or me.

I authorized to download the medication history automatically from Pharmacy Benefit Manager (PBMs). I authorized to receive automated phone calls from One Stop Family Clinic, LLC, phones calls may be about appointments, test results, and more.

I acknowledge that I have received One Stop Family Clinic, LLC's Notice of Privacy Practices. I recognized the information gathered by One Stop Family Clinic, LLC may need to be disclosed or obtained to/from a third party for purpose of administration, prescription history, treatment, payment, and other healthcare operations. I consent to such release.

I have read and understand the above items regarding insurance, finance, responsibility, authorization of charges, consent, and medical records and agree to the terms and conditions related to each item.

_____ _____/_____/_____
Patient Name (Please Print) **Date of Birth**

_____ _____/_____/_____
Patient or Responsible Party Signature **Today's Date**

_____
Relationship to Patient

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One Stop Family Clinic, LLC

HIPAA/Permission Form

The Health Insurance Portability and Accountability Act (HIPPA) require One Stop Family Clinic, LLC to notify patients regarding how their Protected Health Information is handled. Our HIPPA policy is posted in the Lobby. You have the right to review policy and take a copy of the policy. With your permission, we may disclose your Protected Health Information to a family member, close friend, or any other person that you identify.

I, _____, authorize One Stop Family Clinic, LLC to release any personal information relating to my health care.

To: _____ Relationship to patient: _____

To: _____ Relationship to patient: _____

To: _____ Relationship to patient: _____

To: _____ Relationship to patient: _____

CHECK BOX IF APLICABLE:

☐ OK to leave a message with personal health information on voicemail

☐ OK to send text messages pertaining to your health care

I have reviewed the HIPPA Notice of Privacy Practices for One Stop Family Clinic, LLC. I hereby acknowledge that I am familiar with and understand the terms of this policy.

Print Patient Name: _____ Date of Birth: _____/_____/_____

Patient / Guardian Signature: _____

Date: _____/_____/_____

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Patient Medical, Surgical, Social & Family History

Medical Providers

Primary Care Provider (PCP) name: _____ Phone: _____

Would you like us to be your Primary Care Provider (PCP)? □Yes □No

Do you see a medical specialist? □Yes □No If yes, please indicate the reason: _____

Allergies to medications? □No □Yes (medicine & reaction) _____

List all Current Medications OR provide us a list to copy (include prescriptions, OTC, hormones, herbal remedies)

Medication	Dosage	How taken? (once per day, at bedtime, etc.)	Why do you take this medication?

Preferred Pharmacy (Name & Address): _____

Patient Health History □ No History of Illness

□ ADD/ADHD
□ AIDS/HIV
□ Abuse/Domestic Violence
□ Allergies/Hayfever
□ Anemia
□ Anesthesia complications
□ Anxiety disorder
□ Arthritis
□ Asthma
□ Autism Spectrum Disorder (ASD)
□ Bedwetting
□ Birth defects/Inherited disease
□ Bladder/Kidney disorder
□ Blood disorder
□ Blood Transfusion
□ Breast Cancer/problem
□ COPD
□ Cancer
□ Chicken Pox
□ Chronic Ear Infections
□ Congestive Heart Failure (CHF)
□ Constipation
□ Coronary Artery Disease (CAD)
□ Depression
□ Diabetes
□ Difficulty Swallowing
□ Diverticulitis
□ Eating Disorder
□ Eczema
□ Fibromyalgia
□ GERD/acid reflux
□ GI problems
□ Gout
□ Headaches
□ Hearing problems
□ Heart disease
□ Heart problems
□ Hepatitis____
□ High Cholesterol
□ High blood pressure/hypertension
□ Hospitalizations
□ Hyper or Hypo Thyroid
□ Infertility
□ Kidney Stones/disease
□ Lung disease
□ MRSA exposure
□ Meniere's Disease
□ Mental Disorder/Illness
□ Muscle, Joint, Bone problems
□ Obesity
□ Osteoporosis
□ Ovarian Cancer
□ Polyps
□ Pre-Eclampsia
□ Pulmonary Embolism
□ Seizure disorder
□ Skin problems
□ Stroke
□ Thrombophilias
□ Tuberculosis
□ Varicosities
□ Vision/Eye problems
Other: _____

For women only

Date of last menstrual period: ____/_____/_____ Date of last pap: ____/_____/____ Abnormal results? □Yes □No

Date of last mammogram: ____/____/_____ Menopause reached? □Yes □No Birth control method: _____

#of Pregnancies: _____ #of C-sections: _____ #of vaginal deliveries: _____ #of miscarriages:_____ # of abortions: _____

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Health Maintenance

Date of last complete physical: ____/____/_____ Last EKG: ____/____/_____ Last tetanus shot: ____/____/_____

Last cholesterol check: ____/____/____ Last dental exam: ____/____/_____ Last colonoscopy: ____/____/_____

Last bone density test: ____/____/_____ Other: _____ ____/____/_____

Patient Surgical History (List year of surgery) □ No History of Surgeries

□ Appendix removed _____
□ Artificial joints _____
□ C-section _____
□ D & C _____
□ Ear tubes _____
□ Gallbladder removed _____
□ Hernia repair _____
□ Hysterectomy (partial or total) _____
□ Mastectomy (uni or bilateral) _____
□ Pacemaker _____
□ Pins/Plates inserted & location _____
□ Spleen removed _____
□ Thyroid removal _____
□ Tonsils removed _____
□ Tubal ligation _____
□Other: _____

Family Health History

Health Problem/Issue	Father (F), Mother (M), Sister (S), Brother (B)	Living (L) or Deceased (D)	Age & cause of death
Arthritis (list type)			
Cancer (list type)			
Diabetes (Type I or II)			
Heart Attack			
Heart Disease			
Hypertension (High blood pressure)			
Mental Illness/Anxiety Disorder			
Stroke			
Other (list type)			
Other (list type)			
Other (list type)			

Social History

Alcohol use? □ No □Yes: Average amount: _____/ Day Week Month Year

Tobacco use? □ No □ Yes: How many Packs per Day_____ Smokeless Tobacco? □ Yes □ No

Recreational Drug Use? □ No □ Yes: please list _____

Caffeine (soda, tea, coffee)? □ No □ Yes: Average amount: _____/ Day Week Month Year

Do you have a living will, durable power of attorney, or advanced directives? □ Yes □ No

Please list any other information that you feel your health care provider should know: _____

_____

Name of person documenting above medical history**:** (if other than patient): _____

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PLEASE CHECK THE SYMPTOMS YOU HAVE EXPERIENCED RECENTLY PERTAINING TO TODAY'S VISIT:

CONSTITUTIONAL:
□ Fever
□ Chills
□ Night sweats
□ Change in appetite
□ Fatigue
□ Weight loss
□ Weight gain

CARDIOVASCULAR
□ Chest pain/pressure
□ Fainting
□ Palpitations/fluttering
□ Leg swelling

NEUROLOGIC:
□ Headache
□ Lightheadedness
□ Loss of consciousness
□ Weakness
□ Numbness/tingling
□ Poor balance

PSYCHIATRIC
□ Anxiety
□ Depression
□ Sleep difficulties

LYMPH
□ Easy bleeding
□ Easy bruising
□ Frequent infections
□ Swollen/painful nodes/glands