Tupelo Medical Group
Tupelo, Mississippi

PATIENT INFORMATION SHEET

Acct Number _____

Patient Information

Your Doctor _____ Referring Doctor _____

Last Name | First Name | Middle | Preferred/Nickname

Maiden Name _____ Circle Mr. Ms. Mrs. Miss | Date of Birth | Sex | Social Security #

RACE:
___White
___Black/African American
___American Indian/Alaska Native
___Asian
___Native Hawaiian/Pacific Islander
___Multiracial

Marital Status | Drivers License | Emergency Contact | Phone #

ETHNICITY: ____Hispanic ____Non Hispanic LANGUAGE: ____English ____Spanish ____Japanese ____Other

Address Information

Address | City/State/Zip | County

Phones

Home | Work | Cell | Fax | Preferred Phone #

Email Address

Please Circle Preferred Method of Contact:
Home Work Cell Email

Other Information

Employer Name | Status | Occupation | Phone/Ext | Hire Date

Address

Insurance Information (please give card to receptionist)

Primary Insurance Carrier (including Medicare)

Insurance Company | Policy Number | Group Number

Policy Holder's Name | Employer | Social Security # | Date of Birth

Effective Dates: | Start Date | End Date | Relationship to Patient | Phone

Secondary Insurance Carrier (please give card to receptionist)

Insurance Company | Policy Number | Group Number

Policy Holder's Name | Employer | Social Security # | Date of Birth

Effective Dates: | Start Date | End Date | Relationship to Patient | Phone

For TMG Use Only
HIPAA ____
Consent ____

Signature | Date

(Continued on Back)

TUPELO MEDICAL GROUP
FINANCIAL POLICY

You will receive important forms that must be completed prior to seeing the doctor in order to provide the highest quality care. Please complete these forms as accurately as you can.

FEES: Fees are considered to be those prevailing in this medical community for the services of internal medicine. We are happy to discuss fees with you and an estimate for any procedure will be given when requested.

PAYMENT: We request payment for your share of office charges at the time of service. This can vary from a stated dollar amount for your co-pay or a percentage of the total charges. You may pay by check, cash, debit cards, American Express, Discover, Visa or MasterCard. **If your insurance claim has not been paid within 60 days, the entire amount of your bill will be due from you.** You may wish to contact your insurer at that time. We will be happy to assist you in following up with your insurer, but you are responsible for payment of your account. If you are self-pay, you will be expected to pay for your services in full at the time of service.

INSURANCE: If we have your correct primary and supplemental insurance information, we will file it as a courtesy, but you will be responsible for payment of the deductibles and co-insurance. It is your responsibility to notify us when your insurance information changes.

IT SHOULD BE UNDERSTOOD THAT YOUR INSURANCE POLICY IS AN AGREEMENT BETWEEN YOU AND YOUR INSURANCE COMPANY TO PAY A CERTAIN AMOUNT FOR MEDICAL CARE. YOUR PHYSICIAN'S BILL IS AN AGREEMENT BETWEEN YOU AND YOUR PHYSICIAN. YOU ARE RESPONSIBLE FOR FULL PAYMENT FOR MEDICAL SERVICES THAT WE PROVIDE, REGARDLESS OF THE STATUS OF YOUR INSURANCE CLAIM.

We are network providers with certain insurance companies. Please check with your insurance company to ensure your doctor is a network provider. While we do honor fee schedules with network providers, you are ultimately responsible for the FULL payment of your account and for questioning your insurance company about delays in payment and the amounts they pay.

If you have any questions about payment options or financial responsibilities, please contact our Billing Department (662) 840-2131.

_____ _____

Signature Date

Tupelo Medical Group, LLC does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, participation in its programs, services, and activities, or employment.

HEALTH HISTORY

(Confidential)

Name _____ Today's Date _____

Age _____ Birthdate _____ Date of last physical examination _____

What is your reason for visit? _____

SYMPTOMS Check (✔) symptoms you currently have or have had in the past year.

GENERAL

- ❒ Chills
- ❒ Depression
- ❒ Dizziness
- ❒ Fainting
- ❒ Fever
- ❒ Forgetfulness
- ❒ Headache
- ❒ Loss of sleep
- ❒ Loss of weight
- ❒ Nervousness
- ❒ Numbness
- ❒ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- ❒ Arms
- ❒ Back
- ❒ Feet
- ❒ Hands
- ❒ Hips
- ❒ Legs
- ❒ Neck
- ❒ Shoulders

GENITO-URINARY

- ❒ Blood in urine
- ❒ Frequent urination
- ❒ Lack of bladder control
- ❒ Painful urination

GASTROINTESTINAL

- ❒ Appetite poor
- ❒ Bloating
- ❒ Bowel changes
- ❒ Constipation
- ❒ Diarrhea
- ❒ Excessive hunger
- ❒ Excessive thirst
- ❒ Gas
- ❒ Hemorrhoids
- ❒ Indigestion
- ❒ Nausea
- ❒ Rectal bleeding
- ❒ Stomach pain
- ❒ Vomiting
- ❒ Vomiting blood

CARDIOVASCULAR

- ❒ Chest pain
- ❒ High blood pressure
- ❒ Irregular heart beat
- ❒ Low blood pressure
- ❒ Poor circulation
- ❒ Rapid heart beat
- ❒ Swelling of ankles
- ❒ Varicose Veins

EYE, EAR, NOSE THROAT

- ❒ Bleeding gums
- ❒ Blurred vision
- ❒ Crossed eyes
- ❒ Difficulty swallowing
- ❒ Double vision
- ❒ Ear ache
- ❒ Ear discharge
- ❒ Hay fever
- ❒ Hoarseness
- ❒ Loss of hearing
- ❒ Nosebleeds
- ❒ Persistent cough
- ❒ Ringing in ears
- ❒ Sinus problems
- ❒ Vision - Flashes
- ❒ Vision - Halos

SKIN

- ❒ Bruise easily
- ❒ Hives
- ❒ Itching
- ❒ Change in moles
- ❒ Rash
- ❒ Scars
- ❒ Sores that won't heal

MEN only

- ❒ Breast lump
- ❒ Erection difficulties
- ❒ Lump in testicles
- ❒ Penis discharge
- ❒ Sore on penis
- ❒ Other

WOMEN only

- ❒ Abnormal Pap Smear
- ❒ Bleeding between periods
- ❒ Breast lump
- ❒ Extreme menstrual pain
- ❒ Hot flashes
- ❒ Nipple discharge
- ❒ Painful intercourse
- ❒ Vaginal discharge
- ❒ Other

Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children? _____

CONDITIONS Check (✔) conditions you have or have had in the past

- ❒ AIDS
- ❒ Alcoholism
- ❒ Anemia
- ❒ Anorexia
- ❒ Appendicitis
- ❒ Arthritis
- ❒ Asthma
- ❒ Bleeding Disorders
- ❒ Breast Lump
- ❒ Bronchitis
- ❒ Bulemia
- ❒ Cancer
- ❒ Cataracts
- ❒ Chemical Dependency
- ❒ Chicken Pox
- ❒ Diabetes
- ❒ Emphysema
- ❒ Epilepsy
- ❒ Glaucoma
- ❒ Goiter
- ❒ Gonorrhea
- ❒ Gout
- ❒ Heart Disease
- ❒ Hepatitis
- ❒ Hernia
- ❒ Herpes
- ❒ High Colesterol
- ❒ HIV Positive
- ❒ Kidney Disease
- ❒ Liver Disease
- ❒ Measles
- ❒ Migraine Headaches
- ❒ Miscarriage
- ❒ Mononucleosis
- ❒ Multiple Sclerosis
- ❒ Mumps
- ❒ Pacemaker
- ❒ Pneumonia
- ❒ Polio
- ❒ Prostate Problem
- ❒ Psychiatric Care
- ❒ Rheumatic Fever
- ❒ Scarlet Fever
- ❒ Stroke
- ❒ Suicide Attempt
- ❒ Thyroid Problems
- ❒ Tonsillitis
- ❒ Tuberculosis
- ❒ Typhoid Fever
- ❒ Ulcers
- ❒ Vaginal Infections
- ❒ Venereal Disease

MEDICATIONS List medications you are currently taking	**ALLERGIES** To medications or substances

(All Information is strictly confidential)

FAMILY HISTORY Fill in health information about your family

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✔) if your blood relatives had any of the following: Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ❒ Yes ❒ No

If yes, please give approximate dates._____

SERIOUS ILLNESS/INJURIES DATE OUTCOME

IMMUNIZATIONS: Type & Date

PREGNANCY HISTORY

Year of Birth	Sex of Birth	Complications if any

HEALTH HABITS Check (✔) which and how often

	Caffeine
	Tobacco
	Drugs
	Alcohol
	Other
	Exercise

OCCUPATIONAL CONCERNS

Check (✔) if your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your occupation:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Signature Date

_____ _____

Reviewed By Date

Tupelo Medical Group

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

Effective Date: September 23, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Tupelo Medical Group LLC ("Provider" or "we") is dedicated to protecting your health information. Provider is required by law to maintain the privacy of protected health information, to provide you adequate notice of your rights and our legal duties and privacy practices with respect to protected health information and to notify affected individuals following a breach of unsecured protected health information. [45 CFR § 164.520] "Protected Health Information" is defined at 45 CFR § 164.501 and includes past, present and future information created or received by Provider. It also includes demographic information that may identify you and that relates to your past, present or future medical condition (physical or mental), the providing of health care to you, or payment for the health care treatment. We will use or disclose Protected Health Information in a manner that is consistent with this notice.

WHAT IS THIS NOTICE?

Provider participates in North Mississippi Medical Center's GE Centricity community/shared health record and also maintains paper health records for patients treated prior to August 2011, subject to Provider's record retention policy. This health record includes the information Provider receives and collects about you and the care we provide to you, such as, without limitation, physicians' orders, assessments, medication lists, clinical progress notes and billing information. This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights regarding your Protected Health Information.

As required by law, Provider maintains policies and procedures about its work practices, including how we coordinate care and services provided to our patients. These policies and procedures include how we create, receive, access, transmit, maintain and protect the confidentiality of all health information in our workforce and with contracted business associates and/or subcontractors; how we provide security of our building and electronic files; and how we educate staff on privacy of patient information.

PERMITTED AND REQUIRED USES AND DISCLOSURES

As our patient, information about you may be used and disclosed to other parties for purposes of **treatment, payment and health care operations** without obtaining your written authorization. Examples of information that may be disclosed:

1. **Treatment**: Providing, coordinating or managing health care and related services, consultation between health care providers relating to a patient or referral of a patient for health care from one provider to another. For example, individual providers confer with you or your designated caregiver to coordinate care and to make referrals.
2. **Payment**: Billing and collecting for services provided, determining plan eligibility and coverage, utilization review (UR), precertification, and medical necessity review. For example, occasionally the insurance company requests a copy of the medical record be sent to them for a coverage review prior to paying the bill.
3. **Health Care Operations**: General Provider administrative and business functions; quality assurance/improvement activities; medical review; auditing functions; developing clinical guidelines; determining the competence or qualifications of health care professionals; evaluating Provider performance; conducting training programs with students or new employees; licensing, survey, certification, accreditation and credentialing activities; internal auditing; and certain fundraising activities, if applicable; and with your authorization, marketing activities. For example, Provider periodically holds clinical record review meetings where Registered Health Information Technicians, employed by Tupelo Medical Group, provide results of auditing of clinical records for meeting professional standards and utilization review.
4. **Appointment Reminders**: We may use and disclose Protected Health Information to remind that you have an appointment for medical care.

The following uses and disclosures do not require your consent, and include, but are not limited to, a release of information contained in financial records and/or medical records, including information concerning communicable diseases such as Human Immune Deficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), drug/alcohol abuse, psychiatric diagnosis and treatment records and/or laboratory test results, if applicable, medical history, treatment progress and/or any other related information as permitted by state law to:

1. Your insurance company, self-funded or third-party health plan, Medicare, Medicaid or any other person or entity that may be responsible for paying or processing for payment any portion of your bill for services;
2. Any person or entity affiliated with or representing us for purposes of administration, billing and quality and risk management;
3. Any hospital, nursing home or other health care facility to which you may be admitted;
4. Any assisted living or personal care facility of which you are a resident;
5. Any physician providing you care;
6. Licensing and accrediting bodies;
7. You to raise funds for Provider. You will be given the right to opt out of receiving such communications, if applicable;
8. Any business associate or institutionally related foundation for the purpose of raising funds for Provider (information may include: demographics – name, address, contact information, age, gender, date of birth; dates of health care provided; department of services; treating physician; outcome information; and health insurance status), if applicable. You will be given the right to opt out;
9. You regarding refill reminders for drugs, biologicals and/or drug delivery systems that have already been prescribed to you;
10. You with marketing communications promoting health products, services and information programs or communications if the communication is made face to face with you or the only financial gain consists of a promotional gift of nominal value provided by Provider; and
11. Other health care providers to initiate treatment.

We are permitted to use or disclose information about you without consent or authorization in the following circumstances:

1. In **emergency treatment situations**, if we attempt to obtain consent as soon as practicable after treatment;
2. Where **substantial barriers to communicating with you** exist and we determine that the consent is clearly inferred from the circumstances;
3. Where we are **required by law** to provide treatment and we are unable to obtain consent;
4. Where the use or disclosure of medical information about you **is required by federal, state or local law**;
5. To provide information **to state or federal public health authorities**, as required by law to: prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify persons of recalls of products they may be using; notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence (if you agree or when required or authorized by law);
6. **For health care oversight activities** such as audits, investigations, inspections and licensure by a government health oversight agency as authorized by law to monitor the health care system, government programs and compliance with civil rights laws;
7. **To business associates** regulated under HIPAA that work on our behalf under a contract that requires appropriate safeguards of Protected Health Information;
8. **In certain judicial administrative proceedings** if you are involved in a lawsuit or a dispute. We may disclose medical information about you in response to a court or administrative order, a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested;
9. **For certain law enforcement purposes** such as helping to identify or locate a suspect, fugitive, material witness or missing person, or to comply with a court order or subpoena and other law enforcement purposes;

10. **To coroners, medical examiners and funeral directors**, in certain circumstances, for example, to identify a deceased person, determine the cause of death or to assist in carrying out their duties;
11. **For cadaveric organ, eye or tissue donation purposes** to communicate to organizations involved in procuring, banking or transplanting organs and tissues (if you are an organ donor);
12. **For certain research purposes** under very select circumstances. We may use your health information for research. Before we disclose any of your health information for such research purposes, the project will be subject to an extensive approval process. We may also request your written authorization before granting access to your individually identifiable health information;
13. **To avert a serious threat to health and safety**: To prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public, such as when a person admits to participation in a violent crime or serious harm to a victim or is an escaped convict. Any disclosure, however, would only be to someone able to help prevent or lessen the threat;
14. **For specialized government functions**, including military and veterans' activities, national security and intelligence activities, protective services for the President, foreign heads of state and others, medical suitability determinations, correctional institution and custodial situations; and
15. **For Workers' Compensation purposes**: Workers' compensation or similar programs provide benefits for work-related injuries or illness.

We are permitted to use or disclose information about you provided you are informed in advance and given the opportunity to individually agree to, prohibit, or restrict the use or disclosure in the following circumstances:

1. To use or disclose in a Provider directory (your name, location, condition described in general terms and/or religious affiliation) when you are receiving treatment at Provider;
2. To provide proof of immunization to a school that is required by state or other law to have such proof with agreement to disclosure by parent, guardian or other person acting in loco parentis of the individual, if the individual is an unemancipated minor; and
3. To provide a family member, relative, friend, or other identified person, prior to, or after your death, the information relevant to such person's involvement in your care or payment for care; to notify a family member, relative, friend, or other identified person of your location, general condition or death.

Other uses and disclosures not covered in this notice will be made only with your written authorization. Authorization is required and may be revoked, in writing, at any time, <u>except in limited situations</u>, for the following disclosures:

1. Marketing of products or services or treatment alternatives, including any subsidized treatment communications, that may be of benefit to you when we receive direct payment from a third party for making such communications, other than as set forth above with regard to face-to-face communications and promotional gifts of nominal value;
2. Psychotherapy notes under most circumstances, if applicable; and
3. Any sale of Protected Health Information resulting in financial gain by Provider unless an exception is met.

<u>YOUR RIGHTS</u>

You have the right, subject to certain conditions, to:

1. **Request restrictions on uses and disclosures of your Protected Health Information** for treatment, payment or health care operations. Except as stated below, we are not required to agree to any requested restriction. Restrictions to which we agree will be documented. Agreements for further restrictions may, however, be terminated under applicable circumstances (e.g., emergency treatment).
   We must agree to your request to restrict disclosure of Protected Health Information about you to a health plan if: 1) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and 2) the Protected Health Information pertains solely to a health care item or service for which you or someone on your behalf paid the covered entity in full. (164.522 Rights to request privacy protection for Protected Health Information).
2. **Confidential communication of Protected Health Information**. We will arrange for you to receive Protected Health Information by reasonable alternative means or at alternative locations. Your request must be in writing. We do not require an explanation for the request as a condition of providing communications on a confidential basis and will attempt to honor reasonable requests for confidential communications.
   If you request your Protected Health Information to be transmitted directly to another person designated by you, your written request must be signed and clearly identify the designated person and where the copy of Protected Health Information is to be sent.
3. **Inspect and obtain copies of Protected Health Information** that is maintained in a designated record set, except for psychotherapy notes, information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding, or Protected Health Information that may not be disclosed under the Clinical Laboratory Improvements Amendments of 1988 *[42 USC § 263a and 45 CFR 493 § (a)(2)].* If you request a copy of your health information, we will charge a reasonable, cost-based fee, that includes only the cost of labor for copying, supplies, postage, if applicable, and preparing an explanation or summary of the Protected Health Information if agreed to, in accordance with applicable state and federal regulations. If the requested Protected Health Information is maintained electronically and you request an electronic copy, we will provide access in an electronic format you request, if readily producible, or if not, in a readable electronic form and format mutually agreed upon. IF YOU REQUEST AN ELECTRONIC COPY, PROVIDER HEREBY EXPRESSLY DISCLAIMS ALL DUTIES AND RESPONSIBILITY FOR THE SECURITY AND PROTECTION OF SUCH INFORMATION ONCE TRANSMITTED TO YOU AND HAS NO CONTROL OVER ACCESS TO THAT INFORMATION AFTER THE TRANSMISSION TO YOU THEREOF. ALL PROTECTED HEALTH INFORMATION MAINTAINED BY PROVIDER WILL CONTINUE TO BE SECURED AND PROTECTED AS REQUIRED BY APPLICABLE LAW.
   If we deny access to Protected Health Information, you will receive a timely, written denial in plain language that explains the basis for the denial, your review rights and an explanation of how to exercise those rights. If we do not maintain the medical record, we will tell you where to request the Protected Health Information if we have knowledge thereof.
4. **Request to amend Protected Health Information** for as long as the Protected Health Information is maintained in the designated record set. A request to amend your record must be submitted in writing using Provider's PHI Amendment Form and must include a reason to support the requested amendment. We will act on your request within sixty (60) days of receipt of the request. We may extend the time for such action by up to thirty (30) days, if within the initial sixty (60) days we provide you with a written explanation of the reasons for the delay and the date by which we will complete action on the request.
   We may deny the request for amendment if the information contained in the record was not created by us, unless you provide a reasonable basis for believing the originator of the information is no longer available to act on the requested amendment; is not part of the designated medical record set; would not be available for inspection under applicable laws and regulations; or the record is accurate and complete. If we deny your request for amendment, you will receive a timely, written denial in plain language that explains the basis for the denial, your rights to submit a statement disagreeing with the denial and an explanation of how to submit that statement.
5. **Receive an accounting of disclosures of Protected Health Information** made by Provider for up to six (6) years prior to the date on which the accounting is requested for any reason other than for treatment, payment or health operations and other applicable exceptions. The written accounting includes the date of each disclosure, the name of the entity or person who received the Protected Health Information and, if known, the address, a brief description of the information disclosed and a brief statement of the purpose of the disclosure or a copy of the written request for disclosure. We will provide the accountings within sixty (60) days of receipt of a written request. However, we may extend the time period for providing the accounting by thirty (30) days if within the initial sixty (60) days we provide you with a written statement of the reasons for the delay and the date by which you will receive the information. We will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests within the applicable 12-month period may be subject to a reasonable cost-based fee, which fee information will be provided to you in advance of fulfilling your request. You will also have an opportunity upon receipt of fee information to withdraw or modify your request for the accounting in order to avoid or reduce the applicable fee.
6. **Receive notification of any breach in the acquisition, access, use or disclosure** of unsecured Protected Health Information by Provider, its business associates and/or subcontractors.
7. **Obtain a paper copy of this notice from us upon request**, even if you had previously agreed to receive this notice electronically.

<u>COMPLAINTS</u>

If you believe that your privacy rights have been violated, you may complain to Provider or to the Secretary of the U.S. Department of Health and Human Services. There will be no retaliation against you for filing a complaint. The complaint should be filed in writing, and should state the specific incident(s) in terms of subject, date and other relevant matters. A complaint to the Secretary must be filed in writing within 180 days of when the act or omission complained of occurred, and must describe the acts or omissions believed to be in violation of applicable requirements. *[45 CFR § 160.306]* For further information regarding filing a complaint, contact:

Business Manager
Tupelo Medical Group
1265 Cliff Gookin Blvd.
Tupelo, MS 38801
(662) 840-2131

<u>EFFECTIVE DATE</u>

This notice is effective September 23, 2013. We are required to abide by the terms of the notice currently in effect, but we reserve the right to change these terms as necessary for all Protected Health Information that we maintain. If we change the terms of this notice (while you are receiving service), we will promptly revise and distribute a revised notice to you as soon as practicable by mail, e-mail (if you have agreed to electronic notice), hand delivery or by posting on our website.

If you require further information about matters covered by this notice, please contact:

Business Manager
Tupelo Medical Group
1265 Cliff Gookin Blvd.
Tupelo, MS 38801
(662) 840-2131