# PATIENT REGISTRATION AND AGREEMENT

Marvel Clinic
1821 N. Washington
Tullahoma, Tennessee 37388

Three other phone numbers
of friends, relatives or neighbors

1)

2)

3)

RACE: _____

COUNTY: _____

**PATIENT IDENTIFICATION** - Please Print

| PATIENT'S LAST NAME | FIRST | MIDDLE | GENDER M F |
|---|---|---|---|
| STREET ADDRESS | APT NO. | SOCIAL SECURITY NUMBER | |
| CITY | STATE | ZIP CODE | MARITAL STATUS SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED ☐ |
| HOME PHONE / BUSINESS PHONE / DATE OF BIRTH MO /DAY /YEAR / AGE | | | |
| PATIENT'S OCCUPATION | EMPLOYER'S NAME | ADDRESS | |
| PERSON TO NOTIFY (NAME & ADDRESS OF RELATIVE OR FRIEND) | | TELEPHONE NUMBER | |
| REFERRED BY | ADDRESS | | |

**FINANCIAL RESPONSIBILITY** (INSURANCE CARD HOLDER INFORMATION)

| PERSON RESPONSIBLE FOR ACCOUNT ☐ MR. ☐ MRS. ☐ MISS | FIRST | MIDDLE I. | LAST | RELATIONSHIP TO PATIENT |
|---|---|---|---|---|
| ADDRESS | CITY | | STATE | ZIP CODE |
| HOME PHONE | BUSINESS PHONE | EMPLOYER | | ADDRESS |
| BIRTHDAY OF CARD HOLDER | SOCIAL SECURITY NUMBER OF CARD HOLDER | | | |

**INSURANCE** (number, name of insurance company, mailing address, contract number, policyholder's name)

_____

_____

_____

I, the undersigned, hereby agree to pay all amounts and charges hereafter incurred by myself and members of my family for services rendered. Failure to make payment when requested or agreed is basis for legal action and the undersigned agrees to pay all cost of collection including a reasonable attorney fee and hereby waive their rights of exemption under the laws of the state of Tennessee and any other state. I understand the fees of The Physicians and Healtcare Specialists at The Marvel Clinic may exceed the amount paid by my insurance. I understand that the terms are cash at the time of services and that I will be given a complete insurance voucher and receipt signed by the doctor on the same day of each office service. I agree to pay 1 1/2 percent interest charge/month on any outstanding balance.

**INSURANCE AUTHORIZATION AND ASSIGNMENT**

I HEREBY AUTHORIZE THE PHYSICIANS AND HEALTHCARE SPECIALISTS AT THE MARVEL CLINIC TO FURNISH INFORMATION TO INSURANCE CARRIERS, CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

_____
DATE

_____ _____
WITNESS (SIGNED) (SEAL)

Jeffrey B. Marvel, MD

**Marvel Clinic & Center for Day Surgery**
1821 North Washington
Tullahoma, TN 37388
931-455-2005

Patient ***CONSENT*** for Physician to use or disclose health care information for treatment, payment and health care operations.

Patient's name: _____ DOB: _____

SSN: _____ ACCT #: _____

I understand that signing this document means that Marvel Clinic or Center for Day Surgery may use and disclose my personal health information to help provide health care to me, to handle billing and payment, and to take care of other health care operations. Failure to sign this consent may result in the physician declining to treat me.

Marvel Clinic and Center for Day Surgery has a detailed document called the "HIPAA Notice of Privacy Practices". It contains more information about the policies and practices used to protect their patients' privacy. I have read and signed the "Notice".

Under the terms of this consent, I can restrict how my personal health information is used or disclosed to carry out treatment, payment, or health care operations.

**I consent to the following:**

| | | |
|---|---|---|
| ☐ YES | ☐ NO | May the staff telephone your home? If no, another contact phone is required: _____ |
| ☐ YES | ☐ NO | May the staff leave a message on an answering machine? |
| ☐ YES | ☐ NO | May the staff leave a message with whomever answers the phone at your home or alternate contact telephone number? |
| ☐ YES | ☐ NO | May the staff mail notices for follow up visits, test results, or educational material to your home mailing address? If no, please provide another address: _____ _____ |
| ☐ YES | ☐ NO | May the staff contact you at work? |

I understand I have the right to cancel or modify this consent in writing, at any time. If I do cancel or modify the consent, I understand that information about me may have already been used or disclosed and canceling or modifying this consent would not affect the information already used or disclosed.

I further understand if I cancel this consent, it may result in the physician declining to treat me.

_____ _____
Patient or legally authorized individual signature Date

_____
Witness

Following is a statement of your rights with respect to your protected health information.

YOU HAVE THE RIGHT TO INSPECT AND COPY YOUR PROTECTED HEALTH INFORMATION. Under federal law. However, you may not inspect or copy the following records: psychotherapy notes: information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. You may request a copy of your electronic medical record in electronic form.

YOU HAVE THE RIGHT TO REQUEST A RESTRICTION OF YOUR PROTECTED HEALTH INFORMATION. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to who you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

YOU HAVE THE RIGHT TO REQUEST TO RECEIVE CONFIDENTIAL COMMUNICATIONS FROM US BY ALTERNATIVE MEANS OR AT AN ALTERNATIVE LOCATION. YOU HAVE THE RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE FROM US, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

YOU MAY HAVE THE RIGHT TO HAVE YOUR PHYSICIAN AMEND YOUR PROTECTED HEALTH INFORMATION. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

YOU HAVE THE RIGHT TO RECEIVE AN ACCOUNTING OF CERTAIN DISCLOSURES WE HAVE MADE, IF ANY, OF YOUR PROTECTED HEALTH INFORMATION.

We reserve the right to change the terms of this notice and will inform you by mail of any charges. You then have the right to object or withdraw as provided in this notice.

COMPLAINTS: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. WE WILL NOT RETALIATE AGAINST YOU FOR FILING A COMPLAINT.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____

Date

Signature: _____





** THIS FORM STARTS ON THE OTHER SIDE **

# HIPAA Notice of Privacy Practices

## 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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

### 1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice and any other required by law.

TREATMENT: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care for you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

PAYMENT: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission. You may instruct your provider not to share information about your treatment with your health insurance company if you paid for your treatment on your own.

HEALTH CARE OPERATIONS: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. You may authorize the use of your health information for research and other purposes in a more streamlined manner.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law. Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR COSENT, Authorization or Opportunity to Object unless required by law

PATIENT NAME _____ DATE _____

PLEASE CIRCLE YOUR MAIN SYMPTOM, MEDICAL PROBLEM, OR REASON FOR THIS VISIT:

COUGH
DIZZINESS
DRAINAGE FROM EARS
EAR ACHE
FEVER
HEADACHE
HEARING LOSS
HOARSENESS
RASH
RINGING IN EARS
RUNNY NOSE
SINUS DRAINAGE
SORE THROAT
STUFFINESS OF NOSE
SWOLLEN GLANDS
WATERY, ITCHING EYES
IF OTHER, PLEASE EXPLAIN:

WHEN DID THIS PROBLEM BEGIN?

DESCRIBE PREVIOUS TREATMENT, IF ANY:

PAST HISTORY: NAME ALL MEDICATIONS NOW TAKEN FOR ANY REASON:

MY DRUG STORE NAME:

DRUG **ALLERGIES** OR SENSITIVITES: LIST ANY DRUGS OR MEDICATIONS TO WHICH YOU ARE ALLERGIC:

NAME ALL PREVIOUS OPERATIONS: (with approximate date or year performed):

DISEASES: HAVE YOU HAD OR DO YOU HAVE (circle those applicable and comment):
ASTHMA, DIABETES, HEART DISEASE, TUBERCULOSIS, CANCER, HIGH BLOOD PRESSURE,
SEIZURES, BLEEDING TENDENCY (free bleeder), OR BRUISE EASILY?

DO YOU HAVE ANY OTHER SIGNIFICANT ILLNESS OR MEDICAL PROBLEM?

ANY FAMILY MEMBERS WITH CANCER, DIABETES OR HEART PROBLEMS?

LAST PHYSICAL EXAM _____

IMMUNIZATIONS UP TO DATE YES _____ NO _____

DID YOU EVER USE TOBACCO? _____ HOW MUCH? _____

ANY PREVIOUS SIGNIFICANT INJURIES? WHEN? (especially to the head, nose, or ear)

PLEASE NAME YOU PRIMARY PHYSICIAN: _____

WHO COMPLETED THIS FORM? PATIENT ____ PARENT ____ SPOUSE ____ OTHER _____

WHO REFERRED YOU FOR THIS VISIT? _____

# Email Request Form

*Marvel Clinic* requests your email address in order to provide you with important medical information on a timely basis.

We assure you that we will NOT share your email address with any 3rd party.

Please complete the information below and return it to one of our staff members.

_____

Primary Email address

_____

Secondary Email address

_____

Patient's name (please print)

_____

Patient's signature

_____

Date