PATIENT INFORMATION

PATIENT FULL NAME (INCLUDE MAIDEN NAME)				
ADDRESS	CITY	COUNTY	STATE	ZIP CODE
HOME PHONE ( ) -	CELL PHONE ( ) -	WORK PHONE (OK TO CALL ?) YES / NO ( )-		
E-MAIL ADDRESS	IS IT OK TO E-MAIL FUTURE NEWSLETTERS TO YOU? YES / NO			
SOCIAL SECURITY #	DRIVERS LICENSE #	DATE OF BIRTH	AGE	
OCCUPATION	MARITAL STATUS (CIRCLE) SINGLE WIDOWED MARRIED DIVORCED			
EMPLOYER NAME AND ADDRESS				
WHOM MAY WE THANK FOR YOUR REFERRAL?	BEST NUMBER TO REACH YOU: HOME /CELL /WORK CAN WE LEAVE A DETAILED MESSAGE AT THIS NUMBER ? YES/NO			

SPOUSE OR PARENT

SPOUSE/PARENT NAME	RELATIONSHIP		
ADDRESS	CITY	STATE	ZIP CODE
EMPLOYER NAME AND ADDRESS		SPOUSE DATE OF BIRTH	
HOME PHONE ( )	WORK PHONE. ( )		
OCCUPATION		SOCIAL SECURITY NO.	

I authorize the release of any medical information necessary to process my claim. I also authorize payment of benefits to Larry D. Gurley, M.D.
As a courtesy we file your insurance claim for you. All health plans are not the same and do not cover the same services. In the event your health 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. If it becomes necessary to send my account to collections, I will be responsible for all collection, attorney and court costs. I understand that this authorization remains in effect as long as I, or my dependent, remain a patient. I have read and understand the policy of this practice and I agree to be bound by its terms.

SIGNED: **DATE:**

Medication Sheet

NAME: _____ D.O.B.: _____

TODAY'S DATE_____

When we prescribe, may we use generics for you when possible? Yes No

Current Pharmacy Name _____ Pharmacy Phone _____

Mail Order Pharmacy Name_____

Current Primary Care Doctor Name _____

May we leave a detailed message about your test results on your answering machine? Yes No

At which Phone number may we leave results? _____

MEDICATIONS:	DOSAGE:	PRESCRIBING PHYSICIAN:

MEDICATION ALLERGIES:

❑ ←——Check here if no allergies

POST-IT NOTE

Date:_____
Please list your concerns today:

1)_____

2)_____

3)_____
If you were referred for consultation by another doctor, please fill in doctor's name_____
Your Age?_____ Number of children_____
Last Menstrual Period_____Last Pap _____
Method used to prevent pregnancy:_____
Do you have a problem now with any of the following?
Yes / No Menses more often than every 24 days_____
Yes / No Menses that last more than 7 days_____
Yes / No Heavy flow (clots, staining clothes or sheets)
Yes / No Bleeding between periods_____
Yes / No Bothersome menstrual pain_____
Yes / No Pain with intercourse_____
Yes / No Pelvic Pain_____
Yes / No Bleeding after intercourse_____
Yes / No Sexual concerns
Yes / No Physical or emotional abuse_____
Yes / No Sexual abuse, assault, or rape_____
Menopausal symptoms
Yes / No Hot flashes
Yes / No Vaginal dryness
Yes / No Sleeping problems
Yes / No Mood swings or crying spells
Yes / No Other_____

If you are having pain, please complete the following questions:
Where is the pain located? _____
When did it start?_____
Circle type(s) sharp dull ache burns twinge cramp
other _____
Score your pain:
0 1 2 3 4 5 6 7 8 9 10
None moderate severe
How often is your pain? _____
Does your pain move to other areas? _____
What increases the pain? _____
or decreases the pain? _____
What do you think is causing your pain?
_____

Breast cancer risk (complete if you are 35 or over)
_____ Age when you had first menstrual period
_____ Age when you had your first live birth
_____ Number of persons who have had breast cancer in your **immediate** family(mom, sister, daughter)
Yes / No Have you had breast biopsies? How many?___
Yes / No Did any biopsy show atypical cells?
_____ Your race

List any **surgery or hospitalizations:**
_____
_____
_____
_____
_____
_____

NAME _____
DOB:_____ **Marital status:**_____
Last :
Bone Density_____**Colonoscopy**_____
Mammogram_____

Family History,If yes, state relationship
Yes / No Breast Cancer_____
Yes / No Ovarian Cancer_____
Yes / No Heart disease prior to age 60_____
Yes / No Osteoporosis_____
Yes / No Diabetes in mother, father, brothers, or sisters__
Yes / No Colon Cancer _____
Yes / No Other disease_____

Your Own Personal Medical History *(circle any that apply)*
Diabetes / High blood pressure / Heart Disease
Lung disease / Blood clots in legs or lungs

Review of Systems *(Office use:for positives, see PCP ☐)*

CIRCLE any SYMPTOMS that apply to you:
Gen: fever/weight change/fatigue_____
Eye: visual changes/eye pain_____
ENT: hearing change/earache/sinus/nosebleed/sore throat
_____
Resp: trouble breathing/persistent cough/bloody cough
Asthma / Tuberculosis_____
CV: chest pain/irregular heartbeat/murmur/transfusion
_____
GI: nausea/vomiting/diarrhea/constipation/indigestion
Hemorrhoids/rectal bleeding or tarry stools
_____
GU: pain or bleeding with urination/urinary infection
Kidney stones/excessive nighttime urination
Loss of bladder control/ DES Exposure
_____
MS: back pain/joint pain/swelling of hands or feet
Neuro: headaches/stroke/dizziness/numbness
Psy: anxiety/depression/insomnia/addictions_____
Endo: thyroid problems/diabetes_____
Hemo: anemia/free bleeding/phlebitis or blood clots in your veins_____
Skin: skin disease/unusual moles_____
Imm: asthma/seasonal allergies_____

Breast: pain/ lump/discharge/fibrocystic/breast cancer
_____
Cigarettes? Y /N number of cigarettes per day _____
Alcohol ? Y / N Number of drinks per day _____
Drugs? Y / N _____

Any **other information** that will help us in our evaluation:
_____
_____
_____
_____
_____
_____

Patient Signature _____

Clinician ____ ROS reviewed and all negative except as noted above.

LARRY D. GURLEY, M.D.

300 20th Avenue North Suite 102 Nashville, TN 37203
615-284-1500 Fax 615-284-1501

Physician to provide records:_____Phone or Fax #_____
Patient name:_____
Social Security #_____DOB_____

Person/facility to receive records:_____
Address:_____
City, State, Zip:_____

Release these records: Initials
1.Only records generated by this facility (not including records received from other sources) _____
2.Only some portion of records maintained at facility (dates of treatment, specify below) _____
3.All medical records at this facility _____

_____

_____

**IF YOU DO NOT WANT CERTAIN PORTIONS OF YOUR RECORDS RELEASED, PLEASE CAREFULLY READ THE SECTION BELOW AND INITIAL THE BOXES FOR INFORMATION YOU DO NOT WANT RELEASED. OTHERWISE, ALL YOUR RECORDS WILL BE RELEASED.

**I authorize the health care provider to release the information specified to the organization, agency or individual named on this request with the EXCEPTION of:

Initials
____Substance abuse, if any
____Psychological or psychiatric conditions, if any

Initials
_____AIDS/HIV, if any

Other (Please specify)_____

Expiration or revocation of authorization- I understand that I may revoke this authorization at any time and that unless an earlier date is specified it will automatically expire 12 months after the date affixed below.

Use of copies- A copy of this authorization may be utilized with the same effectiveness as an original.

Patient name (print):
_____

_____
Patients signature

Date_____

Person authorized to sign for patient (print):
_____

_____
Signature

_____
Relationship

*copying fees may be charged

PATIENT FULL NAME	PATIENT DOB
E-MAIL ADDRESS	
SPOUSE NAME (if applicable)	SPOUSE DOB
EMERGENCY CONTACT NAME (complete if different from above)_____ RELATIONSHIP_____ ADDRESS_____ _____ PHONE	

In order to be compliant with US Standards for electronic Medical Records, we are required to collect the following information. It has nothing to do with the treatment of our patients, but is mandatory that we collect and report this data.

Please check the information that best describes you;

___Hispanic or Latino
___Not Hispanic or Latino
___Refuse to Report

Also please check below;

___American Indian or Alaska Native
___Asian
___Black or African American
____Hispanic
___Native Hawaiian or other Pacific Islander
___White
___Other Race
___Refuse to Report

Preferred Language_____

Pharmacy name, number and/or address_____
2nd Pharmacy (including Mail Order)_____
What medications would go to your 2nd Pharmacy?
_____

I authorize Dr Gurley to access my pharmacy history
I authorize the release of any medical information necessary to process my claim. I also authorize payment of benefits to Larry D. Gurley, M.D. As a courtesy we file your insurance claim for you. All health plans are not the same and do not cover the same services. In the event your health plan determines a service to not be covered, you will be responsible for the complete charges. Payment is due upon receipt of a statement from our office. If it becomes necessary to send my account to collections, I will be responsible for all collection, attorney and court costs. I understand that this authorization remains in effect as long as I, or my dependent, remain a patient. I have read and understand the policy of this practice and agree to be bound by its terms.

Signed:_____Date:_____

Notification for Lab Results, Appointments, and Reminders

Lab results are relayed via our patient portal. Please provide your email address for initial set-up.
This method allows us to notify our patients in a timely manner.

Email: _____

You will receive an email to access the portal. There is **nothing to download**, just **click on the link**.
If you do not receive an email, please check your Junk mail. It would have either Dr Gurley's name, e-clinical works or Healow. These are secure sites in our system.

If you prefer not to be notified by any of the listed methods, please check "Do not use" by the method.

__Cell phone text message	__Do not use
__Cell phone or voice message	__Do not use
__Home phone or voice message	__Do not use
__Work phone or voice message	__Do not use

Also, please note if there are any other persons with whom you wish us to be able to discuss your care:

_____ relationship:_____

_____ relationship:_____

_____ relationship:_____

_____ relationship:_____

You may change any of the above at any time by contacting the office with your new preferences. Thank you.

Name_____Date of Birth _____

Signature _____ Date _____

FINANCIAL POLICY

- ALL CO-PAYS/PAYMENTS ARE DUE PRIOR TO SERVICE AS WELL AS PAST DUE BALANCES UNLESS PRIOR ARRANGEMENT HAVE BEEN MADE
- WE DO NOT ACCEPT CASH FOR PAYMENTS
- IF YOUR DEDUCTIBLE HAS NOT BEEN SATISFIED, WE RESERVE THE RIGHT TO COLLECT PAYMENT FOR YOUR OFFICE VISIT AT TIME OF SERVICE
- ALL BALANCES NOT PAID BY YOUR INSURANCE ARE DUE UPON RECEIPT OF STATEMENT
- IF YOUR ACCOUNT BECOMES PAST DUE IT WILL BE REFERRED TO A THIRD PARTY FOR COLLECTION AT WHICH TIME ADDITIONAL FEES WILL BE ADDED
- IF YOUR ACCOUNT IS REFERRED FOR FURTHER COLLECTION, WE RESERVE THE RIGHT TO DISCHARGE YOU FROM OUR PRACTICE
- RETURNED CHECKS WILL BE ACCESSED A $30.00 SERVICE CHARGE. ALL FUTURE PAYMENTS FOR YOUR ACCOUNT MUST BE MADE VIA CREDIT/DEBIT CARD ONLY
- FORM FEE OF $30.00 IS REQUIRED PRIOR TO COMPLETION
- MEDICAL RECORDS FEE IS A **MINIMUM** OF $20.00 AND IS REQUIRED PRIOR TO RELEASE
- ANY APPOINTMENT CANCELLED WITHIN 24 HOURS OR NOT KEPT IS SUBJECT TO THE FOLLOWING FEE: OFFICE VISIT-$75.00, ULTRASOUND-$150.00, SURGERY-$250.00. THIS WILL NOT BE BILLED TO INSURANCE AND MUST BE PAID IN FULL PRIOR TO THE RESCHEDULING OF A NEW APPOINTMENT-NO EXCEPTIONS WILL BE GIVEN
- PLEASE NOTE: WE DO NOT PROVIDE CHARITY CARE. IF THIS IS NEEDED, WE WILL REFER YOU TO A FACILITY/PROVIDER ABLE TO ACCOMMODATE YOUR NEEDS. GURLEY SURGERY CENTER IS WHOLLY OWNED BY DR LARRY D. GURLEY. NO OTHER PHYSICIAN OR BUSINESS HAS OWNERSHIP IN THE GURLEY SURGERY CENTER.

I GRANT PERMISSION AND CONSENT TO ADVANCED HEALTH AND ITS AGENTS, ASSIGNEE, AND CONTRACTORS WHICH MAY INCLUDE THIRD PARY DEBT COLLECTORS FOR PAST DUE OBLIGATIONS TO: (1) CONTACT ME BY MAIL/PHONE/TEXT MESSAGE/EMAIL AT ANY NUMBER/ADDRESS ASSOCIATED WITH ME, IF PROVIDED BY ME OR ANOTHER PERSON ON MY BEHALF, (2) LEAVE MESSAGES FOR ME AND INCLUDE IN ANY SUCH MESSAGE AMOUNTS OWED BY ME (3) USE PRERECORDED/ARTIFICIAL VOICE MESSAGE AND/OR AUTOMATED TELEPHONE DIALING SYSTEM AS DEFINED BY THE TELEPHONE COMSUMER PROTECTION ACE IN CONNECTION WITH ANY COMMUNICATION MADE TO ME AS PROCIDED HERIN OR ANY RELATED SCHEDULED SERVICES AND MY ACCOUNT. I UNDERSTAND THAT MY REFUSAL TO PROVIDE THE CONSENT DESCRIBED IN THIS PARAGRAPH WILL NOT AFFECT, DIRECTLY OR INDIRECTLY, MY RIGHT TO RECEIVE HEALTHCARE SERVICES.

BY SIGNING BELOW I ACKNOWLEDGE AND AGREE TO ALL TERMS LISTED ABOVE.

SIGNATURE DATE

HIPAA & Your Privacy Rights

We strongly believe in doing everything we possibly can to safeguard the privacy and security of your health information and records. As a result, we have made some changes in our office management procedures to make sure we follow the Health Information Portability and Accountability Act (HIPAA). Passed into law in 1996, HIPAA sets federal standards for the privacy and, security of patient information for all healthcare providers, plans, insurance companies and anyone they do business with. HIPAA gives you additional rights regarding control and use of your health information, meaning **you have more access and control than ever.** Please take a few minutes to review these new rights. We're happy to answer any questions you may have.

Control Over Your Health Information

All healthcare providers (and health plans) are now required to give you a written explanation of how they use and disclose your personal health information before they can treat you. This way, you can decide if a provider is doing everything they should to protect your privacy before you choose them as your caregiver.

We must, by law, post a Notice of Privacy Practices, which outlines how we secure the privacy of patient information, in a place where you can easily see it.

We must get your signature for non-routine uses and disclosures of your information. A non-routine use is any situation not directly related to treatment, payment or operations. For example, if your child is going to summer camp and the camp needs a medical history, you will be asked to authorize us to release it before we can send the information. You have the right to say no, and you don't have to tell anyone why.

Authorizations of non-routine information are one-time-only, case by case, for the use defined by you.

Access To Your Health Information

You can get copies of your medical records simply by asking for them. Healthcare providers are required to get you a copy of your records within 60 days of your request. There may be a cost for this service.

Providers also must give you a history of non-routine disclosures if you ask for it. All you need to do is ask for the record and it is provided to you - no justification is needed.

You can also amend your medical records. You cannot change the existing record, but you can add notes or comment on any procedures, treatments, payments or operations.

The provider then has the right to respond to your amendment. This way, you can be sure your records reflect your side of the story about treatment and payment issues.

Patient Recourse If Privacy Protections Are Violated

Every healthcare provider must also inform you of grievance procedures. If your privacy is violated, **report the incident to our Privacy Officer immediately.** You also have the right to report any violation to the Department of Health and Human Services, Office of Civil Rights, 200 Independence Avenue, S.W., Washington, D.C. *20201.*

If you decide to file a grievance either with us or with the Department of Health and Human Services, we are not allowed to discriminate or retaliate against you in any way.

Aside from these new rights to access and control of your medical information under HIPAA, there are also clear limits on all healthcare providers regarding how they disclose medical information. Here are some of the key aspects of these boundaries:

Providers must ensure that health information is not used for non-health purposes. Health information (covered by the privacy roles) generally may not be used for purposes not related to health care - such as disclosures to employers to make personnel decisions, or to financial institutions - without your explicit authorization.

There are clear, strong protections against using health information for marketing.

The privacy rules set new definitions, restrictions and limits on the use of patient information for certain marketing purposes. Providers must get your specific authorization before sending you any materials other than those related to treatment.

Use only the minimum amount of information necessary. In general, uses or disclosures of information will be limited to the minimum necessary. This does not apply to disclosure of records for treatment purposes, because physicians, specialists and other providers may need access to the full record to provide quality care.

Exceptions

There are situations where healthcare providers may not have to follow these privacy rules. They include: emergency circumstances; identification of a body or the cause of death; public health needs; judicial and administrative proceedings; limited law enforcement activities; and activities related to national defense and security.

We understand your right to have your medical information kept confidential. Our *compliance* with the Health Information Portability and Accountability Act is one example of our advocacy and leadership on issues of patient's rights and privacy of information. We encourage you to ask questions and look forward to working together to improve the quality of your healthcare experience.