TRI-MED
FAMILY CARE

PATIENT INFORMATION

Last Name:_____ First Name:_____ M.I._____

Preferred Name:_____

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

Street Address:_____

City:_____ State:_____ Zip Code:_____

Email Address:_____

Primary Phone:_____ Secondary Phone:

_____ Would you like a text reminder of scheduled

appointments? ☐Yes No☐

When is the best time to reach you? Morning☐ Afternoon☐ Evening☐

Would you like to receive text reminders of scheduled appointments? ☐Yes No☐

TMFC can now send and receive text messages. Message and data rates may apply depending on your carrier. Please note texting may not always be 100% secure depending on the mobile service you use. Let us know how you prefer to be contacted. Generic messages will only contain the patient's name and request to call TMFC.

Please indicate your preferences for voicemail and text messages below. Check √ all that apply. Circle Home or cell to indicate which number to use to leave messages.

	General Voicemail	Detailed Voicemail	Generic Text	Detailed Text
Appointments Home or Cell	_____	_____	_____	_____
Financial Home or Cell	_____	_____	_____	_____
Lab Results Home or Cell	_____	_____	_____	_____
Medical Home or Cell	_____	_____	_____	_____

I authorize Tri-Med Family Care to contact me and leave messages in the manner that is specified above. I am aware that if this needs to be changed, I must notify TMFC in writing.

Emergency Contact Name:_____Phone_____

Relationship to Patient:_____

Employment Information:

Employer Name:_____ Occupation:_____

Work Phone:_____ Extension:_____ Email:_____

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Patient Financial & Demographic information

Patient Name:_____ Date:_____

Number of individuals in the household_____

Total Income level of household (please check one)

☐$0-$15,000 ☐$35,001-$45,000 ☐$65,001-75,000

☐$15,001-$25,000 ☐$45,001-$55,000 ☐$75,001 and up

☐$25,001-$35,000 ☐$55,001-$65,000

Are you interested in applying for the sliding scale discount program? ☐ Yes ☐No

Primary Insurance:

Name of insured:_____ Relationship_____

Insured date of birth:____/____/_____ Gender:_____ SS#_____

Insured employer:_____ Employer Phone #_____

Insurance Company Name:_____

Insurance Policy Number:_____ Group #_____

Secondary Insurance:

Name of insured:_____ Relationship_____

Insured date of birth:____/____/_____ Gender:_____ SS#_____

Insured employer:_____ Employer Phone #_____

Insurance Company Name:_____

Insurance Policy Number:_____ Group #_____

Demographic Information

Race: ☐Native American ☐Asian (*Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, Other Asian*) ☐African American/Black ☐Caucasian/White ☐Pacific Islander (*Native Hawaiian, Guamanian or Chamorro, Samoan, Other Pacific Islander*) ☐ Hispanic, Latino/a, Spanish Origin, ☐ more than 1 Race ☐Other ☐Decline to answer ☐Russian

Ethnicity: ☐Mexican, Mexican American, Chicano/a; Puerto Rican; Cuban; Another Hispanic, Latino/a, or Spanish Origin

☐ Hispanic, Latino/a, Spanish Origin, Combined, ☐ Non-Hispanic/Latino or Spanish Origin ☐Decline to answer

Sexual Orientation: ☐Heterosexual (or straight) ☐ Homosexual ☐Lesbian or Gay ☐Bisexual ☐Unsure ☐Decline to answer

Housing status: Own or Rent Home☐ Public Housing☐ Homeless/Shelter☐ Street ☐Transitional living ☐ Living with family/friends☐ Migrant/Seasonal/Farm worker☐

Military Service: Currently serving☐ Veteran ☐ non-veteran☐

Principal Language: English☐ Spanish ☐ Other: ☐ Do you need an interpreter? If yes☐

Marital Status Single☐ Married☐ Widowed☐ Divorced☐

The following information is confidential and will only be used by your provider to make sure you receive the proper care.

Medical History

Have you or a close family member ever had the conditions/diagnosis below? Please indicate if it is yourself or family member by checking the appropriate box

Condition	Self	Mother	Father	Sibling
Diabetes				
Heart Attack				
High blood pressure				
Seizures				
Liver Disease				
Stroke				
Mental Illness				
HIV				
Tuberculosis				
Sickle Cell				
Kidney Problems				
Chronic Bronchitis/COPD				
Asthma				
Cancer (what type?)				
Emphysema				
List Other				

Surgical History

Please list any surgeries you have had, and the date surgery was performed

Social History

Do you currently or previously use(d) tobacco products (including vape) Yes ☐ No☐

Do you drink alcohol? Yes ☐ No☐

Do you use recreational drugs? Yes ☐ No☐

Are you sexually active? Yes ☐ No☐

Do you practice safe sex? Yes ☐ No☐

What form of birth control are you currently using:

How many sexual partners do you currently have?

How many sexual partners have you had in your lifetime?

Are you currently pregnant? Yes ☐ No☐ Do you plan a pregnancy in the next 12 months? Yes ☐ No☐

How important is preventing pregnancy? Not at all important ☐ Somewhat important ☐ Very important ☐

Have you been tested for STD's or HIV? Yes ☐ No☐ If yes, when was your last test _____

_____ What was the result of the test ☐ Positive ☐ Negative| If positive, what was the infection?_____ What sexually transmitted infections have you had in the past?

Tri-Med Family Care is a grantee of the Title X Family Planning Program, officially known as Public Law 91-572 or "Population Research and Voluntary Family Planning Program." Title X is the only federal grant program dedicated solely to providing individuals with comprehensive family planning and related preventative health services. Title X is legally designed to prioritize needs of low-income families or uninsured people who might not otherwise have access to these healthcare services. These services are provided to such individuals at reduced or no cost. It's overall purpose is to promote positive birth outcomes and healthy families by allowing individuals to decide the number and spacing of children.

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Payment and Medical Treatment Consent

Consent for Treatment: I hereby consent to any treatments, diagnostic tests to include but not limited to HIV Testing or studies necessary by any provider or clinical staff member of Tri-Med Family Care Healthcare Team.

I ALSO AUTHORIZE THE PHYSICIAN, NURSE PRACTITIONER, PHYSICIAN ASSISTANT, CERTIFIED NURSE, OR LICENSED CLINICAL SOCIAL WORKER TO GIVE ME/MY DEPENDENT REASONABLE AND PROPER MEDICAL CARE BY TODAY'S STANDARDS. INCLUDING TREATMENT RENDERED IN AN EMERGENCY WITHOUT FURTHER CONSENT.

Tri-Med Family Care is an entity that participates in Title X Services and a patient can receive Confidential & Voluntary Family Planning Services if requested. Adolescents can consent for themselves to receive Family Planning Services.

I also authorize the release of any medical information, including information related to psychiatric care, drug and alcohol abuse, and HIV/Aids confidential information required in the processing of an insurance claim, or any medical information that is needed for utilization review or quality assurance activities.

I hereby authorize my insurance or Medicare benefits to be paid directly to Tri-Med Family Care. I also understand that any portion that is not covered by Insurance is my responsibility to pay. Payment is expected at time of service and Tri-Med Family Care may use any means deemed necessary to collect a debt. Patients will be billed directly for any non-covered charges.

I understand that some professional services, such as laboratory and pathology services may be independent contractors and will bill me separately for their services.

I understand that I have a right to refuse treatment after the risks and benefits have been explained.

A photocopy of this authorization shall be considered as effective and valid as the original.

All the above information is correct, and this will remain in effect until revoked by me in writing.

Patient's Signature/Representative: _____ **Date:** _____

Relationship if other than Patient: _____

TRI-MED

HIPAA Privacy Laws
Patient Acknowledgement of Understanding

Patient Name:_____ **Date of Birth:**_____

I understand patient's health information is private and confidential. I understand that Tri-Med Family Care (TMFC) works diligently to protect patient's privacy and preserve the confidentiality of patient's personal health information.

I understand TMFC may use and disclose patient's personal health information to help provide healthcare to the patient, to handle billing and payment, and to take care of other healthcare operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission.

TMFC possesses a detailed document called "Notice of Privacy Practices." It contains more information about the policies and practices protecting patient's privacy. I understand that I have the right to read the "Notice" before signing this Acknowledgment. TMFC may update this Acknowledgment and "Notice of Privacy Practices." I understand if I ask, TMFC will provide me with the most current "Notice of Privacy
Practices."

Federally mandated HIPAA "Notice of Privacy Practices" is a complete description of my privacy/confidentiality rights. These rights include, but are not limited to, access to my medical records, restrictions on certain uses, receiving an accounting of disclosures as required by law, and requesting communication by specified methods of communication or alternative action.

TMFC's established procedures help meet its obligations to patients. These procedures may include other signature requirements, written acknowledgments, and authorizations, reasonable timeframes for requesting information, charges for copies and non-routine information needs, et cetera. I will assist TMFC by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices."

My signature below indicates I reviewed a current copy of TMFC's "Notice of Privacy Practices."

_____ _____

Patient Signature **Date**

If signed by someone other than patient, relationship to patient_____

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PATIENT AUTHORIZATION FOR RELEASE OF INFORMATION

INDIVIDUAL RIGHTS IN ACCORDANCE WITH HIPAA PRIVACY RULE 45 C.F.R.§§ 164.522-164.528

To request the provider: 1). Limit the use or disclosure of his/her PHI 2). Restrict the persons to whom disclosure may be made 3). Amend PHI in his/her clinical record 4). To obtain an "Accounting of Disclosures" of his/her PHI

The patient is entitled to revoke this PHI Authorization for Release of Information at any time for any reason. This revocation must be made in writing and the date of written revocation becomes the void date for this release. A new release must be completed for any additions/changes to released individuals to be made.

Patient Name:_____ Date of Birth:_____

PART A: I AUTHORIZE TRI-MED FAMILY CARE, 6120 ALABAMA HIGHWAY, RINGGOLD, GA 30736, TO RELEASE AND TO RECEIVE MY PERSONAL HEALTH INFORMATION AS DEEMED NECESSARY TO PROVIDE THE BEST QUALITY CARE FROM AGENCIES, REFERRALS, SPECIALIST OR OTHER DOCTOR'S OFFICES

PATIENT SIGNATURE:_____ **Today's Date:**

_____ **PART B:** I AUTHORIZE THE FOLLOWING

INFORMATION TO BE USED OR DISCLOSED ON MY BEHALF:

Entire Medical Record (provider progress notes, laboratory and diagnostic test results, financial and billing information, and medical history including immunization records, screening tests, allergy record, nutritional evaluation, surgical and past medical history, social and family history, and for pediatric patients a neonatal history), to be released to the following individuals:

NAME: PHONE NUMBER RELATIONSHIP TO PATIENT

_____

_____

_____

_____

Patient Initials as authorization to release the following information:

_____The disclosure of information, if any, concerning testing for HIV and/or treatment for HIV or AIDS and any related conditions

_____ Disclosure of alcohol and/or substance use information, if applicable

_____Behavioral health information including progress notes, diagnosis, assessment, testing and any other psychiatric information, as appropriate. 45 C.F.R. §164.508:42 C.F.R. Part 2

_____ Other as noted:_____

Upon signing this Authorization of Release of Information, you are stating that you have received a copy of the HIPAA Privacy Rules and Regulations and Patients' Rights.

Part C: *Expiration Date***:** If not previously revoked, this authorization will terminate one year from the signature date below:

_____ _____ _____

PRINT NAME ***PATIENT SIGNATURE*** ***DATE***

TRI-MED

Patient Centered Medical Home

Tri-Med Family Care is committed to providing you with the best possible medical care based on your health needs. Our hope is that we can form a partnership to keep your whole self as healthy as possible, no matter what your current state of health.

How will a Medical Home lead to better care for me? As your primary care provider, we will:

- ✔ **Learn about you, your family, life situation, health goals and preferences. We will remember these and your health history every time you seek care and suggest services that make sense for you.**
- ✔ **Take care of any short-term illness, long-term chronic disease, and your all-around wellbeing.**
- ✔ **Keep you up to date on all your vaccines and preventative screenings.**
- ✔ **Connect you with other members of your care team (specialists, health coaches, etc.) and coordinate your care with them, as your health needs change.**
- ✔ **Be available to you after hours for urgent needs.**
- ✔ **Notify you of test results in a timely manner.**
- ✔ **Communicate clearly so you understand your condition(s) and all your options.**
- ✔ **Listen to your questions and feelings. We will respond promptly to you – and your calls – in a way you understand.**
- ✔ **Help you make the best decisions for your care.**
- ✔ **Give you information about classes, support groups, or other services that can help you learn more about your condition and help you stay healthy.**

Will my Medical Home help take care of myself? We trust you as our patient to:

- **Know you are a full partner with us in your care.**
- **Come to each visit with any updates on medications, dietary supplements, or remedies you are using, and questions you may have.**
- **Let us know when you see other healthcare providers so we can help coordinate the best care for you.**
- **Keep scheduled appointments or call to reschedule or cancel as early as possible.**
- **Understand your health condition, ask questions about your care, and tell us when you do not understand something.**
- **Learn about your condition(s) and what you can do to stay as healthy as possible.**
- **Follow the plan we have agreed is best for your health.**
- **Take medications as prescribed.**
- **Call if you do not receive your test results within one week.**
- **Contact us after hours if your concern cannot wait until the next business day.**

What types of services does my Medical Home provide for me? We offer same day appointments / preventative care and physicals (health risk assessments, school, sports, DOT) / chronic disease management (diabetes, heart disease, arthritis, asthma, and more) / acute care for illness and injury / well woman exams / group visits and classes to help you lead a healthy lifestyle / 24x7 phone access to your care team / online access to your medical records / referrals to vetted specialists / management of multi-specialty care plans including mental health

How do I access my Medical Home? We offer convenient same day and next day appointments, extended hours, and *after-hours phone access*, twenty-four hours a day, seven days a week by calling (706) 935-6442. After hours phone access is for emergencies only. Unfortunately, we cannot schedule appointments or provide medication refills after hours.

TMFC Office Hours: Monday, Tuesday, Thursday – 7:30 am -5:30 am, Wednesday – 7:30am – 7:00 pm, Friday – 8:00 am – 12:00 noon. To make an appointment, call (706) 935-6442

How can I transfer my records to my Medical Home? We will need your consent to obtain records from your previous provider or from specialists you have seen in the past. Consent forms are available at the front desk or online at www.TMFC.com.

Can I be in a Medical Home if I do not have health insurance? We accept many insurance plans, cash patients, and in some cases, you may be eligible for our sliding scale fee. Once you become a patient in our practice, we provide you with the same access and care regardless of your health insurance status.

We look forward to working with you as your primary care provider in your patient-centered medical home!