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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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 reserves the right to change their notice and information practices and that I may view a copy of the current *Notice* on Holston Medical Group'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

I understand that my protected health information will only be verbally communicated to those individuals listed below. Those individuals 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 individuals that you want protected health information given to:

_____ _____

_____ _____

FOR INTERNAL USE ONLY:

Reason Acknowledgement Could Not Be Obtained:

_____

_____

_____

_____ _____
Employee Signature Date