Fatigue Clinic LLC
Collierville Holistic Health
364 New Byhalia Road Ste 1
Collierville, TN 38017
901-221-8621 Phone
901-221-8631 Fax
Fatigueclinic@yahoo.com

PATIENT REGISTRATION FORM

Patient Name _____ Date of Birth _____

Address _____ Age _____

City _____ Zip _____

Home Phone _____ Work Phone _____ Social Sec# _____

Female _____ Male _____ Email _____

Marital Status ☐ Child ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employer _____ Address _____

City _____ State _____ Zip _____

SPOUSE INFORMATION OR RESPONSIBLE PARTY

Name _____ Date of Birth _____

Address _____ Relationship _____ Age _____

City _____ State _____ Zip _____ Female _____ Male _____

Home Phone _____ Work Phone _____ Social Sec# _____

Employer _____ Employer Address _____

IN CASE OF EMERGENCY

Name _____ Phone Number _____

Relationship _____

ADDITIONAL INFORMATION

Referred to us by _____

Primary Care Physician _____ Phone _____

Address _____

PRIMARY INSURANCE

Insurance Name _____

Address _____

Policy or ID number _____

Group Number _____

Main Policy Holder _____

SECONDARY INSURANCE

Insurance Name _____

Address _____

Policy or ID number _____

Group Number _____

Main Policy Holder _____

Preferred Pharmacy
Name _____
Address _____
Phone # _____

Social History

Occupation _____
Environmental Exposures _____
Travel History _____
Tobacco, Alcohol and Other Drug Use _____
Diet and Exercise _____
Education _____

Review of Systems (CIRCLE ALL THAT APPLY)

Constitutional (fever, chills, night sweats, weight change, fatigue, malaise nutrition, deformities, grooming)

Eyes (vision, pain, discharge, photophobia)

Ears/Nose/Throat (hearing, tinnitus, dizziness, pain, discharge, smell, hoarseness, nose bleeds, lesions)

Mouth/Dental (tooth decay, gum disease, last visit to the dentist , speech problems, sinus drainage, taste, snoring)

Breast (lumps, nipple discharge, family history of breast cancer, self breast exam)

Cardiovascular (Palpitations, angina, heart attack, chest pains, shortness of breath, PND, syncope, hypertension, edema, Cyanosis, varicosities, adema)

Respiratory (asthmas, dyspnea, cough/sputum, hemoptysis, TB skin test status)

Gastrointestinal (dysphagia, anorexia, nausea, vomiting, hematemesis, diarrhea, constipation, melena, rectal bleeding, Change in bowel habits, hemorrhoids, jaundice, abdominal pain, food intolerance)

Genito-Urinary (dysuria, hematuria, frequency, polyuria, urgency, hesitancy, incontinence, renal stones, nocturia, Infections, retention)

Male Reproductive (penile discharge, STD history, testicular pain or mass, infertility, impotence, libido)

Female Reproductive (menarche, last period, age of menopause, post menopausal symptoms, post menopausal bleeding, abnormal periods, STD history, last PAP test, OB-hx, discharge, odor, infertility, libido, method of contraception

Musculoskeletal (joint pain (mono or poly articular) edema, heat, redness, stiffness, deformity, muscle pain, tenderness, fatigue (e.g. with arthritis) atrophy.

Neurological (headache, syncope, vertigo, seizures, loss of vision, diplopia, parasthesias paralysis, weakness in any limbs, tremor, ataxia, memory loss)

Skin (itching, rash, lump, and bumps, hair and/or nails changes, da/pigmentation)

Endocrine (excessive thirst, sweating, dizziness, palpitations, weight change)
Hematologic/Lymphatic (Bruising, Cyanosis, Lesions, enlarged lymph nodes)

Psychiatric (stress, insomnia, previous psychiatric illness, depression, anxiety, hallucination, memory loss)

Fatigue Clinic Collierville Holistic Health

HISTORY AND PHYSICAL EXAM

CHIEF COMPLAINT:

HISTORY OF PRESENT

Past Medical History

Previous Hospitalizations/Surgery

MEDICATIONS:

Medication Allergies/Adverse Reactions

FAMILY HISTORY :

Father:

Mother:

Financial Policy Patient Financial Agreement

The Fatigue Clinic is committed to serving our patients with professionalism and caring and from our patients we expect the same commitment. This includes being on time for your appointment and calling to cancel an appointment if you can't make it. It also includes financial responsibility, like presenting your identification and insurance cards at every appointment and making your copay and deductible payments at the time of your office visit with cash, check or credit card.

Your responsibility is to provide us with accurate and complete information concerning your primary and secondary insurance medical benefits, including referral documents from other providers. Current identification and insurance benefit cards are to be presented at each office visit if necessary. If you are a Medicare or Blue Cross/Blue Shield patient, we will file the claims for you. The Fatigue Clinic will provide you with claim information so you may file to your insurance company if NOT Medicare or Blue Cross/Blue Shield.

For services outside of our clinic, like radiology, laboratory, surgery centers, physical therapy, hospitals and rehabilitation centers, it is your responsibility to know which facility you are required to use. If you aren't sure, please talk to your insurance member services or one of our staff before scheduling.

For Medicare patients: Medicare Patient's Signature – I authorize payment to be made on my behalf to The Fatigue Clinic for any services provided to me by my provider. I authorize my provider to release to the Health Care Financing Administration and its agents any information needed to determine my benefits.

I understand that my signature requests payment be made to pay my claim. My signature also authorizes the release of medical information necessary to pay my claim. My signature also authorizes the release of benefits payable and medical information necessary to pay any secondary insurance payer.

I have read and I understand The Fatigue Clinic's financial policies and I accept responsibility for the payment of any fees associated with my care.

Patient Name:(Print)_____

Patient Signature:_____Date: _____

Patient Financial Responsibility Contract

Please read, **initial** each blank and sign where indicated – this document describes your financial responsibilities.

The Fatigue Clinic DOES NOT ACCEPT CHECKS!

This is a legally binding contract between The Fatigue Clinic and you. The words, *I, me, my, you* and *your* all refer to the patient.

_____ (initial) I agree to be financially responsible for payment of The Fatigue Clinic's services. Cash or credit cards are acceptable forms of payment for these services.

_____ (initial) Current acceptable insurance cards must be presented at every office visit. The Fatigue Clinic is not responsible for filing your insurance claim but as a courtesy we will file valid claims. I agree to pay the remaining balance after my insurance has paid on my claim immediately upon receipt of a statement.

_____ (initial) I agree to give The Fatigue Clinic my complete and accurate insurance information for primary and secondary insurance benefits including referral documents from other providers, if needed. I understand that if I fail to give complete and accurate information about my insurance benefits this may result in a denial of my claim or a delay in payment. I agree to pay The Fatigue Clinic the balance on my account after my insurance claim has been processed.

_____ (initial) I agree that if my insurance benefit requires me to provide a referral and if the referral is not in place before my appointment, that I will pay in advance an estimate of charges for my office visit or reschedule my appointment.

_____ (initial) I understand that I will be financially responsible for any missed appointments or any cancelled appointments in which a 48 hour notice was not given. There will be a fee of $50.00 for this.

_____ (initial) I understand that all services provided to me by The Fatigue Clinic are considered medically necessary. If I fail to have a procedure performed or do not comply with my provider's instructions it may be against medical advice and may void my insurance benefits. Should this occur, I agree to pay the balance remaining on my account after my insurance has been processed.

_____ (initial) I understand that Medicare and Blue Cross may or may not agree to the usual, customary or reasonable charges for my local area. I understand that my benefits may not cover all services or might deny payment for services that have been approved of in advance. I agree to pay the balance remaining on my account after insurance has been processed.

_____ (initial) If I have a high deductible policy or do not currently have insurance benefits, I agree to pay an estimate of charges for my office visit in advance and understand that other charges may apply.

_____ (initial) If The Fatigue Clinic has a contract with my insurance company, The Fatigue Clinic will receive payments from my insurance company for ***covered*** services provided by my insurance benefits. I agree to pay co-payments and deductibles at the time of service. If co-payments are not made at the time of service, I understand that my appointment may be rescheduled.

_____ (initial) I agree to pay any balance remaining on my account for any reason upon receipt of a statement and I understand that when requested, I must give The Fatigue Clinic my current address and other contact information. I understand that if I fail to pay the balance on my account this may result in The Fatigue Clinic pursuing any collection means possible.

_____ (initial) If my account becomes delinquent, it may be forwarded to an outside collection agency without notice. If this happens, I will be responsible for all costs of collection, including but not limited to interest, rebilling fees, court costs, attorney fees, and collection agency costs.

_____ (initial) If the reason for my appointment is related to a work injury or auto accident, I agree to give The Fatigue Clinic the case number or policy number, the workman's compensation or insurance carrier's name, address or other contact information at the time of my appointment so that The Fatigue Clinic can bill workman's compensation or the auto insurance carrier for my visit. If I do not provide this information at the time of the visit, I agree to pay all charges for my visit.

I have read and I understand The Fatigue Clinic's financial policies and I accept responsibility for the payment of any fees associated with my care.

Patient Signature :_____Date: _____

ASSIGNMENT OF BENEFITS

I hereby authorize direct payment of medical benefits, including medical benefits to which I am entitled to The Fatigue Clinic, PC. This is a **DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS.** This authorization will remain in effect until cancelled by me in writing. A copy of this authorization is as valid as the original document.

I authorize the release of any medical information necessary to in order to obtain payment and I understand that I am financially responsible for all charges, late fees, interest, attorney fees and collection charges considered patient responsibility by my insurance company. I understand that if I am not insured I am responsible for the charges of all services provided to me. I authorize The Fatigue Clinic to deposit checks received on my account when made out in my name. I have read and I understand The Fatigue Clinic's financial policies and I accept responsibility for the payment of any fees associated with my care.

Patient Signature:_____Date:_____

The Fatigue Clinic
364 New Byhalia Rd Ste 1
Collierville, TN 38017
901-221-8621

Notice of Privacy Practices
Patient Acknowledgement

Patient Name: _____ Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
  - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
  - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
  - The right to receive confidential communications of protected health information.
  - The right to inspect and copy protected health information.
  - The right to amend protected health information.
  - The right to receive an accounting of disclosures of protected health information.
  - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____ Date: _____

Relationship to patient (if signed by a personal representative of patient): _____

Authorization of Release of Information

Patient Name _____ Date of Birth _____ Last 4 of SS# _____

Person / Organization requesting information is:

The Fatigue Clinic, Susan Earl, ACNP-BC, 364 New Byhalia Rd Ste 1, Collierville, TN 38017
Phone 901-221-8621 Fax 901-221-8631 **Method of Release Fax to 901-221-8631**

Specific Records to be Released : Hospitalization Clinic / Other
Inpatient Hospitalization/Discharge Summary/Office Note
EKG/NST/Echo
Laboratory Report(s) / Pathology
Progress Reports
COMPLETE RECORDS

The purpose of this disclosure of information is health care. (i.e., continuing care, insurance claim, legal counsel, etc.)

I understand that my medical records may include information relating to sexually transmitted disease, acquired Immunodeficiency Syndrome (AIDS), human immunodeficiency virus (HIV), treatment of alcohol and/or substance use, and genetic testing results. I authorize my medical provider to release all information to The Fatigue apart from:

Substance Abuse _____ **AIDS/HIV** _____ **Psychological or Psychiatric conditions** _____

I have the right to inspect and obtain a copy of the records that are to be disclosed (CFR164.524). I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I understand that I am not required to sign this authorization at any time presenting my written revocation to The Fatigue Clinic. I understand that the revocation will not apply to information that has already been used or disclosed under this authorization. I understand that this revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand there may be a charge to obtain copy of these records.

ATTENTION: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this page. If the patient is 18 years of age or older, the patient must sign and date the form. If the patient is 18 years of age or older and is incapable of signing, a legally authorized substitute may sign and date the form. Please indicate your legal authority and include documentation of your relationship: Legal Guardian or Conservator Health Care Agent (Health Care Power of Attorney) if the patient is 18 years of age or younger, the patient's parent or legal guardian must sign and date the form unless an exception exists under state or federal law.

_____ _____

Printed Name of Patient on Personal Rep **Signature of Patient or Personal Rep**