TRUE MEDICAL GROUP DEMOGRAPHIC INFORMATION

Referred by: _____

PATIENT INFORMATION

PATIENT NAME: _____ DOB: _____ SSN: _____

MAILING ADDRESS: _____ PHONE: _____ CELL: _____

CITY, STATE, ZIP: _____ EMAIL ADDRESS: _____

MARITAL STATUS: S M W D SEX: _____ RACE: _____

EMPLOYER:_____ WORK PHONE:_____ OCCUPATION: _____

SPOUSE' S NAME: _____ DOB: _____

RESPONSIBLE PARTY

NAME: _____ RELATIONSHIP TO PATIENT:_____ PHONE: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ SUSCRIBER' S NAME: _____ DOB: _____

GROUP NUMBER: _____ CONTRACT NUMBER: _____

SECONDARY INSURANCE: _____ SUSCRIBER' S NAME: _____ DOB: _____

GROUP NUMBER: _____ CONTRACT NUMBER: _____

IS THIS A WORKMAN' S COMP. CLAIM? Y N INJURED IN AN AUTO ACCIDENT? Y N

EMERGENCY CONTACT INFORMATION

NAME: _____ PHONE: _____ RELATIONSHIP: _____

EXPLANATION OF PAYMENT POLICY/INSURANCE FILING/ELECTRONIC ACCESS

I hereby authorize True Medical Group and Lister Healthcare, Corp. to release any and all information acquired in my examination and treatment to my insurer listed above. If I am covered by Blue Cross, Medicare, and/or Medicaid, I will furnish my insurance cards and signature. If I am covered by other insurance,'I will furnish the necessary forms/cards to this office. I authorize Dr. True and Dr. Barco and/or his staff to use electronic means to access my medical and insurance information. I hereby assign and authorize payment directly to Terry J. True, MD or Roy Barco, MD, PhD of any medical and surgical benefits otherwise payable to me. Should an insurance payment be received that is less than the physician' s usual charge for the service provided, I will be responsible for the difference. I also agree to pay all cost of collection, including but not limited to, reasonable attorney' s fees, and waive all claims of exemption under Alabama law. I authorize treatment by Lister Healthcare Corp., Terry J. True, MD, Roy Barco, MD, Phd, and personnel. This form must be signed and dated by the patient or responsible party.

PATIENT/PARTY SIGNATURE: _____ DATE: _____

TRUE MEDICAL GROUP/ LISTER HEALTHCARE CORP.

Notice of Privacy Practices Acknowledgement Form

Today's Date:_____

I acknowledge receipt of the Notice of Privacy Practices with detailed information regarding how Lister Healthcare Corporation may use and disclose my protected health information. I understand that LHCC reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me.

_____

Printed Name

_____

Patient Signature, Parent/Guardian, or Legal Representative

OFFICE USE ONLY-DOCUMENTATION OF GOOD FAITH EFFORT

_____(patient) was provided with a copy of the LHCC Notice of Privacy Practices. A good faith effort was made to obtain a written acknowledgment of receipt of the notice, however, the patient declined to sign the above acknowledgement form.

_____

Employee Signature and Date

Revised 8/2011

CONSENT FOR INFORMATION RELEASE

I, _____, hereby authorize True Medical Group/ LHCC to release any and all information acquired in my examination and treatment to:

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

Please check additional authorizations that may apply:

- ☐ Please do **NOT** phone me at home.
- ☐ Please do **NOT** phone me at work.
- ☐ Please do **NOT** leave messages on my answering machine.
- ☐ Please send mail, including monthly statements, to another address I will provide.

Signature:_____ Date: _____

True Medical Group

Terry J. True, MD
Roy Barco, MD, PhD
Joyce Shea, CRNP, DNP
Elizabeth Livingston, CRNP
Tabitha Clemons, CRNP
Melissa Aycock, CRNP
104 Physicians Drive, Ste. A, Muscle Shoals, AL 35661
Phone: 256-383-6070 Fax: 256-381-4022

Authorization to Use/Disclose Health Information

Patient Name: _____

Date of Birth: _____ SSN: _____

Signature: _____ Date: _____

Witness: _____

I authorize the use or disclosure of health information and/or records, including but not limited to:

- Last two (2) progress notes
- Most recent EKG
- Most recent DEXA, CT, MRI, GXT, Echo, and Mammogram reports
- Plain film x-ray reports (Within the last year)

Other: _____

From: _____ To: _____

_____ _____

_____ _____

Phone: _____ Phone: _____

Fax: _____ Fax: _____

True Medical Group

Terry J. True, MD
Roy Barco, MD, PhD
Joyce Shea, CRNP, DNP
Elizabeth Livingston, CRNP
Tabitha Clemons, CRNP
Melissa Aycock, CRNP

POLICY ON CHRONIC PAIN AND NERVE MEDICATIONS

For all patients requesting pain or nerve medications, this office will review pharmacy data, insurance information, and any other information available regarding a patient's use of controlled prescriptions.

Pain Medications: This is to inform patients that True Medical Group does NOT treat chronic pain with narcotics or give narcotics for long- term use. Narcotics include Lortab, Lorcet, Oxycontin, Morphine, Opana, Percocet, Suboxone, Tylox, Fentanyl, and many others. I recommend you see a pain management specialist. Please do not ask that we make an exception as we will be unable to do so.

Nerve Medications: As well, we don't prescribe Xanax, Librium, Valium, or Ativan. If you need one of these medications, we will be happy to refer you to a psychiatrist.

Psychiatric Medications: We require that any patients diagnosed with Bipolar Disorder or ADHD/ADD have a psychiatrist following their care. We will not write prescriptions for Lithium, Seroquel, or other medications that a psychiatrist needs to be monitoring.

HOSPITAL ADMISSION POLICY

Please be aware that Dr. True and Dr. Barco admit patients to Shoals Hospital. If you choose to go to Helen Keller Hospital emergency department and are admitted, you will be assigned to whichever doctor is covering as hospitalist.

I have read and understand the policies stated above.

_____ _____

Patient Signature Date

LISTER HEALTHCARE, CORP. NOTICE OF HEALTH INFORMATION PRIVACY PROTECTION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

Lister Healthcare Corporation is required to maintain the privacy of your health information and to provide you with a notice of its legal duties and privacy practices. LHCC will not use or disclose your health information except as described in this notice. This notice applies to all medical records generated by LHCC. Electronic and paper. This notice further describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations 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.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

TREATMENT: LHCC will use your health information in the provision and coordination of your healthcare. We may disclose all or any portion of your medical record information to your physician, consulting physician(s), nurses, technicians, medical students, pharmacists, and other healthcare providers who have a legitimate need for such information in the care of your continued treatment.
PAYMENT: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. LHCC may release medical information about you for the purpose of determining eligibility, coverage, claims management, reviewing services provided to you for medical necessity, and undertaking utilization review activities.
HEALTHCARE OPERATIONS: LHCC may use and disclose health information about you in connection with health care operations necessary to run our practice, including review of our treatment and services, training, evaluating the performance of our staff and health care professionals, quality assurance, financial or billing audits, legal matters, and business planning and development.
APPOINTMENT REMINDERS: LHCC may use and disclose your medical information to contact you as a reminder that you have an appointment for treatment or medical care at a hospital or other healthcare facility. We may contact you using a postcard, letter, voicemail, or email.

YOUR RIGHTS WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION

ACCESS: You may request to review or request a copy of your health information. We may deny your request under certain circumstances. You will receive written notice of a denial and can appeal it. We will provide a copy of your health information in a format you request if it is readily producible. If not ready producible, we will provide it in a hard copy format or other format that is mutually agreeable. If your health information is included in an EHR, you have the right to obtain a copy of it in an electronic format and to direct us to send it to the person or entity you designate in a electronic format. We may charge a reasonable fee to cover our cost to provide you with copies of your 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 laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed.
AMENDMENTS: If you believe that your health information is incorrect or incomplete, you may request that we amend it. We may deny your request under certain circumstances. You will receive written notice of a denial and can file a statement of disagreement that will be included with your health information that you believe is incorrect or incomplete.
RESTRICT USE AND DISCLOSURE: You may request that we restrict uses of your health information to carry out treatment, payment or health care operations or to your family member or friend involved in your care or the payment for your care. We may not (and are not required) agree to your requested restrictions. You may pay out of pocket in full for services you receive from us and request we not submit claim to health insurance.
ACCOUNTING OF DISCLOSURES: You have a right to receive an accounting of disclosures of your health information for the six years prior to the date that the accounting is requested except for disclosures to carry out treatment, payment, health care operation (and certain other exceptions as provided by HIPAA). A charge may be imposed for this service.
RECEIVE A PAPER COPY OF THIS NOTICE: You have the right to receive a paper copy of this notice upon request.

HITECH SAFEGUARDS TO PROTECT HEALTHCARE INFORMATION (Health Information Technology for Economic and Clinical Health)

ADMINISTRATIVE SAFEGUARD: LHCC has in place, policies and procedures relating to the use and disclosure of protected health information by LHCC's workforce, other providers of health care and business associates. (5.1)
TECHNICAL SAFEGUARD: LHCC safeguards include, but not limited to: computer log-in and protected passwords, maintenance of electronic storage, back-up and destruction systems, and maintenance of all computer systems in compliance with HITECH.
PHYSICAL SAFEGUARD: LHCC safeguards include, but not limited to: locked medical record storage, environment that is secure from unauthorized individuals for areas where hard copies of health information are used, and appropriate protection from fire or water damage.
FOR MORE INFORMATION OR TO REPORT A PROBLEM: If you have questions and/or would like additional information, contact your physician's office manager. If you believe your privacy rights have been violated, you may file a complaint with LHCC or with the Secretary of the Department of Health and Human Services. To file a complaint with LHCC, please contact Pat Whiteside, Compliance Officer at P. O. Box 298, Florence, AL 35631 or you may leave a voicemail at 256-767-7494 ext. 45. All complaints are confidential.
The privacy of your health information is important to us. We will not retaliate against you in any way if you choose to file a complaint.

CHANGES OF THE LHCC NOTICE OF PRIVACY PRACTICES: We reserve the right to change the terms of this Notice at any time. Any change will apply to the health information we have about you or create or receive in the future. We will promptly revise the Notice when there is a material change to the uses or disclosures, individual rights, our legal duties, or other privacy practices discussed in this Notice. Revised 8/1/2011

Confidential

Patient Name _____ Today's Date _____

Age _____ Birthdate _____ Date of last physical examination _____

What is your reason for visit? _____

Symptoms

Check (✓) symptoms you currently have or have had in the past year.

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only

- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children _____

Conditions

Check (✓) conditions you currently have or have had in the past year.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

Medications

List medications you are currently taking.

_____

_____

_____

_____

Pharmacy Name _____ Phone _____

Allergies

_____

_____

_____

_____

_____

Health History

Family History

Fill in health information about your immediate family.

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if, your blood relatives had any of the following: Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

Hospitalizations

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give approximate dates _____

Serious Illness/Injuries	Date	Outcome

Pregnancies

Year of Birth	Sex of Birth	Complications if any

Health Habits

Check (✓) which you use and how much you use.

	Caffeine	
	Tobacco	
	Street Drugs	
	Other	

Occupational

Check (✓) if your work exposes you to:

	Stress		Hazardous Substances
	Heavy Lifting		Other

Occupation _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

_____ _____

Reviewed By — Date