FIRST CHOICE MEDICAL CARE, PLLC

PATIENT INFORMATION

(Please fill out completely.)

Date: _____

First Name: _____ Last Name: _____ Date of Birth: _____

Sex: M or F (circle one) Marital Status: Single Married Divorced Widowed Other _____ (circle one)

Address: _____ City: _____ State: ____ Zip Code: _____

Primary Phone # _____ Cell Phone #: _____ Social Security #: _____

Emergency Contact: _____ Phone #: _____
(not living with you)

Email address: _____ Preferred Contact via: ____Voice ____ Text

Employer: _____ Work Phone # _____

Employer Address: _____

Pharmacy: _____ Pharmacy Phone #: _____

SPOUSE/PARENT INFORMATION

(Please fill out completely.)

Spouse/Parent: _____ Date of Birth: _____ Social Security #: _____

Address (if different than above): _____ City: _____ State: ___ Zip: _____

Employer: _____ Employer Address: _____

City, State, Zip: _____ Work Phone #: _____

INSURANCE INFORMATION

(Cards Must Be Provided at Check-IN.)

Primary Insurance: _____ Effective Date: _____

Insured's Name: _____ Date of Birth of Insured: _____
(if not self)

Secondary Insurance: _____ Effective Date: _____

Insured's Name: _____ Date of Birth of Insured: _____
(if not self)

I hereby authorize First Choice Medical Care, PLLC to bill the insurance provided for services provided and to release my medical information about me or my dependent to my insurance company to determine the benefits or the benefits payable for related services. I understand I am financially responsible for all charges, whether or not covered by said insurance. This assignment will remain in effect until revoked by me in writing.

Patient/Guarantor's Signature: _____ Date: _____

First Choice Medical Care, PLLC

PAYMENT AGREEMENT

1. According to insurance guidelines, insurance co-pays and deductibles are due upon arrival for your office visit.

2. We will file claims with your insurance company(s) as a courtesy to you. After we have received an explanation of benefits and/or payment from you insurance company, we will bill you the amount that your insurance company states is your responsibility. This includes fees for services and deductibles not met. Please be advised that we need current insurance information in order to file claims. When you receive new insurance cards, please let us know so that we can update your information.

3. If your insurance company requires that another physician refer you, it is your responsibility to obtain the referral and bring it with you at the time of your appointment. If you do not obtain a referral, we can not file claim with your insurance company, therefore making you responsible for all charges.

4. If your insurance terms, payment arrangements must be made prior to any services rendered.

5. In order to keep you account current, we require a monthly payment on any outstanding balance. If we do not receive a payment in three consecutive months, you account will be turned over to our collection agency. Customer, patient, borrower, etc. agrees to pay all cost of collection including attorney fees, collection fees, and contingent fees to collection agencies of not less than 25%, such contingency fee to be added and collected by the collection agency immediately upon your default and our referral of your account to said collection agency.

6. Please make every effort to keep scheduled appointments. This time has been reserved for you therefore preventing us from scheduling other patients.

I HAVE READ AND UNDERSTAND AND AGREE TO MY FINANCIAL OBLIGATIONS AS OUTLINED ABOVE AND THEREFORE CONSENT TO TREATMENT BY THE PROVIDERS AND STAFF. IF NEEDED, I AUTHORIZE THE RELEASE OF ANY INFORMATION CONCERNING ME (or my child's) HEALTHCARE, ADVISE, AND TREATMENT FOR THE PURPOSE OF EVALUATING AND ADMINISTERING CLAINS TO THE INSURANCE CARRIER ON BEHALF OF MY BENEFITS. I FURTHER AGREE TO AUTHORIZE PAYMENT OF INSURANCE BENEFITS TO BE MADE PAYABLE TO THIS CLINIC.

Person responsible for account

Date

First Choice Medical Care, PLLC
Patient Financial Responsibilities

Every effort is made to keep the cost of your health care services to a minimum. In keeping with this effort we request your assistance in the following areas:

- You are responsible for all charges. We file insurance as a service to our patients it is your responsibility to provide us with accurate information in a timely manner. Failure to do so could result in your incurring unnecessary expense.

- You are responsible for knowing you insurance benefits, their protocols for being seen by a specialist, and the lab network they utilize. Please make the staff aware of these so that we can ensure you do no incur unnecessary expense.

- Full payment of charges will be expected if you do no present an insurance cart at the time of visit.

- The portion of the visit not covered by your insurance will be expected at the time of the visit. This includes all unmet deductibles, co-insurances and co-payments. Insurance benefits will benefits will be verified at the time of service.

- Patients will be expected to make full payment on previous unpaid balances unless prior arrangements have been made.

- For your convenience, we accept Cash, Visa, Mastercard, American Express, Money Orders and Personal Checks. ($35.00 returned check fee applies)

- Refunds of overpayments will be cheerfully refunded upon your request.

- Failure to meet your financial responsibility may result in your being denied further medical treatment.

I understand and agree to my financial obligation as outlined above and therefore consent to treatment by the providers and staff of First Choice Medical Care, PLLC. If needed, I authorize the release of any information concerning me or my child's health care, advice and treatment for the purpose of evaluating and administering claims to the insurance carrier on behalf of my benefits. I further agree to authorize payment of insurance benefits to be made payable to this clinic.

Signature of Patient/Guarantor: _____

Date: _____ Witnessed by: _____

HIPAA Release Form

Please complete all sections of this HIPAA release form. If any sections are left blank, this form will be invalid and it will not be possible for your health information to be shared as requested.

Section I

I,_____, give my permission for First Choice Medical Care, PLLC to share the information listed in Section II of this document with the person(s) or organization(s) I have specified in Section IV of this document.

Section II – Health Information

I would like to give the above healthcare organization permission to:

Check the appropriate box(es) below.

☐ Disclose my complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions.

Or

☐ Disclose my complete health record except for the following information

- ☐ Mental health records
- ☐ Communicable diseases including, but not limited to, HIV and AIDS
- ☐ Alcohol/drug abuse treatment records
- ☐ Genetic information
- ☐ Other (Specify)

_____

_____

_____

_____

Form of Disclosure:

- ☐ Electronic copy or access via a web-based portal
- ☐ Hard copy
- ☐ Voice Mail
- ☐ I consent to receive SMS text messages from [your location name] for appointment reminders, marketing messages, and general two-way communication. Message frequency varies. Message & data rates may apply. Reply HELP for support. Reply STOP to opt out. Refer to our privacy policy for more information.

Section III – Who Can Receive My Health Information

I give authorization for the health information detailed in section II of this document to be shared with the following individual(s) or organization(s)

Name: _____

Organization: _____

Address: _____

I understand that the person(s)/organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

Section IV – Duration of Authorization

This authorization to share my health information is valid:

Tick as appropriate

☐ a) From _____ to _____

Or

☐ b) All past, present, and future periods

Or

☐ c) The date of the signature in section VI until the following event:

_____

I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to:

Name: _____

Organization: _____

Address: _____

- In the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.
- I understand that I do not need to give any further permission for the information detailed in Section II to be shared with the person(s) or organization(s) listed in section IV.

- I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

Section VI – Signature

Signature: _____ Date: _____

Print your name: _____

If this form is being completed by a person with legal authority to act an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of person completing this form: _____

Signature of person completing this form: _____

Describe below how this person has legal authority to sign this form:

_____

_____

_____

_____

Medical Care

ALLERGY INTAKE FORM

Name:_____ Phone Number:_____ DOB:___/___/____

Provider's Name:_____Date of Visit:_____

CIRCLE ALL THAT APPLY:

Do you suffer from allergies? YES NO If **yes**, which seasons: SPRING | SUMMER | FALL | WINTER | ALL YEAR

If **yes**, which of the following symptoms do you typically have:

SNEEZING | ITCHY AND/OR WATERY EYES | SCRATCHY THROAT | CONGESTION | CHRONIC COUGH | FATIGUE

RESTLESSNESS | POSTNASAL DRIP | JOINT PAIN | ITCHY DRY SKIN | HIVES | RUNNY NOSE

OTHER: _____

How long have you had these symptoms?_____years_____months

When do you typically experience them the most: Morning Afternoon Night All Day

YES NO Do you frequently get sinus infections, colds, flu, or a runny nose?

YES NO Have you been diagnosed with Asthma? If **yes**, is it controlled? YES NO

YES NO Do you take any antihistamine medications to control these symptoms? If **yes**, please list them below & date last taken: _____

Please list **ALL** medications you are currently on, and the date last taken:

YES NO Are you Pregnant? If **not**, are you planning on becoming pregnant within the next year? YES NO

YES NO Are you HIV positive or have AIDS?

YES NO Are you taking any Beta Blocker Medications? If **yes**, which one: _____

YES NO Are you taking any Antibiotic Medications? If **yes**, which one: _____

YES NO Do you have any Auto Immune Diseases? If **yes**, which one: _____

YES NO Have you been Allergy Tested in the last 12 months? If **yes**, are you on immunotherapy? YES NO

YES NO Are you planning on relocating within the next 12 months?

YES NO Have you ever had a life-threatening allergic reaction and need emergency medical attention?

YES NO Do you have Derma graphism?

YES NO Do you have any known food allergies? If **yes**, which one: _____

Patient Signature:_____Date: _____

Allergy Tech Name:_____ Allergy Tech Signature: _____

FIRST CHOICE
Medical Care

Patient Name: _____ DOB: _____ DOS: _____

HT: _____ WT: _____ BP: _____ Pulse: _____ O2: _____ Temp: _____ RR: _____

Allergy Diagnosis (Office use only)

Ear	
H65.0	Serous Otitis Media Acute
H65.2	Serous Otitis Media Chronic
Nose and Sinus	
J33.0	Polyp of Nasal cavity
J31.0	Chronic Rhinitis
J32.0	Chronic Maxillary Sinusitis
R09.82	Postnasal Drip
Skin	
L20.84	Intrinsic (Allergic) Eczema
L20.81	Atopic Neurodermatitis
L20.89	Atopic Dermatitis
L23	Allergic Contact Dermatitis
L27.0	Dermatitis Due to Drugs/Medication
L23.7	Plant Contact
T78.3	Uticaria/Angioedema Allergic
Upper Respiratory	
R05	Cough
J20.9	Acute Bronchitis
R05	Cough Extrinsic
J45	Asthma Extrinsic
J06.90	URI Multiple Sites
J45.998	Other Asthma
R06.2	Wheezing
Allergies	
J30.1	Rhinitis due to Pollen (Hay Fever)
J30.2	Other seasonal allergic rhinitis
J30.5	Rhinitis due to Food
J30.89	Other allergic rhinitis
J30.81	Rhinitis due to Animal Dander
J34.3	Hypertrophy of Nasal Turbinates
Eye	
H10.1	Acute Atopic Conjunctivitis
H10.3	Chronic Atopic Conjunctivitis

Patient previously seen, treated, or complained about listed symptoms: YES NO

Referred for Allergy Testing: YES NO

Provider Notes: _____

Medications to remain off (if any): _____

Provider Signature: _____

First Choice Medical Care, PLLC
Dr. Aslam and Dr. Yousuf
Health History Questionnaire

Date:			
Name:	☐ M ☐ F	Birth Date:	**Emergency Contact:** (name & phone number)
Address:	Home Phone:		Mobile Phone:

BRING ALL YOUR MEDICATIONS TO EACH VISIT

How would you rate your overall health and well being? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
What are your major health concerns? _____

When did you last have the following? **Please list year:**

_____ physical exam
_____ dental exam
_____ blood pressure check
_____ stool test for blood
_____ complete eye exam
_____ test for glaucoma
_____ hearing test
_____ skin test for tuberculosis
_____ pap smear
_____ mammogram
_____ breast exam

List any problems or abnormal results related to the above tests: _____

ALLERGIC REACTIONS:

Have you ever had an allergic reaction or side effect to any medications? ☐ Yes ☐ No
If yes, please list medication and your reaction:

_____

Have you ever had any other serious allergic reactions? ☐ Yes ☐ No
(bee sting, asthma, severe poison ivy, specific foods, injections)
If yes, please list: _____

MEDICATIONS:

Do you regularly or frequently take any medications? ☐ Yes ☐ No
(include aspirin, vitamins and minerals, prescription and non-prescription)
Please list: _____

_____

HOSPITALIZATIONS:

Please list all inpatient hospitalizations: (medical and surgical, biopsies, fractures, obstetric/gynecologic and psychiatric) Start with the most recent admission:

Nature of Problem	Date	City and State	Hospital

Check those items you would like to discuss with a health professional today.

☐ family
☐ work
☐ exercise
☐ diet/food intake
☐ emotional control
☐ grieving
☐ stress/anxiety
☐ high blood pressure
☐ alcohol use
☐ drug use
☐ smoking
☐ venereal disease
☐ sex
☐ osteoporosis
☐ menopause
☐ anger
☐ cancer signs
☐ sexually transmitted disease
☐ depression

☐ other (please specify): _____

Thank you for completing this questionnaire!!!

First Choice Medical Care, PLLC
1950 Cook St. Suite C & D
Dyersburg, TN 38024

CONSENT FORM

The undersigned consents to an examination (x-ray or otherwise), including but not limited to medication, lab procedures or any other treatment that may be deemed necessary by the attending physicians

Patient or Guardian signature for consent of treatment:

_____ Date: _____
Patient or Guardian signature

Independent
Radiology Associates, PLC
P.O. Box 1296, Dyersburg, TN 38025-1296
(800) 427-5375, (731) 285-2346, Fax No. 285-0526

OFFICE MANAGER: JENNIFER CATON

DIAGNOSTIC IMAGING AND
INTERVENTIONAL RADIOLOGY

THOMAS R. THOMPSON, M.D.
JAMES H. WOLFE, M.D.
J. MARK LEGAN, M.D.
MARK A. JONES, M.D.
FREDERICK M. WITTBER M.D.
JIMMY R. CARROLL JR., M.D.

EMERITUS
JOHN A. REAVES, JR., M.D.

ASSIGNMENT OF BENEFITS

RELEASE OF INFORMATION AND AUTHORIZATION TO PAY INSURANCE BENEFITS

I understand my imaging exam will be read by Independent Radiology Associates, PLC, and that I will receive a separate bill for the reading of my imaging exam from Independent Radiology Associates, PLC. I authorize release of medical or other pertinent information to party or party's responsible for payment of all or a portion of the charges of Independent Radiology Associates, PLC, including, but not limited to insurance companies, employers, and welfare funds.

SIGNATURE DATE

Notice of Privacy Practices Acknowledgement

First Choice Medical Care, PLLC

If you have any questions regarding this notice or our health information privacy policies, please contact the Privacy Officer, First Choice Medical Care, PLLC, 1950 Cook Street, Suite C & D, Dyersburg, TN 38024.

I hereby acknowledge that I have been presented with a copy of First Choice Medical Care's "Notice of Privacy Practices".

Signature: _____

Patient name (printed): _____

Date: _____