PATIENT REGISTRATION

FARMER AND ASSOCIATES INTERNAL MEDICINE
1860 CHADWICK DR. STE 303 * JACKSON, MS 39204

DOCTOR Farmer

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOW

TODAY'S DATE ____________ REFERRED BY ____________ DATE OF BIRTH ____/____/____

PATIENT NAME ____________ SEX ☐ MALE ☐ FEMALE
LAST FIRST MI

ADDRESS ____________
STREET CITY STATE ZIP

SOC SEC # ____________ HOME PHONE ____________ WORK PHONE ____________

INSURANCE INFORMATION

PRIMARY INSURANCE ____________ POLICY # ____________ GROUP # ____________

NAME OF INSURED ____________ RELATION TO PATIENT ____________

SECONDARY INSURANCE ____________ POLICY # ____________ GROUP # ____________

NAME OF INSURED ____________ RELATION TO PATIENT ____________

EMPLOYMENT

YOUR PLACE OF EMPLOYMENT ____________ PHONE ____________ Occupation ____________

ADDRESS ____________
STREET CITY STATE ZIP

SPOUSE'S NAME ____________ PHONE ____________

EMERGENCY CONTACT

NAME ____________ PHONE ____________

ADDRESS ____________
STREET CITY STATE ZIP

AUTHORIZATION OF RELEASE

I agree to pay for all services rendered to me as a patient of Dr. John Farmer, MD and Farmer and Associates Internal Medicine and hereby authorize release of medical information for processing insurance claims.

AUTHORIZATION FOR RELIEASE OF MEDICAL INFORMATION

I authorize any holder of medical information about me to release said medical information requested by insurance companies with whom I have coverage or any public agency and its agents to determine benefits for services provided or benefits related to services.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of medical benefits to Dr. John Farmer and Farmer and Associates Internal Medicine for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance. I certify that the information given by me in applying for payment is correct. I request that payment of authorized benefits be made on my behalf.

Patient Name (please print) ____________ Signature X ____________

Patient Representative (please print) ____________ Date ____/____/____

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Health History

Patient's Name ______________________ Today's Date ____________

Age ________ Birthdate ______ Date of last physical exam? __________

What is your reason for this visit? ____________________________________

SYMPTOMS

General

- [ ] Chills
- [ ] Depression
- [ ] Dizziness
- [ ] Fainting
- [ ] Fever
- [ ] Forgetfulness
- [ ] Headaches
- [ ] Sleeplessness
- [ ] Weight loss
- [ ] 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/Throat/Nose

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

Skin

- [ ] Bruise easily
- [ ] Hives
- [ ] Itching
- [ ] Change in moles
- [ ] Rash
- [ ] Scar
- [ ] 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 menstral period ____________

Date of last pap smear ____________

Have you had a mammogram? ____________

Are you pregnant? ______

Number of children ______

Conditions

☐	AIDS	☐	Chemical dependency	☐	High cholesterol	☐	Prostate problem
☐	Alcoholism	☐	Chicken pox	☐	HIV positive	☐	Psychiatric care
☐	Anemia	☐	Diabetes	☐	Kidney disease	☐	Rheumatic fever
☐	Anorexia	☐	Emphysema	☐	Liver disease	☐	Scarlet fever
☐	Appendicitis	☐	Epilepsy	☐	Measles	☐	Stroke
☐	Arthritis	☐	Glaucoma	☐	Migraine headaches	☐	Suicide attempt
☐	Asthma	☐	Goiter	☐	Miscarriage	☐	Thyroid problems
☐	Bleeding disorders	☐	Gonorrhea	☐	Mononucleosis	☐	Tonsillitis
☐	Breast lump	☐	Gout	☐	Multiple Sclerosis	☐	Tuberculosis
☐	Bronchitis	☐	Heart disease	☐	Mumps	☐	Typhoid fever
☐	Bulimia	☐	Hepatitis	☐	Pacemaker	☐	Ulcers
☐	Cancer	☐	Hernia	☐	Pneumonia	☐	Vaginal infections
☐	Cataracts	☐	Herpes	☐	Polio	☐	Venereal Disease

Medications	Allergies	Surgeries/Hospitalizations
______	______	______
______	______	______
______	______	______
______	______	______

Family History

#		Alive/Deceased	Present health or Cause of death
	Father		
	Mother		
	Spouse		
____	Brothers		
____	Sisters		
____	Children		

List any illness that have affected any of your blood relatives.

______

______

______

______

______

______

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Our Financial Policy

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

1. Payment is due at the time of service unless arrangements have been made in advance by your carrier. We accept Cash, Check, Visa and MasterCard.

2. Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor—in other words, if you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.

3. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them, and you are required to pay a co-payment at the time of your visit.

4. If you are insured by a plan that we do not have a prior arrangement with, we will prepare and send the claim for you on an unassigned basis. This means the insurer will send the payment directly to you. Therefore, our charges for your care are due at the time of service.

5. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

6. We will bill your insurance company for all services provided in the hospital. You are responsible for any balance due.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

X ____

Signature of patient (or responsible party, if minor) Date

____

Please print the name of the patient

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Privacy Policy Acknowledgement

I acknowledge that I have received and read the Privacy Policy for Dr. John Farmer and Associates, Internal Medicine.

______________________________ X ______________________________

Patient/Responsible Party Name (Please Print)

Patient/Responsible Party Signature

____

Today's Date

NOTICE OF PRIVACY PRACTICES*

We Care About Your Privacy

1. Our Pledge Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. Our Legal Duty

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. Use and Disclosure of Your Medical Information

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

For Treatment:

We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

For Payment:

We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

For Health Care Operations:

We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

Additional Uses and Disclosures:

In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Facility Directory:

Unless you notify us that you object, the following medical information about you will be placed in our facility directories: your name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

Notification:

We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief:

We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising:

We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

Research in Limited Circumstances:

We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner:

To help them carry out their duties, we may share the med-

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ical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions:
Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings:
We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities:
As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence:
We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation:
We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities:
We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement:
Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Appointment Reminders:
We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

Alternative and Additional Medical Services:
We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

4. Your Individual Rights

You Have the Right to:

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photo copies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may ask the receptionist for the form needed to request access. There may be charges for copying and for postage if you want the copies mailed to you. Ask the receptionist about our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to our Privacy Officer.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you wish to receive a paper copy of this privacy notice, then you have the right to obtain a paper copy by making a request in writing to our Privacy Officer.

Questions and Complaints

If you have any questions about this notice, please ask the receptionist to speak to our Privacy Officer.

If you think that we may have violated your privacy rights, you may speak to our Privacy Officer and submit a written complaint. To take either action, please inform the receptionist that you wish to contact the Privacy Officer or request a complaint form. You may submit a written complaint to the U.S. Department of Health and Human Services; we will provide you with the address to file your complaint. We will not retaliate in any way if you choose to file a complaint.

*These privacy practices are currently in effect and will remain in effect until further notice.