TIDELANDS HEALTH GROUP

Patient Information

Last Name			Primary Care Physician
First Name	MI		Referring Provider
Previous Name			Date of Birth (mm/dd/yyyy)
Address			Social Security #
City			Gender ❑ Male ❑ Female
State	Zip	County	Marital Status ❑ Single ❑ Divorced ❑ Married ❑ Widowed
Home Phone	Cell Phone		Race : ❑ American Indian or Alaska Native ❑ Asian ❑ Native Hawaiian or Other Pacific ❑ Black or African American ❑ White ❑ Hispanic ❑ Other ❑ Refuse to report
Work Phone Ext.			Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Refuse to report
Email Address		Emergency Contact Name & Relation	Emergency Contact Ph #
Preferred Pharmacy		Pharmacy Location	Pharmacy Telephone #

Responsible Party or Guarantor (If under 18 years of age)

Last Name		Relation		
First Name	MI	Address		
Home Phone	Cell Phone	City	State	Zip

Patient Employer Information

☐ Employed ☐ Retired ☐ Full-time Student ☐ Part-time Student ☐ Disabled ☐ Unemployed				
Employer Name		Occupation		
Address	City	State	Zip	Work Phone

Insurance Information

Primary Insurance Company Name	Subscriber's Name	Subscriber's Date of Birth
Subscriber's Social Security/ID Number	Subscriber's Address	Subscriber's Home Phone
Secondary Insurance Company Name	Subscriber's Name	Subscriber's Date of Birth

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Health Maintenance Risk Assessment

Patient Name: _____ Patient DOB: _____

Dementia Screening

Please check yes or no if you are having any of the following:

☐ Yes ☐ No Problems with judgment
☐ Yes ☐ No Lack of interest in hobbies/activities you usually enjoy
☐ Yes ☐ No People complain that you repeat questions, comments, stories or statements
☐ Yes ☐ No Trouble learning how to use a new tool or appliance
☐ Yes ☐ No Trouble remembering the month or year
☐ Yes ☐ No Difficulty paying bills on time
☐ Yes ☐ No Difficulty remembering appointments
☐ Yes ☐ No Consistent problems with thinking and/or memory

Depression Screening

For the past two weeks, have you experienced any of the following:

☐ Yes ☐ No Have little interest in activities you usually enjoy?
☐ Yes ☐ No Feeling down or depressed?

Please list all doctors or other medical equipment providers below:

Eyes: _____ Other: _____

Ears, Nose, Throat: _____

Heart: _____

Lungs: _____

Stomach: _____

Urinary Tract: _____

Ob/Gyn: _____

Allergist: _____

Surgeon: _____

Review of functional ability and level of safety:

☐ Yes ☐ No Safety issues in home. If yes, please list: _____
☐ Yes ☐ No Can you bathe, cook, dress and clean without difficulty?

If no, list why: _____

Date: _____

TIDELANDS HEALTH GROUP

Patient Name

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Age: _____

Primary Reason for Visit:

Please check any of the following that are causing you concern or difficulty:

- ☐ Skin or Hair
- ☐ Head
- ☐ Eyes
- ☐ Ears
- ☐ Nose
- ☐ Mouth or Throat
- ☐ Neck
- ☐ Lungs, Check or Breathing
- ☐ Heart
- ☐ Stomach or Bowels
- ☐ Kidneys, Bladder or Urinary System
- ☐ Genitals or Sex
- ☐ Muscles, Bones or Joints
- ☐ Glands, Including Thyroid or Diabetes
- ☐ Stress or Anxiety
- ☐ Depression or Moods
- ☐ Bad Habits
- ☐ Relationships
- ☐ Anything else?

Medical conditions for which you are being treated:

Medications and Dosages (including prescribed herbs, vitamins, and/or over the counter medications)

Medication Name	Dosage

Pharmacy name	Pharmacy Number

Allergies

Past Operations/Surgery	Year

TIDELANDS HEALTH GROUP

Hospitalizations

Reason for Hospitalization	Year

Accidents/Injury

Type of Accident/Injury	Year

Answer the following:	**Yes**	**No**
Have you ever received a Blood Transfusion?		
Have you ever had hepatitis?		
Have you ever had TB (tuberculosis?		
Have you ever had a sexually transmitted disease?		
Have you ever had HIV/AIDS?		
Have you ever had Rheumatic Fever?		
Do you smoke?		
Do you drink alcohol?		

Have any of your family members (Parents, Grandparents, Siblings, Children or Extended Family) suffered from any of the following?

Problem	**Yes**	**No**	**If yes, List Relative**
High Blood Pressure			
Heart Disease			
Stroke			
Diabetes			

Cancer	**Yes**	**No**	**If yes, List Age**
Breast			
Colon			
Prostate			
Lung			
Other			

TIDELANDS HEALTH GROUP

Patient Request for Confidential Communications

Patient Name: _____

Patient Date of Birth: _____

This is a request for confidential communications of my protected health information (PHI). When the doctor, nurse or other members of your office want to contact me please use the following guidelines. I understand that you will do your best to adhere to the following requests.

Please check all that apply to this request:

_____ Please do not phone me at home. Use the following alternative phone number to contact me:_____

_____ Please do not phone me at work. Use the following alternative number to contact me:_____

_____ Please do not contact me by email.

_____ Other request(s) (describe in detail): _____

_____

_____ When contacting me by phone it is ok to leave messages and discuss my health information with:

Name:_____Relationship_____

Name: _____Relationship _____

_____ **(Please initial) I understand that the physician or provider to whom I am making this request will make reasonable efforts to accommodate this request. I further understand that in some emergency situations, my PHI may be released. I authorize my medications from the Pharmacy Data Base be released to Tidelands Health Group.**

Advanced Directive Planning

Do you have an Advanced Directive? ☐ Living Will ☐ Power of Attorney ☐ DNR ☐ I do not have an Advanced Directive

Consent for Medical Treatment

I/we voluntarily consent to medical treatment and diagnostic procedures provided by Tidelands Health Group and its associated physicians, clinicians and other personnel. I/we am/are aware that the practice of medicine and surgery is not an exact science and I/we acknowledge that no guarantee has been made as to the result of treatments or examinations.

Assignment of Benefits and Patient Responsibility

I certify the information on all Tidelands Health Group forms is true to the best of my knowledge. I accept responsibility for the medical charges incurred by the patient and agree to pay bills at time of service unless other arrangements are made. I authorize my insurance claim to be paid directly to the clinic. I further understand my health care insurance carrier or payor of my health benefits may pay less than the actual bill for services, and all second opinion and pre-admission review requirements are ultimately my responsibility.

Signature of Patient (or patient's personal representative):_____

Relationship of representative to patient: _____

Date: _____

TIDELANDS HEALTH GROUP

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW PATIENTS CAN OBTAIN ACCESS TO THIS INFORMATION.

We have a legal duty to safeguard our patients protected health information. The Privacy Rights and Practices of Tidelands Health Group were established to protect the health information of our patients as required by Section 164.520 of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The following categories describe different ways we may use and disclose medical information without your specific consent or authorization. Not all possible uses and disclosures are listed.

- **For Treatment**: We may use and disclose your medical information to provide you with medical treatment and services.
- **For Payment:** We may use and disclose your medical information to bill and collect payments for medical services rendered.
- **Health Care Operations:** We may use and disclose your medical information for health care operations to assure that you receive quality care.

Other Uses or Disclosures that Can Be Made Without Consent or Authorization

- **Public Health Activities**
- **Health Inspection Agencies**
- **Law Enforcement Purposes**
- **Workers Compensation**
- **Government Functions (Military/ Veterans Activities)**
- **Reporting Abuse, Neglect, or Domestic Violence**
- **Judicial Proceedings**
- **Disclosures about Decedents (Coroner/Funeral Director)**
- **Avert Serious Threat to Public Health or Safety**

YOUR RIGHTS CONCERNING YOUR PROTECTED HEALTH INFORMATION:

- The Right to request limits on uses and disclosures of your health information.
- The Right to choose how we send health information to you or how we contact you.
- The Right to see or to get a copy of your protected health information.
- The Right to receive a list of certain disclosures of your health information that we have made.
- The Right to ask to correct or update your health information.
- The Right to ask questions about the Privacy Policy.
- The right to opt out of fundraising communications
- The right to restrict certain disclosures of PHI to a health plan where the individual pays out of pocket in full.
- The right to notice in the event of a breach of unsecured PHI
- The right to limit the use of generics information for health plan underwriting purposes
- The Right to file a complaint with Tidelands Health Group or the Secretary of Health and Human Services without the fear of any reprisals if you feel your rights have been violated.

Tidelands Health Group is required by law to abide by the terms outlined in this notice. However, Tidelands Health Group reserves the right to change the terms of this Privacy Notice and make the new provisions effective for all protected health information that we maintain. Before we make an important change to our policies, we will promptly change this Notice and post a new Notice in our receptionist area. You may also request a copy of our Notice of Privacy Practices at any time.

Patient Name: _____

Patient/Guardian Signature: _____ Date: _____

Witness: _____ Date: _____

Copy is available at your request

TIDELANDS HEALTH GROUP

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

TIDELANDS HEALTH GROUP

I hereby authorize: _____ _____

_____ _____

_____ _____

To release the following information from the health records for:

1. **Patient's** Name:_____ **Patient's** Date of Birth:_____

Patient's Social Security Number (Last 4 digits): **XXX-XX-** _ _ _ _ **Patient's** Telephone:_____

2. **Covering The Periods of Treatment: From:** _____ **To:**_____

3. **Information To Be Released As Checked:**

_____ Abstract *(discharge summary, consultation reports, emergency department reports, history & physical, laboratory reports, operative reports, pathology reports, x-ray reports)*
_____ Consultation Report
_____ Discharge Summary
_____ Emergency Department
_____ Other ***[Please Specify]:***_____

_____ History & Physical
_____ Laboratory Report
_____ Operative Report
_____ Pathology Reports
_____ X-ray Reports
_____ Cardiac Studies

_____ Complete Record
_____ Medication Admin. Records
_____ Nurses Notes
_____ Other Diagnostic Reports
_____ Progress Notes
_____ X-Ray Films/CD

4. *Type of Access Requested:* _____*Copy of the record/s* _____*Inspection of the record/s*

5. _____ I understand that this information may include references to or treatment of drug or alcohol abuse,
Initials psychological illness, or test results for HIV/AIDS.

6. **Information Is To Be Released To**: Name:_____

Address:_____ City:_____ State:_____ Zip:_____

Telephone Number:_____ Fax Number:_____

7. Purpose of Disclosure: _____Continued Health Care ____Personal Reasons ____Insurance ____Legal ____Other

8. **This Authorization expires six {6} months from the date signed below and covers only treatment for the dates specified.**

9. *I understand that this authorization may be withdrawn by me at any time as explained in the Tidelands Health Notice of Privacy Practices except to the extent that action has been taken in reliance upon it. I understand that information disclosed under this authorization may be re-disclosed by the recipient of the information and the information may not be given the same protection it receives from Tidelands Health Group. Tidelands Health Group is released and discharged of any liability and the undersigned will hold Tidelands Health Group harmless, for complying with this "**Authorization for Release of Medical Information**." I understand that I have the right to refuse to sign this authorization and Tidelands Health Group may not condition treatment based upon my refusal to sign the authorization unless the authorization is necessary for research related treatment of healthcare related services provided solely for the purposes of releasing the information to a 3rd party.*

10. A photo static copy of this authorization is to be considered as valid as the original.

11. Fees/charges will comply with all laws and regulations applicable to release of information.

12. ***I understand that Tidelands Health Group has up to thirty [30] days to provide access to my record for records stored on-site, and up to sixty [60] days to provide access to records stored off-site.***

Signature of Patient or Guardian:_____ Date:_____

Patient/Guardian/Requester Picture ID [Copy]:_____ Guardian's Relation to Patient:_____

Documentation of Healthcare Power of Attorney for adult patient or emancipated minor [copy attached] _____

Processed by:_____/_____ Date_____
Print name of Processing Staff Signature of processing staff