LARRY D. GURLEY, M.D.
Physician & Surgeon

615-284-1500
Fax 615-432-2007

Appointment Reminder Letter

Dear ______________________,

This is to remind you of your appointment on ______________________________________.
Arriving 15 minutes prior to your appointment time is recommended. Please allow additional time for parking in the garage.
***Attached is an information packet. **Please fill out all pages completely and bring them with you to your appointment. Incomplete information will delay your appointment time.**
PLEASE READ & SIGN ALL PAGES PRIOR TO THE DATE OF YOUR APPOINTMENT. PLEASE REMEMBER TO BRING THEM WITH YOU.

***It is important that you **bring your insurance card and drivers license/photo ID for photocopying**. We need to keep a current copy in your chart. **All co-pays are to be paid on date of service.**

Thank you for allowing us to provide you with your gynecological care. We look forward to seeing you. If you are unable to keep the scheduled appointment, please call the office as soon as possible.

Sincerely,

Dr. Larry D. Gurley & Staff

300 20th Avenue North Suite 102 Nashville, TN 37203

www.gyncenter.com

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.

Office use only | □Estrog. Def. at incr. risk osteop. □ Review. _________ no change, or see below

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.

DIRECTIONS TO OUR OFFICE

Take I-40 to Church Street, exit 209. Turn on Church Street, traveling west.

Turn right on 20th Avenue North (St. Thomas Midtown will be on your left). Our building (20th Avenue Medical Office Building) will be on your right, at the corner of 20th and State Street.
For parking, turn right on State Street and the entrance to the parking garage will be on your left. There is a crosswalk from the parking garage to our building. It is located on the 2nd floor of the garage, but becomes the 1st floor of the medical building. You will pass a food court on your right and our office (Suite 102) will be the first office on the left.

If you are traveling on I-24 Eastbound or I-65 Southbound (before I-24 / I-65 merge):
1) Follow signs to I-65 South.
2) Exit at Charlotte Pike - exit 209.
3) Turn right at the bottom of the exit ramp. (See below for directions from Charlotte.)

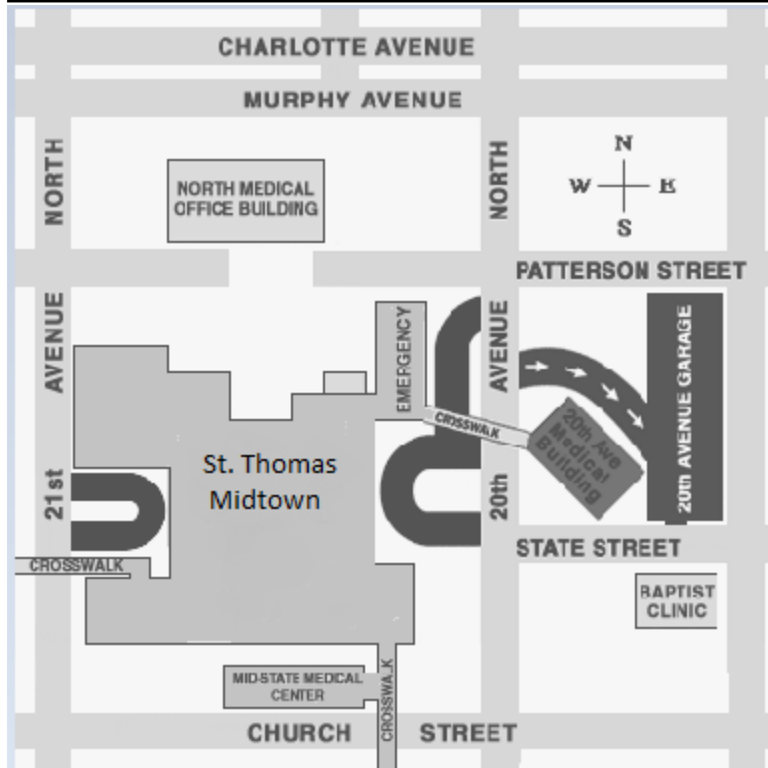
If you are traveling on I-65 Northbound or I-24 Westbound:
1) Follow signs to I-40 West.
2) Exit at Church Street/Charlotte Pike - exit 209)

If you are traveling on I-40 Eastbound:
1) Exit at Charlotte Pike - exit 209.
2) Turn right at the bottom of the exit ramp. (See below for directions from Charlotte.)

Directions from Charlotte Pike exit:
1) Proceed five blocks west away from town.
2) Turn left onto 19th Avenue North.
3) The 2nd 4-way stop is State Street. Turn right & enter the parking garage on the right.

Our building is conveniently located between Church Street & Charlotte Avenue. If you are coming from West End Avenue, you will turn on 20th Avenue North @ Amerigo's Restaurant. After you cross over Church Street, follow the above directions.

<u>WE NOW OFFER FREE VALET PARKING AT THE GROUND LEVEL ENTRANCE OF OUR BUILDING</u>



*St. Thomas Midtown previously Baptist

FINANCIAL POLICY

Our office accepts cash, check, debit cards, MasterCard, Visa, American Express, Discover and Care Credit.

All co-pays are due at time of service. These will be collected at the check-in window. If it has been determined that your deductible has not been satisfied, you may be asked to make a payment towards that at the time of service.

After your insurance has paid, you will be billed for any co-insurance that has been determined by your insurance company as your responsibility. These balances are due upon receipt of statement.

We review past due accounts frequently and at every statement cycle. Your communication and involvement to ensure your balance is paid timely is important to us. It is imperative that you maintain communications and fulfill your financial agreement and arrangements to keep your account active and in good standing.

If your account becomes sixty (60) days past due, further steps to collect this debt may be taken. If you fail to pay on time and we refer your account(s) to a third party for collection, a collection fee will be assessed and will be due at the time of the referral to the third party. The fee will be calculated at the maximum percentage permitted by applicable law, not to exceed 18 %. In addition, we reserve the right to deny future non-emergency treatment for any and all debtor-related unpaid account balances.

I grant permission and consent to Advanced Health and it agents, assignees, and contractors (which may include third party debt collectors for past due obligations): (1) to contact me by phone at any number associated with me, if provided by me or another person on my behalf, (2) to leave messages for me and include in any such messages amounts owed by me, (3) to send me text messages or emails using any email address I provided or any phone number associated with me, if provided by me or another person on my behalf and (4) to use prerecorded/artificial voice messages and /or automated telephone dialing system (an auto dialer) as defined by the Telephone Consumer Protection Act in connection with any communications made to me as provided herein 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.

Returned checks will be assessed a $30.00 service charge. All returned checks and fees, must be paid by cashiers check, money order, cash or credit card within 10 days.

There is an $8.00 charge for any form presented to us that requires completion by the physician or staff. This is due when the form is turned in. There is a $30 minimum charge for medical record copies. If records are in our offsite storage facility, the minimum cost will be $35 for retrieval fees plus copying and mailing records.

We want you to be aware that our surgery center, Gurley Surgery Center, is wholly owned by Dr. Gurley. No other physician or business has ownership in our surgery center.

If you fail to keep an appointment, or give at least 24 hour notice of cancellation, you are subject to a $50 charge, $75 if appointment was for ultrasound and $250 if appointment was in our surgery center.

I have read and fully understand the information on this form.

____

Patient Signature Date

AMBULATORY SURGERY CENTER
PATIENT RIGHTS AND RESPONSIBILITIES
Patient's have:

1. The right to quality care and treatment given with respect, consideration and dignity.
2. The right to appropriate privacy.
3. The right to the privacy of information regarding patient's diagnosis, treatment options, communication, and the potential outcomes of the treatment as well as access to information contained in his/her medical record.
4. The right to participate in decisions concerning care and treatment.
5. The right to know the physician performing his/her procedure may have financial interest or ownership in this ASC.
6. The right to be informed of patient responsibilities, conduct, and ASC rules affecting the patient's treatment.
7. The right to knowledge of services provided at this facility.
8. The right to discharge instructions, including information about after hours' care.
9. The right to detailed information regarding service fees and all charges.
10. The right to refuse participation in experimental research.
11. The right to receive the policy on advance directives, and living wills in the facility and to be given information upon request.
12. The right to receive information on this ASC's non participation in advanced directives.
13. The right to knowledge of the medical staff credentialing process, upon request.
14. The right to know the names of those treating the patient.
15. The right to truthful marketing or advertising utilized by the facility.
16. The right to be informed if the physician does not carry malpractice insurance.
17. The right to address a grievance.
18. The right to refuse a treatment, as permitted by law. One can refuse treatment and still receive alternate care.
19. The right to be fully informed regarding one's condition.
20. The right to understand and sign an Informed Consent form before receiving care.
21. The right to appropriate assessment and management of pain.
22. The right to continuity of care. If overnight care is required, staff will arrange for transportation of a patient to the transfer hospital.
23. The right to respectful, safe care and treatment free from seclusion, restraints, abuse and harassment.
24. The right to have a family member notified of his/her admission as-well as notification of his/her personal physician, if requested by the patient.
25. The right to leave the facility against the advice of his/her physician.
26. The right to express spiritual and cultural beliefs.

Patient Responsibilities

1. The patient is responsible for providing accurate/complete information related to his/her health; reporting perceived risks in his/her care, and for reporting unexpected changes in his/her health.
2. The patient and family are responsible for asking questions when they do not understand, what a staff member has told them about the patient's care or expectations of what they are
to do.
3. The patient is responsible for following the treatment plan established by his/her physician, including the instructions of nurses and other health professionals as they carry out the physician's orders.
4. The patient is responsible for notifying the ASC office when unable to keep a scheduled appointment.
5. The patient is responsible for providing his/her healthcare insurance information, and assuring the financial obligations of
his/her care are fulfilled as promptly as possible.
6. The patient is responsible for the consequences if he/she refuses treatment or fails to follow the practitioner's instructions.
7. The patient is responsible for being respectful and considerate of other patients and organizational personnel.

These rights and responsibilities outline the basic concepts of service here at the Ambulatory Surgery Center. If you believe, at any time, our staff has not met one or more of the statements during your care here, please ask to speak to the Medical Director or Nurse Manager. We will make very attempt to understand your complaint/concern. We will correct the issue you have if it is within our control, and you will receive a written response.

PATIENT COMPLAINT OR GRIEVANCE
Patient complaints or grievances may be filed through the facility administrator:

Gurley Surgery Center
Attn: Facility Administrator
300 20th Ave N., Suite 102
Nashville, TN. 37203
615 284-1500
ldgmd@bellsouth.net

or with the State of Tennessee Office of Investigations:

TN. Department of Health
Office of Investigation
665 Mainstream Drive
2nd Floor, Suite 201
Nashville, TN. 37243
615 741-8485
1 800 852-2187

All Medicare beneficiaries may also file a complaint or grievance with the Medicare Beneficiary Ombudsmen at www.**cms**.hhs.gov/center/**ombudsman**.asp

I have read and fully understand the information on this form.

____
Signature Date

____
Witness Date

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

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 ____________________

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:__________________