If your insurance requires you to pay a deductible amount out-of-your-pocket for office visits, we will request a $50 deposit at check-in. You will be billed for the remainder after your insurance is billed and we are informed of your final patient responsibility. This also helps the patient to break up the payment into two different dates. (the date of visit and after the 1st bill for the remainder). CREDIT CARD ON FILE IS REQUIRED.

We ask that you allow plenty of time to get to the office for your appointment. You may be asked to reschedule your appointment if you are more than 10 minutes late. We will strive to stay on time. From time to time, a patient emergency arises and we may be running late for your visit. You will have the option to re-schedule or stay to be seen and we will keep you informed of how long of a delay you may experience.

Our office policy for a missed appointment is:

We understand that appointments sometimes need to be changed, so we ask that you call at least 24 hours in advance if you cannot keep your scheduled appointment.

If you need to reach the provider after hours, you can reach our answering service at 931-245-1701. Non-urgent calls will be returned the next business day.

Elite Primary Care is affiliated with Northcrest Medical Center and Gateway Medical Center. We will be directing our patients to use our in-house laboratory collection services by PathGroup Labs unless otherwise requested by the patient. Our in-house x-ray is billed 100% by Elite Primary Care so you will not get an additional bill from a radiology group for x-rays done here.

We must inform you about our non-smoking premises. In addition to the risk to your health and others, smoking is prohibited by our property management group. Anyone smoking on property will be fined $100.00 This is not something we have control of.

Welcome to our practice and thank you for choosing Elite Primary Care for all your health care needs.

ELITE PRIMARY CARE

2690 Madison St. Suite 130
Clarksville, TN 37043

Phone: 931-245-1701
Fax: 931-245-1720
www.eliteprimarycaretn.com

Office Visit Guidelines

Thank you for choosing us as your health care providers. In order to assure the most appropriate and effective care, it is our policy that a provider sees you in the office for any of the following circumstances:

- Any new medical conditions
- Any new occurrence or recurrence of a condition previously treated at EPC
- Any request for diagnostic or laboratory testing
- Patients on prescription medications who have not had a comprehensive exam/visit within 1 year
- Diabetic, high cholesterol and high blood pressure patients who have not had an office visit within 6 months
- Request for any medication not previously prescribed by an EPC provider

Medication Refills

Elite Primary Care does not offer chronic pain management and will not dispense chronic pain medication (for example, chronic daily narcotics). We will provide you with a referral to a pain management center if you need this specialized form of care after evaluation by our physicians

Prescription medications, while important in managing acute and chronic illnesses and injuries, can be harmful if given incorrectly. Many medications also require monitoring to make sure they are working without causing unwanted side effects. It is for your safety that Elite Primary Care asks that you **schedule an office visit for all prescription refills.**

For the safety and well-being of our patients, requests for new medications (including antibiotics) and medication refills will not be taken over the phone or over the Internet during office hours without an appointment and evaluation by the physician. At your scheduled appointment, your caregiver will discuss treatment goals, appropriate monitoring intervals for your health issues, and medication and will make sure you have enough refills until the next scheduled appointment.

It is important you schedule office visits for medication refills in a timely manner. A good reminder can be when your medication bottle shows “No remaining refills” or “Contact provider before additional refills provided”. Please call to schedule an appointment at least 2 weeks before you run out of medication. Another tip is to check all your medications before coming in to decrease amount of refill visits. Always bring a printed list of your medications or all medicine bottles to your appointment. Also, make sure you have taken your medications prior to your appointment time, even if you come in fasting. This allows your providers to make sure they are working appropriately. **One exception, please note that diabetic patient should not take insulin or diabetic medication while fasting.**

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PRIMARY CARE PATIENT AGREEMENT

As a patient, you may receive prescriptions for medications and/or orders for tests. These medications and tests are for your own well-being. It is your responsibility to ensure that you take the full course of any medication per the provider's orders unless you have an adverse reaction, in which case, you should contact our office so that the provider may prescribe an alternate treatment.

It is your responsibility to ensure that you perform any tests that have been ordered by the provider.
Tests ordered by the provider fall into 4 categories:

1. *Voluntary / Patient Requested tests* - If you ask the provider to order a test for you and the provider agrees to do so.
2. *Screening tests* - Tests recommended as standard of care to ensure that you are healthy, free of any cancer, diseases, or other medical conditions that are being tested for. (Mammograms and Colonscopy Studies are the most common screening tests that we order)
3. *Diagnostic tests* - Test that the provider is ordering based upon your current physical exam and/or interaction with the provider. (Blood Tests, Ultrasounds, and other Imaging Studies are the most common diagnostic tests that we order)
4. *Procedures* - In-office, outpatient, or inpatient procedures may be ordered for diagnostic or treatment purposes. (Biopsies, VAT, ABI and other procedures to be performed by the provider or by other providers/facilities may be ordered)

Many people feel complacent about screening tests as they frequently indicate that there are no problems. Nevertheless, it is very important for you to get regular screening to ensure that we have the best chance to catch problems before they become more serious or even deadly. Screening is not a guarantee of detection, but it is currently the standard of care and is very effective. Please help us help you by getting your screening tests on a regular basis. When the provider orders diagnostic testing or procedures, it is very important that you follow-through and get these performed. These are being ordered as a direct result of your current medical condition (screening test results, physical exam, your complaints, etc.). These orders are to help the provider determine the severity of your condition and determine the course of your treatment. Delaying or ignoring these orders could result in irreversible worsening of your condition, and in some cases death.

We employ the use of an automated patient reminder system and use an electronic medical records system to track orders & results and make every attempt to follow-up with you if we do not receive results from test that were ordered. Unfortunately, no system is fool-proof and the ultimate responsibility for follow-up is yours. If you are unable or unwilling to perform any test or take any medication, please contact our office immediately and let us know so that we can note this in your chart. This will stop any automated reminder messages, but will not stop any condition you have from progressing. We strongly advise against this action, but recognize your right to decide if/when you will comply with the provider's orders. In certain cases, the provider may insist that you follow orders or leave our practice.

Patient Acknowledgement:
I have carefully read and fully understand my responsibility to follow-through with the provider's orders and/or communicate with the office if there is any reason why I cannot or will not do so.

_____

Signature of Patient / Patient's Representative Print Name & Relation Date

Complete this form so that we may obtain your records from your previous doctor, specialists, or hospital.

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(All sections must be completed)

I hereby authorize:

Provider: _____ Provider: _____

Address: _____ Address: _____

Phone: _____ Fax: _____ Phone: _____ Fax: _____

and its physicians employees and agents to release or disclose to the below-named recipient all of my medical records including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, sexually transmitted disease, or HIV/AIDS infection.

Patient Name: _____Date of Birth: _____

I hereby authorize the release of medical records to: __Elite Primary Care_____

Purpose of disclosure: ○Changing PCP ○Moving out of town ○Other: _____

The authorization will expire on: _____

Date or Event may not exceed one year

This request and authorization applies to:

_____ Please send only the **SUMMARY OF CARE** document unless otherwise indicated:

Attn: RELEASING ENTITY Do NOT send entire chart.

_____

_____ Health care information relating to the following treatment, condition, or dates of treatment:

_____

_____

_____ Specific records to be released (eg. Labs, imaging reports, other):

_____

If you DO NOT WANT certain portions of your medical records released, please initial the box for the information you do not want released.

_____Substance abuse _____ Psychological or psychiatric treatment ____HIV/AIDS/STD

I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.

_____

Signature of Patient or Authorized Representative **Date Signed** **Relationship to Patient**

ELITE PRIMARY CARE REGISTRATION FORM Today's Date: _____

Patient's Last Name: First: Middle:				
Marital status:	Birth date: Age:			
Ethnicity: ○ Not Hispanic * ○ Hispanic ○ Latin	Race:	Sex: ○ M ○ F	Driver's License #:	Social Security #:
Address:				
Home phone:	Cell phone:		Email:	
Occupation:	Employer:		Work phone:	

Your Pharmacy/location:
Chose clinic because/referred to clinic by:
Other family members seen here:

INSURANCE INFORMATION *(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)*

Person responsible for bill: *(self or parent)*	Birth date:	Address (if different):	Phone:
Is this person a patient here?	☐ Yes ☐ No	Occupation/Employer:	Work phone:

Please indicate **primary insurance** name:

Subscriber's name:	Subscriber's S.S. #:	Employer:	Birth date:	Relationship to patient:

Name of **secondary insurance** name (if applicable):

Subscriber's name:	Subscriber's S.S. #:	Employer:	Birth date:	Relationship to patient:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone:	Work phone:

MEDICAL INFORMATION DISCLOSURE

May we disclose your appointment information or medical information to members of your family? *circle one:*

Medical info only *Appointment info only* *Both*

Person's Name: Relationship to patient:

To enhance your care, we access your prescription history and pharmacy benefit files that are available electronically based on pharmacy, state, and insurance data. Please indicate here if you wish to deny this access.

* (this does not apply to controlled substances) ○ I elect to OPT-OUT

AUTHORIZATION OF TREATMENT, ASSIGNMENT OF BENEFIT, & FINANCIAL POLICY

I authorize Elite Primary Care to provide medical treatment. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to Elite Primary Care for all medical and surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. I understand that payment for today's visit and future visits are due at the time of treatment. Charges for the collection of delinquent accounts, court costs, and or reasonable attorney's fees will be added to the total balance; including contingent fees to collection agencies of not less than 35%, such contingency fees to be added and collected by the collection agency immediately upon your default and our referral of your account to said collection agency. A photocopy of this authorization shall be considered as effective and valid as the original.

I understand that if my provider, or any person employed by or under the direction and control of my provider, is directly exposed to my body fluids in any manner which may, according to the then current guidelines for the Center for Disease Control, transmit the human immunodeficiency virus (HIV) or hepatitis B or C virus, that I am deemed by law to have consented to testing for infection with HIV or Hepatitis B or C viruses. I further understand by law I will have deemed to have consented to the release of these test results to the person who is exposed to my body fluids.

_____ _____

Patient/Guardian signature **Date**

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

2690 Madison Street, Suite 130
Clarksville, TN 37043
Phone (931) 245-1701
Fax (931) 245-1720

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

CONFIDENTIAL HEALTH HISTORY QUESTIONNARIE - PAST MEDICAL HISTORY

Print Form

Name: _____ Date of Birth: _____ Age: _____ Date: _____

ALLERGIES

(list any allergies to medicines or other substances) ☐ None

SURGERY/HOSPITALIZATION

Date	Reason	☐ None

MEDICAL PROBLEMS

List any chronic or recurrent medical problems - Date of onset

☐ None

List All Medication You Take Regularly (Prescription and Non-Prescription)

Medicine Dose ☐ None

CHECK ANY THAT YOU HAVE HAD OR NOW HAVE:

Past/Current		Past/Current	
☐	Abnormal Electrocardiogram	☐	Heart Attack
☐	Abnormal Pap Smear	☐	Heart Murmur or Heart Disease
☐	AIDS or HIV	☐	Hepatitis or Cirrhosis
☐	AlcoholDrug Overuse/Abuse	☐	Herniated or Ruptured Disc
☐	Allergies or Hay Fever	☐	Herpes
☐	Anemia (low iron)	☐	High Blood Pressure
☐	Ankles swell frequently	☐	Hodgkin's Disease, Lymphoma, or Leukemia
☐	Anexiety or Panic Attacks	☐	Intolerance of dairy/fatty Foods
☐	Arthritis or Gout	☐	Irregular Heartbeat
☐	Asthma		
☐	Frequent Backaches	☐	Irritable Bowel Syndrome
☐	Bladder Infection	☐	Kidney Disease or Nephritis
☐	Blood Clots or Bleeding Prob.	☐	Kidney Stones
☐	Blood in Bowel Movement	☐	Lung Problems
☐	Blood Transfusion	☐	Lupus
☐	Boils or Cysts - Recurrent	☐	Malaria
☐	Bone or Joint Disease	☐	Seizures, Convulsions or Epilepsy
☐	Bowel or Colon Disease	☐	Meningitis
☐	Breast Lumps	☐	Migraine Headache
☐	Bronchitis - Recurrent	☐	Mole Changes
☐	Bruise Easily	☐	Muscle Disease or Weakness
☐	Bursitis or Tendonitis	☐	Pancreatitis
☐	Cancer	☐	Phlebitis
☐	Chest Pain	☐	Pleurisy
☐	Chills or night sweats	☐	Pneumonia
☐	Cholesterol-Elevated	☐	Polio
☐	Chronic Cough	☐	Problems with urination
☐	Colitis	☐	Rheumatoid Arthritis
☐	Color-blindness	☐	Rheumatic Fever
☐	Concerns about fertility	☐	Seizures, Convulsions or Epilepsy
☐	Concussion or Head Injury	☐	Sensory Changes
☐	Constipation	☐	Sexual Problems/Concerns
☐	Depression or Suicide	☐	Shortness or Breath
☐	Diabetes	☐	Sickle Cell Disease or Trait
☐	Difficulty swallowing	☐	Skin Disease - Chronic
☐	Dizziness or Fainting	☐	Skin Infections - Recurrent
☐	Emphysema	☐	Sleep Difficulties/Disorders
☐	Excessive Stress	☐	Sprains or Dislocations
☐	Frequent colds/sinus problems	☐	Stomach Pain
☐	Frequent earaches	☐	Stroke or Brain Attack
☐	Frequent or painful urination	☐	Swelling of joints
☐	Frequent/severe sore throat	☐	Thyroid Disease
☐	Frequent/severe nosebleeds	☐	Tremors/shaking of hands
		☐	Tuberculosis (TB) or positive test
☐	Gallbladder Disease or Gallstone	☐	Ulcer Disease or Gastritis
		☐	Unexpected weight loss
☐	Glaucoma	☐	Urinate frequently at night
		☐	Varicose Veins
☐	Gonorrhea, Syphilis or Chlamydia	☐	Venereal Disease
		☐	Wheezy or whistling chest
☐	Growth on skin	☐	Yellow Jaundice
☐	Gum bleed easily		
☐	Frequent/severe sore throat		
☐	Hearing Problems		

IMMUNIZATION HISTORY

			DATE OF LAST
Chickenpox or Shot	☐ Yes	☐ No	
Hepatitis B Series or Shots	☐ Yes	☐ No	
Influenza Shot	☐ Yes	☐ No	
Pneumonia Shot	☐ Yes	☐ No	
Rubella Shot or Blood Test	☐ Yes	☐ No	
Tetanus Shot	☐ Yes	☐ No	

FAMILY HISTORY

	If Alive, Age	If Dead, Age and Cause
Father		
Mother		
Brother/Sister		
Spouse/Sig Other		
Son(s)/Daughter(s)		

Primary Language in Home:

PLEASE CHECK FOR ANY CONDITION WHICH APPLIES TO A BLOOD RELATIVE

Condition	Who
☐ Alcohol/Drug Abuse	
☐ Allergies/Asthma	
☐ Arthritis/Gout	
☐ Bleeding Disorder	
☐ Cancer (Type)	
☐ Diabetes	
☐ Epilepsy/Seizures	
☐ Glaucoma	
☐ Heart Disease	
☐ High Blood Pressure	
☐ High Cholesterol	
☐ HIV/AIDS	
☐ Kidney Disease	
☐ Mental Illness	
☐ Migraine Headaches	
☐ Sickle Cell Condition	
☐ Stroke	
☐ Suicide/Depression	
☐ Thyriod Disease	
☐ Other	

SOCIAL HISTORY

My current status is:

With whom do you now live?

Highest education achieved?

Your Occupaton?

Exposure to hazardous condition/substances at work? ☐ No ☐ Yes

Type:

Religious preference/beliefs:

Do you have a living will? ☐ No ☐ Yes

Are you an organ donor? ☐ No ☐ Yes

PERSONAL HISTORY

QUESTIONS FOR WOMEN ONLY:

MENSTRUATION:

Age periods began: How often:

Date of last menstrual period:

Now Pregnant?	☐ Yes	☐ No
Vaginal Discharge?	☐ Yes	☐ No
PMS?	☐ Yes	☐ No
Menopause?	☐ Yes	☐ No
Unexplained Vaginal Bleeding?	☐ Yes	☐ No
Discharge from nipples?	☐ Yes	☐ No
Skin changes in breasts?	☐ Yes	☐ No

PREGNANCIES:

Total Number: Full Term:

Date of last Pap Smear:

Date of last mammogram:

Premature:

Miscarriages:

Abortions:

Tubal Pregnancies:

QUESTIONS FOR MEN ONLY:

Prostate Trouble?	☐ Yes	☐ No
Discharge from penis?	☐ Yes	☐ No
Sore on penis?	☐ Yes	☐ No
Do you examine your testicles?	☐ Yes	☐ No

QUESTIONS FOR MEN AND WOMEN ONLY:

What kind of Birth Control/Protection do you and/or your partner use?

How would you describe your sexual orientation?

Do you use sunscreen?	☐ Yes	☐ No
Do you always wear seatbelts?	☐ Yes	☐ No
Do you wear protective sports equipment?	☐ Yes	☐ No
Is your house a smoke-free house?	☐ Yes	☐ No
Do you have a working smoke detector?	☐ Yes	☐ No
Are there any guns/weapons in your home?	☐ Yes	☐ No
Do you floss your teeth regularly?	☐ Yes	☐ No
Do you wear dentures?	☐ Yes	☐ No

Last dental visit? Date:

Do you wear glasses/contacts? ☐ Yes ☐ No

Last eye exam? Date:

DIET, EXERCISE & HABITS:

Do you follow a special diet? If so, explain:

Current Weight? Desired? One year ago?

What kind of exercise do you do and how often?

TOBACCO USE:

Do you smoke? What type:?

If yes, how much per day: Per week?

Have you quit smoking? When?

Do you use other tobacco products? Type:

If so, how much?

How long have you been using tobacco ?

ALCOHOL USE:

Do you drink alcohol? How many drinks per week?

Has anyone ever expressed concerns about your alcohol use?

If yes, please explain:

How long have you been consuming alcohol?