TAPP MEDICAL CLINIC

WE DO NOT PRESCRIBE ANY NARCOTIC PAIN MEDICATION

Bring the following items to your first appointment

1. ***Medical Records from previous PCP***
2. ***Copies of any imaging (x-rays, CT's, MRI's, etc)***
3. ***Print out from all pharmacies used in the last 12 months***
4. ***All Pill bottles***

PATIENT NAME		DATE OF BIRTH	AGE	SEX MALE FEMALE
RACE	LANGUAGE	MARTIAL STATUS		
STREET ADDRESS		APARTMENT NUMBER	CELL PHONE NUMBER	
CUTY/ STATE	ZIP CODE	E-MAIL ADDRESS	HOME PHONE NUMBER	
EMPLOYER		WORK NUMBER	SOCIAL SECURITY NUMBER	
EMERGENCY CONTACT		PHONE NUMBER	RELATIONSHIP	

INSURANCE INFORMATION

PRIMARY INSURANCE	IDENTIFICATION NUMBER
INSURED NAME	INSURED DOB
SECONDARY INSURANCE	IDENTIFICATION NUMBER
INSURED NAME	INSURED DOB

IF WORK RELATED COMPLETE THIS SECTION

NAME OF WORKER'S COMPENSATION CARRIER	DATE OF INJURY	CLAIM NUMBER
ADDRESS OF WORKER'S COMPENSATION CARRIER		STATE/ ZIP CODE
EMPLOYER AT THE TIME OF INJURY		EMPLOYER'S PHONE NUMBER
ADJUSTERS NAME	ADJUSTERS PHONE NUMBER	ADJUSTERS FAX NUMBER
QRC'S NAME	QRC'S PHONE NUMBER	QRC'S FAX NUMBER

IF AUTO RELATED COMPLETE THIS SECTION

NAME OF AUTO INSURANCE CARRIER	DATE OF INJURY	CLAIM NUMBER
ADDRESS		STATE/ ZIP CODE
ADJUSTERS NAME	ADJUSTERS PHONE NUMBER	ADJUSTERS FAX NUMBER

HOW DID YOU HEAR ABOUT US? PLEASE CIRCLE ONE

NEWSPAPER ( ) **PATIENT ( )** **INTERNET ( )** **RADIO ( )** **PHYSICIAN ( )** **OTHER ( )**

PATIENT REFERRAL – REFERRING PATIENTS NAME:

DOCTOR REFERRAL – PLEASE PROVIDE REFERRING DOCTORS NAME AND PHONE NUMBER

TAPP MEDICAL CLINIC

New Patient Medical History** - **Please complete this two-sided form prior to your first appointment

Name: ______________________________ Date of Birth: ___/___/ 19___ Age: ____ Sex: ____
How did you hear about our practice?

♦ Please briefly state in the box below the reason for your visit ♦

♦ Past Medical History ♦

Condition / Disease	*Year Began*	*Condition / Disease*	*Year Began*
❑ Hypertension		Other(s):	
❑ High Cholesterol			
❑ Hypothyroidism (low thyroid)			
❑ COPD, Emphysema or Asthma			
❑ Diabetes			
❑ GERD			
❑ Depression or Anxiety			
❑ Heart Problems -			

♦ Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures ♦

Operation / Hospitalization / Injury	*Month / Yr*	*Operation / Hospitalization / Injury*	*Month / Yr*

♦ Other Physicians and Specialists ♦

List below your other physicians (i.e., Gyn, Dermatology, GI, Orthopedics, Urology, Psychiatry, etc)

Name	Address	Phone Number	Speciality

TAPP MEDICAL CLINIC

♦ Medication or Food Allergies or Intolerances ♦			
List below medications or foods causing an allergic reaction (i.e., rash, swelling) or intolerance (i.e., nausea)			
Medication / Food	***Reaction***	***Medication / Food***	***Reaction***

♦ Medications, Vitamins and Herbal Supplements ♦					
Medication	***Strength***	***Number of pills taken & frequency***	***Medication***	***Strength***	***Number of pills taken & frequency***
Example: *Tylenol*	*500 mg*	*1 - twice daily*			

♦ Social, Educational and Work History ♦		
Marital Status:	Age of children, if any:	
Work Status (circle one): Employed Unemployed / Retired / Disabled	Current or Prior Occupation:	Hours worked per week:
Highest Level of Education:	Completed at which institution / school:	
What type of exercises do you perform, duration & frequency?		
In what type of residence do you live (i.e., house, assisted living, nursing home)?		
What are your hobbies?		
Do you drink alcohol?	What type of alcohol?	No. of drinks per week?
Are you a current smoker?	If you smoke, how many packs per day?	
Are you a former smoker?	If so, what year did you quit?	No. of years you smoked?
On average, how much did you smoke per day?		
Are you sexually active: Yes / No	Do you have sex with: Men / Women / Both	How many partners have you had during the past 12 months?
Are you concerned that you may have been exposed to HIV? Yes / No		

TAPP MEDICAL CLINIC

♦ **Family Health History** ♦ *Please list below the health history of your blood (genetic) first degree relatives*				
Relative	***Living or Deceased***	***Current age or age at death***	***Cause of Death***	***Health Problems***
Father:				
Mother:				
Brother(s):				
Sister(s):				

♦ **Review of Systems** ♦ *Please review the following symptoms and circle those items that are a problem for you*				
Vision problems	Wheezing	Lumps in breast	Frequent Urination	Excessive hunger
Hearing problems	Asthma / COPD	Breast discharge	Incontinence	Excessive thirst
Sinus trouble	Emphysema	Trouble swallowing	Blood in Urine	Weakness
Hay fever	Bronchitis	Nausea	History of STD's	Fatigue
Nosebleeds	TB exposure	Vomiting	Anemia	Fever / Sweating
Sore throat	Chest pain	Abdominal pain	Easy bruising	Fainting
Hoarseness	Chest discomfort	Hepatitis / Jaundice	Pain in legs	Seizures / Tremor
Lumps in neck	Shortness of breath	Gallstones	Joint pain / stiffness	Headaches
Tooth problems	High blood pressure	Diarrhea	Blood clot	Numbness/tingling
Cough	Diabetes	Constipation	Weight loss / gain	Anxiety/Depression
Coughing blood	High cholesterol	Blood in stool	Heat/cold intolerance	Difficulty sleeping

♦ **Disease Prevention and Health Maintenance** ♦ *Please list below the most recent dates of your vaccines and health screening tests*					
	Month/Yr		***Month/Yr***		***Month/Yr***
Flu Vaccine		Mammogram		Eye Exam	
Pneumonia Vaccine		Pap Smear		Heart Catheterization	
Tetanus Vaccine		Colonoscopy		Endoscopy (EGD)	
Hepatitis B Vaccine		Bone Density		Heart Stress Test	
Shingles Vaccine		EKG		Ab Aneurysm Screen	
Gardasil Vaccine		Chest X-Ray		HIV Test	

The information I have given is accurate

Patient Signature Date

TAPP MEDICAL CLINIC

PATIENT POLICIES

Walk-In Hours – we take walk-ins between the hours of 8-10 am and 1-3 pm daily. Walk-ins are reserved for sick visits only. If you need medication refills you will have to schedule an appointment.

Chronic Pain/Pain Clinics – At Tapp Medical we do not treat chronic pain, you will be referred to a pain clinic. If you get discharged from any pain clinic we will not be able to refer you to another one. You will be responsible for finding one on your own. Once you find one that will accept you, if they need a referral from us we will be happy to do the referral then.

Narcotic Pain Medication - WE DO NOT PRESCRIBE ANY NARCOTIC PAIN MEDICATION

Chronic Disease Management – Visits for Chronic Disease management or medication refills will not be handled at the same time as a sick visit. Example if you are here for a sore throat, flu, strep, Urinary Tract Infection, rash or any other type of acute visit, that is all you will be seen for. You will not receive refills on maintenance medications, no will your chronic diseases be discussed.

Lab Results – You will need to schedule a follow up appointment to get your lab results, these will not be given over the phone.

Refills – No refills will be authorized if you have not been seen in at least the last three months. Controlled substances require that you been seen monthly. Refills will not be called in, if you need a refill please have your pharmacy send a refill request to us electronically.

Financial Policy

You are responsible for all charges you incur at Tapp Medical Clinic. We accept money order, check, and credit cards. We know that both cost and quality of care are important to you. Ask if you have questions about fees.

INSURANCE
As your medical provider, our relationship is with you. Your insurance is a contract between you and your insurer, which may not cover all your care. We will file your claim as a courtesy. It is your responsibility to contact your insurance to determine if we are in network with your insurance and if any referral is needed.

To prevent fraud, you must present a valid insurance card and valid photo ID. You must pay any applicable co-payment, deductible; or past-due balance at each visit. If your insurance has changed, you may need to pay the full cost of your visit. We understand your frustration and will assist you in obtaining reimbursement or credit from your insurer.

Payment Plan Arrangements
Medical expenses are often not anticipated. We are willing to have our Billing Department work with you if you are in need of payment plan arrangements; our billing department handles these arrangements.

TAPP MEDICAL CLINIC

FORMS/APPEALS
Insurance covers only your medical care. It does not cover submitting forms that may assist you in collecting disability benefits, or maintaining employment. The charge for form completion ranges between $25-$300 depending on the type and length of form. This is not billable to insurance and has to be paid by you before the form is completed. Please allow seven (7) to ten (10) working days for completion.

ASSIGNMENT OF BENEFITS
I authorize all insurance benefits to be paid directly to Tapp Medical Clinic. I authorize the release of all necessary information to file and complete all insurance claims.

UNPAID BILLS
Accounts that are 60 days past due will be assessed a late fee. You will also be responsible for collection costs including court and attorney fees. Returned checks are subject to a $35.00 service charge.

MISSED AND CANCELLED APPOINTMENTS
Be respectful to other patients. If you cannot keep an appointment, please give us at least 24 hours notice, so that we can make this time available for other patients. We will charge a $25.00 fee if this notice is not given (weekends not included). If you arrive ten minutes or later to an appointment, you may be asked to reschedule. This type of missed appointment will also acquire a charge.

I HAVE READ AND UNDERSTAND ALL THE INFORMATION ON THIS FINANCIAL POLICY. I AGREE TO ITS TERMS, AND TO THE ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION DESCRIBED ABOVE. WITH MY SIGNATURE I AM ALSO AUTHORIZING MEDICAL TREATMENT TO BE PERFORMED BY MIDDLE TENNESSEE HEALTH & WELLNESS CENTER, INC.

____
(PATIENT/GUARDIAN SIGNATURE)

____
(PRINT PATIENT/GUARDIAN NAME)

Date Signed____

By signing this form, you acknowledge receipt of the Notice of Privacy Practices from the Tapp Medical Clinic. The Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to review it carefully. The Notice of Privacy Practices is subject to change.

I acknowledge receipt of the Notice of Privacy Practices from Tapp Medical Clinic

Signature: _________________________________ Date Signed: ____________
(Client / Parent / Guardian)

TAPP MEDICAL CLINIC

HIPAA Omnibus Notice of Privacy Practices

Tapp Medical Clinic
414 Old Morgantown Road
Bowling Green, KY 42101
270-781-1483

This Notice of Privacy Practices is NOT an authorization. It describes how we, our Business Associates, and their subcontractors 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 that identifies you individually, including demographic information that relates your past, present, or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

We may use and disclose your Protected Health Information in the following situations:

- **Treatment:** We may use or disclose your Protected Health Information to provide medical treatment and/or services in order to manage and coordinate your medical care. For example, we may share your medical information with other physicians and health care providers, DME vendors, surgery centers, hospitals, rehabilitation therapists, home health providers, laboratories, nurse case managers, worker's compensation adjusters, etc. to ensure that the medical provider has the necessary medical information to diagnose and provide treatment to you.

- **Payment:** Your Protected Health Information will be used to obtain payment for your health care services. For example, we will provide your health care plan with the information it requires prior to paying us for the services we have provided to you. This use and disclosure may also include certain activities that your health plan requires prior to approving a service, such as determining benefits eligibility and prior authorization, etc.

- **Health Care Operations:** We may use and disclose your Protected Health Information to manage, operate, and support the business activities of our practice. These activities include, but are not limited to, quality assessment, employee review, licensing, fundraising, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your Protected Health Information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

- **Minors:** Protected Health Information of minors will be disclosed to their parents or legal guardians, unless prohibited by law.

- **Required by Law:** We will use or disclose your Protected Health Information when required to do so by local, state, federal, and international law.

- **Abuse, Neglect, and Domestic Violence:** Your Protected Health Information will be disclosed to the appropriate government agency if there is belief that a patient has been or is currently the victim of abuse, neglect, or domestic violence and the patient agrees or it is required by law to do so. In addition, your information may also be disclosed when necessary to prevent a serious threat to your health or safety or the health and safety of others to someone who may be able to help prevent the threat.

- **Judicial and Administrative Proceedings:** As sometimes required by law, we may disclose your Protected Health Information for the purpose of litigation to include: disputes and lawsuits; in response to a court or administrative order; response to a subpoena; request for discovery; or other legal processes. However, disclosure will only be made if efforts have been made to inform you of the request or obtain an order protecting the information requested. Your information may also be disclosed if required for our legal defense in the event of a lawsuit.

- **Law Enforcement:** We will disclose your Protected Health Information for law enforcement purposes when all applicable legal requirements have been met. This includes, but is not limited to, law enforcement due to identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or warrant, and grand jury subpoena.

- **Coroners and Medical Examiners:** We disclose Protected Health Information to coroners and medical examiners to assist in the fulfillment of their work responsibilities and investigations.

- **Public Health:** Your Protected Health Information may be disclosed and may be required by law to be disclosed for public health risks. This includes: reports to the Food and Drug Administration (FDA) for the purpose of quality and safety of an FDA-regulated product or activity; to prevent or control disease; report births and deaths; report child abuse and/or neglect; reporting of reactions to medications or problems with health products; notification of recalls of products; reporting a person who may have been exposed to a disease or may be at risk of contracting and/or spreading a disease or condition.

- **Health Oversight Activities:** We may disclose your Protected Health Information to a health oversight agency for audits, investigations, inspections, licensures, and other activities as authorized by law.

- **Inmates:** If you are or become an inmate of a correctional facility or under the custody of the law, we may disclose Protected Health Information to the correctional facility if the disclosure is necessary for your institutional health care, to protect your health and safety, or to protect the health and safety of others within the correctional facility.

- **Military, National Security, and other Specialized Government Functions:** If you are in the military or involved in national security or intelligence, we may disclose your Protected Health Information to authorized officials.

- **Immunizations:** We will provide proof of immunizations to a school that requires a patient’s immunization record prior to enrollment or admittance of a student in which you have informally agreed to the disclosure for yourself or on behalf of your legal dependent.

- **Worker's Compensation:** We will disclose only the Protected Health Information necessary for Worker's Compensation in compliance with Worker's Compensation laws. This information may be reported to your employer and/or your employer's representative regarding an occupational injury or illness.

- **Practice Ownership Change:** If our medical practice is sold, acquired, or merged with another entity, your protected health information will become the property of the new owner. However, you will still have the right to request copies of your records and have copies transferred to another physician.

- **Breach Notification Purposes:** If for any reason there is an unsecured breach of your Protected Health Information, we will utilize the contact information you have provided us with to notify you of the breach, as required by law. In addition, your Protected Health Information may be disclosed as a part of the breach notification and reporting process.

- **Research:** Your Protected Health Information may be disclosed to researchers for the purpose of conducting research when the research has been approved by an Institutional Review or Privacy Board and in compliance with law governing research.

- **Business Associates:** We may disclose your Protected Health Information to our business associates who provide us with services necessary to operate and function as a medical practice. We will only provide the minimum information necessary for the associate(s) to perform their functions as it relates to our business operations. For example, we may use a separate company to process our billing or transcription services that require access to a limited amount of your health information. Please know and understand that all of our business associates are obligated to comply with the same HIPAA privacy and security rules in which we are obligated. Additionally, all of our business associates are under contract with us and committed to protect the privacy and security of your Protected Health Information.

USES AND DISCLOSURES IN WHICH YOU HAVE THE RIGHT TO OBJECT AND OPT OUT

- **Communication with family and/or individuals involved in your care or payment of your care:** Unless you object, disclosure of your Protected Health Information may be made to a family member, friend, or other individual involved in your care or payment of your care in which you have identified.

- **Disaster:** In the event of a disaster, your Protected Health Information may be disclosed to disaster relief organizations to coordinate your care and/or to notify family members or friends of your location and condition. Whenever possible, we will provide you with an opportunity to agree or object.

- **Fundraising:** As necessary, we may disclose your Protected Health Information to contact you regarding fundraising events and efforts. You have the right to object or opt out of these types of communications. Please let our office know if you would NOT like to receive such communications.

USES AND DISCLOSURES THAT REQUIRE YOUR WRITTEN AUTHORIZATION

We will not disclose or use your Protected Health Information in the situations listed below without first obtaining written authorization to do so. In addition to the uses and disclosures listed below, other uses not covered in this Notice will be made only with your written authorization. If you provide us with authorization, you may revoke it at any time by submitting a request in writing:

- **Disclosure of Psychotherapy Notes:** Unless we obtain your written authorization, in most circumstances we will not disclose your psychotherapy notes. Some circumstances in which we will disclose your psychotherapy notes include the following: for your continued treatment; training of medical students and staff; to defend ourselves

during litigation; if the law requires; health oversight activities regarding your psychotherapist; to avert a serious or imminent threat to yourself or others; and to the coroner or medical examiner upon your death.

- Disclosures for marketing purposes and sale of your Protected Health Information

PROTECTED HEALTH INFORMATION AND YOUR RIGHTS

The following are statements of your rights, subject to certain limitations, with respect to your Protected Health Information:

- **You have the right to inspect and copy your Protected Health Information (reasonable fees may apply):** Pursuant to your written request, you have the right to inspect and copy your Protected Health Information in paper or electronic format. Under federal law, you may not inspect or copy the following types of records: psychotherapy notes, information compiled as it relates to civil, criminal, or administrative action or proceeding; information restricted by law; information related to medical research in which you have agreed to participate; information obtained under a promise of confidentiality; and information whose disclosure may result in harm or injury to yourself or others. We have up to 30 days to provide the Protected Health Information and may charge a fee for the associated costs.

- **You have a right to a summary or explanation of your Protected Health Information:** You have the right to request only a summary of your Protected Health Information if you do not desire to obtain a copy of your entire record. You also have the option to request an explanation of the information when you request your entire record.

- **You have the right to obtain an electronic copy of medical records:** You have the right to request an electronic copy of your medical record for yourself or to be sent to another individual or organization when your Protected Health Information is maintained in an electronic format. We will make every attempt to provide the records in the format you request; however, in the case that the information is not readily accessible or producible in the format you request, we will provide the record in a standard electronic format or a legible hard copy form. Record requests may be subject to a reasonable, cost-based fee for the work required in transmitting the electronic medical records.

- **You have the right to receive a notice of breach:** In the event of a breach of your unsecured Protected Health Information, you have the right to be notified of such breach.

- **You have the right to request Amendments:** At any time if you believe the Protected Health Information we have on file for you is inaccurate or incomplete, you may request that we amend the information. Your request for an amendment must be submitted in writing and detail what information is inaccurate and why. Please note that a request for an amendment does not necessarily indicate the information will be amended.

- **You have a right to receive an accounting of certain disclosures:** You have the right to receive an accounting of disclosures of your Protected Health Information. An "accounting" being a list of the disclosures that we have made of your information. The request can be made for paper and/or electronic disclosures and will not include disclosures made for the purposes of: treatment; payment; health care operations; notification and communication with family and/or friends; and those required by law.

- **You have the right to request restrictions of your Protected Health Information:** You have a right to restrict and/or limit the information we disclose to others, such as family members, friends, and individuals involved in

your care or payment for your care. You also have the right to limit or restrict the information we use or disclose for treatment, payment, and/or health care operations. Your request must be submitted in writing and include the specific restriction requested, whom you want the restriction to apply, and why you would like to impose the restriction. Please note that our practice/your physician is not required to agree to your request for restriction with the exception of a restriction requested to not disclose information to your health plan for care and services in which you have paid in full out-of-pocket.

- **You have a right to request to receive confidential communications:** You have a right to request confidential communications from us by alternative means or at an alternative location. For example, you may designate we send mail only to an address specified by you which may or may not be your home address. You may indicate we should only call you on your work phone or specify which telephone numbers we are allowed or not allowed to leave messages on. You do not have to disclose the reason for your request; however, you must submit a request with specific instructions in writing.

- **You have a right to receive a paper copy of this notice:** Even if you have agreed to receive an electronic copy of this Privacy Notice, you have the right to request we provide it in paper form. You may make such a request at any time.

CHANGES TO THIS NOTICE

We reserve the right to change the terms of this notice and will notify you of such changes. We will also make copies available of our new notice if you wish to obtain one. **We will not retaliate against you for filing a complaint.**

COMPLAINTS

If at any time you believe your privacy rights have been violated and you would like to register a complaint, you may do so with us or with the Secretary of the United States Department of Health and Human Services.

If you wish to file a complaint with us, please submit it in writing to our Privacy/Compliance Officer to the address listed on the first page of this Notice.

If you wish to file a complaint with the Secretary of the United States Department of Health and Human Services, please go to the website of the Office for Civil Rights (www.hhs.gov/ocr/hipaa/), call 202-619-0257 (toll free 877-696-6775), or mail to:

Secretary of the US – Department of Health and Human Services
200 Independence Ave S.W.
Washington, D.C. 20201

Carla Scarbrough	270-781-1483	carlas.tmc@gmail.com
HIPAA COMPLIANCE OFFICER	**PHONE**	**EMAIL**

We are required by law to provide individuals with this notice of our legal responsibilities and privacy practices with respect to Protected Health Information. We are also required to maintain the privacy of, and abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at the number listed above.