# REGISTRATION FORM

(please fill out COMPLETELY)

7341 Chapman Highway, Knoxville, TN 37920
865-577-9212 phone --- 865-577-9282 fax

Former Provider: Phone#

**Name_____Date_____**
**(First, Middle and Last)**
**Parent/Guardian Name(s)_____**

**Is patient in the custody of someone other than biological parent? Yes____ No_____**

**Address_____City, State, Zip_____**

**Home Phone_____ Mobile Phone_____**

**Date of Birth_____Social Security Number_____**

**(Circle one) ~~ *Gender:* MALE FEMALE ~**

**If there are non-custodial parents who may or may not have access to the patient's PHI (Protected Health Information) – please list their names and circle which applies to the person listed. (Legal documents may be needed to corroborate this information.)**

_____may / may not have the patient's PHI
_____may / may not have the patient's PHI

**Preferred Pharmacy_____Location_____**

**Emergency Contact** **Relationship** **Home Phone#**
(not living at the same address)

_____

**Primary Insurance Company_____**

**Secondary Insurance Company_____**

Please provide the front desk staff member with your insurance card to scan into your chart. If you do not have a copy, please contact your insurance company and request a copy. Please bring it with you to your next visit.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. ***I understand that as the child's parent/guardian, I am financially responsible for any balance***. I also authorize Dayspring Family Care, PLLC or insurance company to release any information required to process my claims.

**Parent/Guardian Signature_____Date_____**


# Release for Non-Parent or Guardian To Bring Minor Child to Appointment

Please print all names for clarity. Thank you.

I, _____, authorize the following
Parent or guardian name
Individual(s) to bring my child/ward _____,
Child's name
_____, to his/her appointment at Dayspring Family Care
Date of Birth
and to make decisions regarding treatment.

| | Name | Phone # |
|---|---|---|
| 1. | _____ | _____ |
| 2. | _____ | _____ |
| 3. | _____ | _____ |
| 4. | _____ | _____ |
| 5. | _____ | _____ |

_____ _____
Signature Date

Dayspring
Family Care
PLLC

**INFORMATION REGARDING ADVANCE DIRECTIVES**

Federal law requires that we give you information about your right to make advance health care decisions. Right now, you may be able to make your own health care decisions. You may not always be able to make such decisions, however. By giving advance directions, you can tell your health care provider and family about the medical care you would like to receive and whether you want another person to be able to accept or refuse treatment for you.

You can name a person to make medical treatment decisions for you by appointing someone to have a "Durable Power of Attorney for Health Care" for you. This person is allowed to make health care decisions for you, including life support decisions, but only after your health care provider certifies that you are no longer able to make your own health care decisions.

You can also leave advance direction about life support by executing a "Living Will". A Living Will tells your health care provider and family about the types of life support that you want to be provided or withheld in case you are ever kept alive by artificial means and are no longer able to make decisions for yourself.

If you already have a Living Will or Durable Power of Attorney for Health Care, please tell your health care provider. We need to put a copy of the document in your medical chart in order to be sure that your wishes are honored. If you want more information on how to name a Durable Power of Attorney for Health Care or how to make a Living Will, please feel free to ask your health provider, hospital, social worker or attorney.

It is our policy to honor our patient's health care decisions to the full extent required or allowed by law. You are NOT required to give advance health care decisions in order to receive care at this facility.

| | |
|---|---|
| DO YOU HAVE A LIVING WILL? | YES____NO____ |
| IF "YES", WILL YOU PROVIDE US WITH A COPY? | YES____NO____ |
| DO YOU HAVE A DURABLE POWER OF ATTORNEY? | YES____NO____ |
| IF "YES", WILL YOU PROVIDE US WITH A COPY? | YES____NO____ |

_____ _____

Patient Signature Date

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## Consent to Treat Patient

I, _____ am presenting myself for diagnosis and treatment at Dayspring Family Care, PLLC. I voluntarily consent to the rendering of such care including diagnostic procedures and medical treatment by authorized agents and employees of the facilities, their medical staff or designees as may in their professional judgment be deemed necessary or beneficial. I acknowledge that no guarantees have been made to me as to the effect of any such examinations or treatment, and I understand any special procedure or treatment involving appreciable risk will be explained to me by a provider and that I may at any time refuse such treatment.

My signature below constitutes:

1. My acknowledgement, that I have **read, understand and agree** to the foregoing.
2. That I hereby give authorization and consent.

_____ _____

Witness to Signature Signature of Patient

_____ _____

Signature of Person Signing for Patient Relationship to Patient
(if patient is a minor or unable to act on his/her own behalf)

# Privacy Policy (rev.3/6/12)

While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information. There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your name, address, telephone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home or at work, a message will be left on your voicemail or answering machine.

As a part of our standard procedures, your prescription medication history (those medications purchased through your insurance company) will be downloaded into your chart. This will help us to avoid any problems with contraindications when prescribing medications and this information is an important part of your overall healthcare. This information will be kept in the strictest of confidence along with all of the rest of your Protected Health Information (PHI).

You may restrict the individuals or organizations to which your health care information is released or revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail.

***Please note that patients may receive telephone calls regarding confidential healthcare information such as lab test results and upcoming appointments. Please indicate who may receive such information on your behalf and how you would like to receive that information. If you would like to receive lab results or reminders for upcoming appointments via e-mail, please provide us with your current e-mail address.**

√ **Check all boxes that apply.**

_____may receive information regarding my personal healthcare.
(Name) relationship (Telephone #)

_____may receive information regarding my personal healthcare.
(Name) relationship (Telephone #)

□ **Leave information on patient's home answering machine** ○ **E-mail address:**_____

□**Leave information on patient's cell phone voicemail.**

□**I choose <u>not</u> to have immunizations that I receive at Dayspring Family Care to be uploaded to the Tennessee statewide database.**

**I authorize you to use or disclose my health information in the manner described above.**

_____ _____
**Patient Name (printed)** **Date**

_____ This authorization will expire seven years after the date on which you last received services from us.
**Signed Name**

_____ _____
**Personal Representative (printed)** **Personal Representative Signture (if patient is a minor or unable to act on his/her own behalf)**

**Description of Personal Representative's Authority to Act for the Patient:**


# Medical Records Release Authorization

**7341 Chapman Highway, Knoxville, TN 37920**
**Phone: 865-577-9212 Fax: 866-777-2790**

I authorize the use / disclosure of health information about me as described below.

Patient Name:_____Date of Birth_____SSN_____

**A. Person(s) or Organization(s) authorized to provide the information:**

**B. Person(s) or Organization(s) authorized to receive the information:**

***Dayspring Family Care, 7341 Chapman Highway, Knoxville, TN 37920***

**C. Specific description of the information that may be used or disclosed (including date(s))**

**D. Specific description of how the information will be used.**

1. I understand that this authorization will expire one year from date of signature.
2. I understand that I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying Dayspring Family Care in writing.
3. I understand that I can **refuse to sign** this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
4. I may **inspect or copy** any information used or disclosed under this agreement.
5. I understand that if the person or organization that receives the information is not a health care provider or plan covered by Federal privacy regulations, the information described above may be re-disclosed and would no longer be protected by these regulations.

_____ _____

Patient's Signature or Patient's Representative Date

_____ _____

Printed name of Patient's Representative (if applicable) Relationship to Patient

**Note:** You have the right to know specifically what information you are authorizing for release (i.e., "results of a lab test performed on 1/4/03" or, if your entire medical record is included, "all health information"). You have the right to know the name(s) or other identification of the person(s) or organization(s) authorized to release the information (i.e., the names of your health care provider(s)).You have the right to know who is going to use it and what it is going to be used for. (e.g., John Smith, PhD / Research).

**YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM**

HIPAA Authorization for Release of Information- This form does not constitute legal advice and covers only Federal, not State, laws.

# Health History Questionnaire

| Surgical History | | |
|---|---|---|
| Surgery | Date | Place |
| | | |
| | | |
| | | |
| | | |

| Past Medical History *(check those that apply)* | | |
|---|---|---|
| ____ Diabetes Type 2 | ____IV Drug Use | ____Diabetes Type 1 |
| ____Hypertension | ____Prescription Med Abuse | ____Glaucoma |
| ____Hyperlipidemia | ____Coronary Artery Disease | ____Heart Attack |
| ____Hypothyroidism | ____Seizures | ____Hepatitis B |
| ____Cancer (specify⇨ | | ____Hepatitis C |
| ____Bipolar Disorder | ____Stroke | ____PVD |
| ____Depression | ____Allergic Rhinitis | ____Suicide Attempt |
| ____Anxiety | ____Anemia | ____Sexually Transmitted Disease |
| ____Alcohol Abuse | ____Asthma | ____Other (specify) |

| MedicationAllergies *(please list medication and reaction)* | | |
|---|---|---|
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| | | |
| | | |

| Social History *(please circle or write your answers)* | |
|---|---|
| | |
| Diet | Regular Vegetarian Vegan Other (specify) |
| General stress level | Low Medium high |
| Exercise Level | None Occasional Moderate Heavy |
| Seat belts used routinely | Yes No |
| Sunscreen used routinely | Yes No |
| Caffeine Intake | None Occasional Moderate Heavy |
| Smoke alarm in home | Yes No |
| Is patient in daycare? | Yes No |
| Guns present in the home | Yes No |
| Smoking status? | Yes No |
| 2nd Smoke exposure? | Yes No |
| Grade in school | 7 8 9 10 11 12 |
| Sexually Active? | Yes No |
| Illicit Drugs? | Yes No |
| Alcohol Intake? | Yes No |

| Family History | | |
|---|---|---|
| Family Member | Illness | Age at death (if deceased) |

| | | |
|---|---|---|
| Parent, grandparents, etc…. | | |
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| Specialty Physician(s) that you currently see for medical care | | |
|---|---|---|
| Name | Specialty | Phone # |
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| MEDICATIONS<br>*(new patients only)* | | |
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| Durable Medical Equipment<br>please list all you currently use – i.e., wheelchair, walker, oxygen, Cpap, etc….) | | Where do you get your DME from? |
|---|---|---|
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