HMG
HOLSTON MEDICAL GROUP

Welcome to our office

Where did you hear about us?
❒ Yellow Pages (YP) ❒ Newspaper (NP) ❒ Website (WS)
❒ Friend or Family (FF) ❒ Physician Referral (PR)
❒ Self Referral (SR) ❒ Other (OT) _____

BILLING PARTY

Your Name, First and Last _____

Address _____

City, State & Zip _____ Your Phone Number _____

Social Security Number _____ Date of Birth _____

Place of Employment _____ Work Phone Number _____

PATIENT INFORMATION

Name, First and Last _____

Address _____

City, State and Zip _____ Marital Status S M W D

Phone Number _____ Emergency Phone _____

Social Security Number _____ Date of Birth _____ Age _____

Place of Employment _____ Phone Number _____

Date of Injury _____

Your Supervisor's Name (If this is Workmans Comp) _____

Is your appointment related to an auto accident _____ Date of accident _____

Name of your Insurance Company _____
We will need to make a copy of the card

Name of Referring Physician _____

MEDICAL HISTORY

Please list any medications you are currently taking: _____

_____

Please list any surgeries you have had: _____

_____

Heart Disease	Yes	No	Diabetes	Yes	No
Hearing Defect	Yes	No	Emphysema	Yes	No
Headaches	Yes	No	High Blood Pressure	Yes	No
Kidney Disease	Yes	No	Low Blood Pressure	Yes	No
Metallic Implant	Yes	No			

I authorize treatment to be rendered by HMG Rehabilitation Services in accordance with my physicians's prescription. I have completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I understand that even though I have some type of coverage, I am responsible for the payment of any charges in excess of payment limitations imposed by third-party payers. I authorized release of medical information necessary to process this claim in the course of my treatment and authorize payment of medical benefits to provider/supplier for services rendered.

Signed (Patient or Responsible Party) _____ Date _____

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Seasons

MRN: _____

Date Received: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have reviewed and/or received a copy of the *Notice of Privacy Practices,* which provides a more complete description of how my protected health information (PHI) may be used or disclosed. I understand that Holston Medical Group (HMG) reserves the right to change their notice and information practices and that I may view a copy of the current *Notice* on HMG's website, www.holstonmedicalgroup.com/hipaa, in any of their offices, or by a request in writing.

I also understand that Holston Medical Group participates in the OnePartner Health Information Exchange (OnePartner HIE) and may make my medical information available electronically or may electronically transmit my medical information to a third party, in order to fulfill provider obligations to release my medical information in the future.

_____ _____

Print Patient Name | Patient Date of Birth

_____ _____

Patient Signature (if applicable) | Date

_____ _____

Authorized Representative Signature | Relationship to Patient

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I understand that my Protected Health Information (PHI) will only be <u>verbally</u> communicated to those individuals listed below and no paper copies of my PHI will be provided without my signature on an *Authorization for Release of Individually Identifiable Health Information* form. I understand that some information may be considered sensitive, including but not limited to pregnancy test results, testing for sexually transmitted infections, Urine Drug Screen results, laboratory test results, medication, or information discussed during an office visit. The individuals listed below, will be required to provide the last four (4) digits of my Social Security Number, along with my date-of-birth, before any information will be discussed with them.

List the individual(s) that you want protected health information verbally discussed with:

Name	Phone Number	Name	Phone Number

FOR INTERNAL USE ONLY:

Reason Acknowledgement Could Not Be Obtained: _____

_____ _____

Employee Signature | Date

Holston Medical Group complies with applicable Federal civil laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Holston Medical Group does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Attention: If you need language or translation services, please ask to speak with the Office Manager.

Atención: Si necesita servicios de idioma o traducción, solicite hablar con el Gerente de Oficina

نبيه: إذا كنت بحاجة إلى خدمات اللغة أو الترجمة، فيرجى طلب التحدث مع مدير المكتب