Patient Information (Please Print)			
Last Name	First Name	Middle	
Mailing Address	City	State	Zip
Home Phone	Cell Phone	Date of Birth	
Marital Status (check one)	☐ Single ☐ Married ☐ Divorced ☐ Widowed		
Social Security #	E-Mail Address		
Spouse's Name or Parent's Name	Work Phone		
Nearest Relative Not Living With You	Phone		
Dentist	Phone		
Emergency Contact Name	Phone		
Employer Information			
Name of Employer	Phone		

I hereby authorize my insurance company to make payment directly to Family Medical Clinic of Crystal Springs, PLLC benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charge for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to Family Medical Clinic of Crystal Springs, PLLC and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment..

I acknowledge that I have been informed of the HIPAA practices of Family Medical Clinic of Crystal Springs, PLLC.

I understand that the providers of Family Medical Clinic of Crystal Springs, PLLC do not admit to hospitals. I understand that if inpatient hospital care is required, the providers will assist in coordinating these services with another physician who will care for me while I remain in the hospital.

I have certify that the information provided is true and correct to the best of my knowledge. ***I understand it is my responsibility to notify you of any changes in the above information.***

*Signature*_____*Date*_____

Parent (if minor) _____*Date*_____

AUTHORIZATION TO LEAVE MESSAGE:

I hereby authorize the personnel of Family Medical Clinic of Crystal Springs to leave a message regarding pending appointments at my place of work, on my answering machine or with another person answering my phone.

*Signature*_____*Date*_____

PATIENT INFORMATION SHEET

FAMILY MEDICAL CLINIC OF CRYSTAL SPRINGS, PLLC
MEDICAL HISTORY

PATIENT MEDICAL HISTORY:

Diabetes.....	NO	YES
Cancer	NO	YES
Hypertension	NO	YES
Stroke.....	NO	YES
Heart Trouble.....	NO	YES
Arthritis/Gout.....	NO	YES
Convulsions(Seizures)...	NO	YES
Excessive Bleeding.....	NO	YES
Venereal Disease.....	NO	YES
Hereditary Defect.....	NO	YES

Other (list):_____

_____

PRIOR SURGERY:

Gallbladder.....	NO	YES	DATE_____
Appendectomy.....	NO	YES	DATE_____
Heart Bypass.....	NO	YES	DATE_____
Hysterectomy.....	NO	YES	DATE_____
Prostate Surgery.....	NO	YES	DATE_____
Tonsillectomy.....	NO	YES	DATE_____

Other (explain)_____

_____

OTHER HOSPITALIZATIONS/SERIOUS INJURIES:

_____

_____

_____

CURRENT MEDICATIONS:

List all medication(s) you are now taking or have taken in the last three (3) months on a regular basis. (Include over-the-counter medication)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

DRUG ALLERGIES

List all medication(s) to which you are allergic or "sensitive."

_____	_____	_____
_____	_____	_____

IMMUNIZATION HISTORY:

Routine Childhood.....	NO	YES
Tetanus Booster.....	_____	
Pneumonia Vaccine.....	_____	

Hepatitis Vaccine..... NO YES

Other:_____

_____

PATIENT SOCIAL HISTORY:

Marital Status: Single_____ Married_____ Separated _____ Divorced _____ Widowed _____

Use of Alcohol: Never_____ Rarely _____ Moderate _____ Daily_____

Use of Tobacco: Never_____ Formerly, but quit_____ Current packs/day _____

Use of Drugs: Never_____ Rarely _____ Moderate _____ Daily_____

Employer/Position:_____

Exposed to loud noises/chemicals/fumes?_____

FAMILY HISTORY:

	Age	**Diseases**	**If Deceased, Cause of Death**
Father	____	_____	_____
Mother	____	_____	_____
Siblings	____	_____	_____
	____	_____	_____
Children	____	_____	_____
	____	_____	_____
Spouse	____	_____	_____

GYN HISTORY (WOMEN ONLY):

Date of Last Period	_____
Date of Last Pap	_____
Date of Last Mammogram	_____
Number of Pregnancies	_____
Number of Births	_____
Number of Miscarriages	_____

Family Medical Clinic of Crystal Springs, PLLC
104 West Railroad Avenue South
Crystal Springs, MS 39059

Financial Policy/Hospital Coverage Acknowledgement

I understand that, if inpatient hospital care is required, our medical staff will assist in coordinating these services with another physician who will care for you while you remain in the hospital.

I also have read and understand the financial policy of Family Medical Clinic of Crystal Springs, PLLC.

Patient Signature:_____ Date:_____

PRIVACY NOTICE ACKNOWLEDGEMENT

Purpose: This form is used to document an individual's acknowledgement of receipt of our Privacy Practices Notice or, when we have not obtained this acknowledgement, to document our good faith effort to obtain the acknowledgement.

Patient Name_____

Medical Record Number_____ Social Security Number_____

I acknowledge that I received a Privacy Practices Notice from Family Medical Clinic of Crystal Springs.

Patient Signature: _____Date:_____

IF NOT SIGNED: (Good faith effort to obtain acknowledgement of receipt.)

I have made a good faith effort to acquire the signature of the above patient. The patient did not sign the Notice of Privacy Practices because:

- ☐ Patient Refused
- ☐ Patient unable to sign due to _____
- ☐ Guardian unavailable

Signed: _____Date:_____

If you request copies, we will charge you a fee for copying and postage if you want the copies mailed to you.

We may deny your request to inspect and copy in very limited circumstances as allowed by law. If you are denied access to your medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your medical information for purposes other than treatment, payment, health care operations, as authorized by you and for certain other activities since January 1, 2004. You must make a request in writing for a listing of disclosures.

Restriction: You have the right to request that we place certain 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 an emergency). Any agreement to additional restrictions must be in writing. You may obtain a form to request additional restrictions on the use or disclosure of your medical information by using the contact listed at the end of this notice. We will not be bound to the restrictions unless our agreement is signed by you and the appropriate practice representative.

Confidential Communication: You have the right to request that we communicate with you about your medical information by alternative means or to alternative locations. For example, you might request that we contact you at work or by mail. You must make your request in writing. Use the contact information at the end of this notice for a form. We must accommodate your request if it is reasonable, specifies the alternative means or location, and provides a satisfactory explanation on how payments will be handled under the alternative means or location you request.

Amendment: If you feel that the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. Your request must be made in writing and must explain why the information should be amended. A form to request an amendment can be obtained from the contact person at the end of this notice. We may deny your request if we did not create the information you want amended and the individual who provided the information remains available 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 to be attached to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

Questions and Complaints:
If you want more information about our privacy practices or have questions, concerns, or complaints please contact the following:

Contact: Mitzi Cline
Phone: (601)892-3063

You will not be retaliated against for filing a compliant. You have the right to complain to us and/or the United States Department of Health and Human Services.

FAMILY MEDICAL CLINIC OF CRYSTAL SPRINGS, PLLC

PRIVACY PRACTICES NOTICE

Our commitment here at Family Medical Clinic is to serve our patients with professionalism and caring, being sure at all times to protect the privacy and security of all Protected Health Information.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review it carefully. The privacy of your medical information is important to us.

If you have any questions about this notice, please contact us at:
(601)892-3063

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your medical information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your medical information. We must follow the privacy practices described in this notice while it is in effect. This notice takes effect 01/01/04 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all medical information that we maintain, including medical information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice, post the new notice at our office, and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF MEDICAL INFORMATION

During the course of serving your interests it may be necessary to share information with other Health Care Providers or Business Associates. The following are examples of instances where information may be shared:

- During treatment, we may find it necessary to acquire a laboratory analysis.
- For payment purposes, we may use the services of a billing service.
- During health care operations, we may need a second opinion.

On Your Authorization: You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your medical information for any reason except those described in this notice.

Appointment Reminders: We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the practice.

To Your Family and Friends: Unless you object, we may disclose your medical information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care.

If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest.

We will also use our professional judgment and our experience with common practice to allow a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of medical information.

By Law or Special Circumstances: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- as required by law
- for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- to report adult abuse, neglect or domestic violence;
- to health oversight agencies;
- In response to court and administrative orders or other lawful processes
- to law enforcement officials after receiving subpoenas and other lawful processes;
- to avert a serious threat to health or safety;
- as authorized by state worker's compensation laws.

Alcohol and Drug Abuse Information: We may not disclose your medical information that contains alcohol and drug abuse information except to you, your personal representative or when otherwise required by law.

Right to Inspect and Copy: You have the right to look at or get copies of your medical information with limited exceptions. You must make a request in writing to obtain access to your medical information. You may obtain a form to request access by using the contact information listed at the end of this notice.

FAMILY MEDICAL CLINIC OF CRYSTAL SPRINGS, PLLC
FINANCIAL POLICY

We are committed to providing you with best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

1. Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our office manager. We accept cash, checks, MasterCard or Visa. As a courtesy to you, we will file your insurance claim-form for reimbursement. If you wish our office to file your insurance for services rendered, a current insurance card and driver's license must be presented to the front office staff at the time of the visit. ***Claim forms will be filed only upon verification of insurance coverage.***
2. We must emphasize that, as medical providers, our relationship is with you , not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.
3. You must realize, however, that:
   a. Your insurance is a contract between you, your employer and the insurance company. We are not party to that contract.
   b. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover
4. Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of 1½% per month. Charges may also be made for broken appointments and appointments cancelled without 24 hours advance notice
5. Our office requires a pre-pay amount of $20 for completion of forms. ***All forms must be submitted to our clinic at least one week prior to the due date of the form.*** This includes but is not limited to FMLA papers, disability papers, and school/camp forms.

If you have any questions about the above information or any uncertainty regarding your insurance coverage, PLEASE do not hesitate to ask us. We are here to help you.