ProHealth Rural Health Services

New Patient Registration

What Services are you interested in both now and in the future?

Medical____ Dental ____ Behavioral Health ____

Suboxone Treatment ____ Lifestyle Assessment ____

Date: ____ - ____ - _____
Patient Name: (Last) ________________, (First)_______________ (MI) ____
Street Address: ____
City: _____________________ State: ___________ Zip: ______________
Patient Phone Number: _____ - ______ - ______
Date of Birth: ___/___/_____ Social Security #: ____-____-____
Sex: M ___ F ___
Marital Status: Single ____ Married ____ Divorced ____
Separated____ Widowed____
Race: White ____ Black ____ American Indian/ Alaska Native ___ Asian ____
Hawaiian/ Pacific Islander ____ Hispanic ____ Other ______________
Email Address: ______________________________@ _____________. Com
Who is responsible for this account: _______________________
Relationship to Patient: ___________________
Employer: ____________________ Occupation/Position: __________________
Employer Address: _____________________________
City:________________ State:____________________Zip:__________________

Employer's Phone: ____ - ________ - _________
Do you have Medical Insurance?
Yes____ Please provide copy of insurance card and Picture ID.
No ____ Please fill out "Family Assistance Plan Application" Form.
If yes: Who is responsible for this account:_____________________
Policyholder/Subscriber ID (SSN/ID#)_______________________
Relationship to Patient: __Self __Spouse __Dependent Child __Other:____
Employer:_______________ Occupation/Position:________________
Employer Address:________________________
City:_____________ State:_________ Zip:__________
Employer's Phone:____-__________-__________

In case of emergency, who should we notify: _______________________
Emergency Contact Phone: _____-_____-_____

I, the undersigned, hereby authorize ProHealth Medical Centers or an agent acting on its behalf to release all information necessary to secure payments of benefits. I assign directly to ProHealth Medical Centers all medical payments and benefits otherwise payable to me for services rendered. I understand that I am responsible for all charges whether or not paid by insurance. I understand that any portions of the charges for the services rendered can be discounted based upon my income. I understand that I am responsible for providing proof of income if I am to utilize the discount program. By signing I am stating that I have received a copy of ProHealth Medical Center's Privacy Policy, and HIPAA disclosure. I authorize the use of this signature for all insurance submissions.
ProHealth Medical providers an integrated health model that looks to ensure that both your medical & psychological wellness is assessed and treated in order to achieve the highest health benefits for you. With that you agree to be seen and evaluated by one of our behavior specialist prior to seeing our medical provider. A large majority of physical illness is directly related to maladaptive behaviors and psychological stress.

Signature: _________________________ Date: _____ - _____ - ______

ProHealth Community Health Centers
Health History

Are you currently taking any prescription or non-prescription medications?

Yes____ No____

If Yes, Please list any medications you are currently taking (name & Dosage):

____

____

____

____

Have you been diagnosed with any of the following?

Diabetes:	Yes	No
High Blood Pressure:	Yes	No
High Cholesterol:	Yes	No
Stroke:	Yes	No
Heart Attack:	Yes	No
Cancer:	Yes	No
Lung Disease:	Yes	No
Liver Disease:	Yes	No
Tuberculosis:	Yes	No
Arthritis:	Yes	No
Seizures:	Yes	No
General Tiredness:	Yes	No
Obesity:	Yes	No
HIV:	Yes	No
Depression:	Yes	No

Other: ____

Please list all surgeries you have received within the last seven (7) years:

____

____

Please list all known Medication Allergies:

____

____

I, the undersigned, certify the above stated information to be completed and accurate:

Signature:____________________________ Date: _____ - _____ - _____

ProHealth Community Health Centers
Dental History Questionnaire

Previous Dentist Name:____
City: ___________________________
Phone #: _____ - _____ - _____
When was your last dental visit: (mo) __________ (yr) __________

Last COMPLETE Dental Exam Date: _________ / _________ / ___________

Last FULL MOUTH X-RAYS Date: ________ / __________ / ___________

Are you having problems now?	YES _____NO_____
Do you wear dentures?	YES _____NO_____
Are you unhappy with your dentures?	YES_____NO_____
Have you had any periodontal (GUM) treatments?	YES_____NO_____
Do your gums bleed, or feel tender, or irritated?	YES_____NO_____
Are you unhappy with the appearance of your teeth?	YES_____NO_____
Are you aware of grinding or clenching your teeth?	YES_____ NO_____
Do you have loose, chipped or shifting teeth?	YES_____ NO_____
Have you worn braces on your teeth? (Orthodontics)	YES_____ NO_____
Do you have discolored teeth that bother you?	YES_____ NO_____
Would you like your smile to look better or different?	YES_____ NO_____
Do you have problems with teeth/fillings breaking?	YES_____ NO_____
Do you regularly use dental floss?	YES_____ NO_____

Are you aware of being allergic to or reacting adversely to any medications or substances?
LIST:
_______________________________________ _______________________________________
_______________________________________ _______________________________________
_______________________________________ _______________________________________
_______________________________________ _______________________________________

ProHealth Community Health Centers
ProHealth Medical Centers Controlled Substance Agreement

Controlled Substances are any substances monitored by the Drug Enforcement Agency or DEA. This contract pertains to any patient who receives any controlled substance through ProHealth Medical Center. This includes all narcotics, most ADD medications some muscle relaxers, and benzodiazepines used for the treatment of anxiety. **Please initial each line and then sign your name at the end**.

_____ Patients must bring any diagnostic exams or previous medical records with previous medications. MRIs must be repeated every 2 years. **New patients may not be given narcotics until medical records or diagnostic exam results are received and reviewed.**

_____ ProHealth Medical Center will **NOT** refill medications early for any reason, including los or stolen medications. It is the responsibility of the patient to store their medications securely. There are **NO EXEPTIONS**, even with a police report.

_____ Patients must see a provider on a monthly basis for any Schedule II or III medications. Refills **will NOT** be called in. Refills will not be given early; patients can make appointments up to 4 days before the next refill is due.

_____ Refills will **NOT** be given on a walk-in basis. Patients must schedule an appointment for refills of controlled substances.

_____ Patients may be subject to random urine drug screens, regardless of insurance status. Failure to pass a urine drug screen may result in dismissal from the practice. Patients will **NOT** receive refills if they refuse a random urine drug screen.

_____ Patients may only obtain Schedule II or III medications from ProHealth Medical Centers – Patients must notify ProHealth Medical Center if they are prescribed narcotics from any other source including the emergency room. If a provider refers a patient to Pain Management, it is assumed that ProHealth will no longer be prescribing narcotic medications.

_____ Patients must agree to obtain all of their controlled substances at the same pharmacy. ProHealth reserves the right to obtain pharmacy records, patients filling prescription at multiple pharmacies may be dismissed from the practice.

_____ Patients agree not to use any illicit substances or any medications that are not prescribed. Use of illicit substances may result in dismissal from the practice.

_____ Once patients require more than 80 morphine equivalent doses of narcotic medication, patients will be referred to a pain management practice.

Patient Signature: ______________________________ Date: ______ - ______ - ______

ProHealth Community Health Centers
Patient Responsibility Agreement

Thank you for choosing ProHealth Medical Center as your healthcare provider. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

• The patient (or patient's guardian, if a minor) is ultimately responsible for the payment of his/her treatment and care.
• We are pleased to assist you by billing for our contracted insurers however, the patient is required to provide us with the most correct and updated information about their insurance and the patient will be responsible for any charges incurred if the information provided is not correct or updated.
• Patients are responsible for the payment of co-pays, co-insurance, deductibles and all other procedures or treatments not covered by their insurance plan. Payment is due at the time of service and for your convenience we accept cash, check, and most major credit cards at our office. Any and all balances assigned as patient responsibility may be subject to collection efforts after 90 days, as well as credit reporting.
• Patients are to be aware that our Laboratory services are provided by Quest Laboratories and drug screen by Ameritox. They are not affiliated with Prohealth and there may be an additional charge if your insurance coverage does not include this laboratory. Please check with your insurance company. Any questions about billing from laboratories are to be resolved by contacting the lab company directly.
• Patients may incur, and are responsible for the payment of additional charges. These charges may include (but are not limited to):
• Charge for returned checks
• Charge for the copying and distribution of patient medical records.
• Any costs associated with collection of patient balances.
• By my signature below, I acknowledge and understand that it is ultimately my responsibility and obligation to be aware of my insurance's requirements, coverage, deductibles and payments.
• By my signature below, I hereby authorize Prohealth Medical Center and the physicians, staff, and hospitals associated to release medical and other information acquired in the course of my examination and/or treatment to the necessary insurance companies, third-party payers, and/or other physicians or healthcare entities required to participate in my care.
• By my signature below, I hereby authorize assignment of financial benefits directly to Prohealth Medical Center and any associated healthcare entities for services rendered as allowable under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment.
I understand that account balances not paid by my insurance company within 90 days are the patient's/my responsibility.
I also understand that account balances not paid within 90 days from the date of service will be sent to collections.
• By my signature below, I authorize Prohealth Medical Center personnel to communicate by mail, answering machine message, voicemail, and/or email according to the information I have provided in my patient registration information.
I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:

_______________________________ _______________________
Signature of Patient or Legal Guardian Date

Waiver of Authorization: I do not wish to have information released and prefer to pay at the time of service and/or to be fully responsible for payment of charges and /or to submit claims to insurance at my discretion.

_____________________________ _________________________
Signature of Patient or Legal Guardian Date

ProHealth Community Health Center
PROHEALTH HIPAA POLICY STATEMENT

Purpose of this Notice
Prohealth respects the privacy of protected health information and understands the importance of keeping this information confidential and secure. This Notice describes how we protect the confidentiality of the protected health information we receive. Health Insurance Portability and Accountability Act of 1996 (HIPAA). Prohealth maintains a process to ensure compliance with applicable provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Since our goal is to provide the highest level of service to our customers and business partners, we want you to know Prohealth complies with the HIPAA directives. Our HIPAA Privacy Policy contains procedures addressing the protection, use and disclosure of protected health information ("PHI"), accounting of disclosures, access by individuals and third parties to PHI, protection of PHI by contractors, business associate agreements and training of employees.

How We Protect Personal Information
We treat personal information securely and confidentially. We limit access to personal information to only those persons who need to know that information to provide support services to our customers. These persons are trained on the importance of safeguarding this information and must comply with our procedures and applicable laws. We employ strict physical, electronic and procedural security standards to protect personal information and maintain internal procedures to promote the integrity and accuracy of that information.

Disclosure of Personal Information
We may use or disclose protected health information to the Food and Drug Administration ("FDA") in connection with the reporting of adverse events, product defects or problems, product tracking or for other purposes as required by the FDA. We may use or disclose protected health information during the course of clinical research activities. We may also disclose personal information as required by law to Individual Rights to Access and Correct Personal information. We have procedures in place for individuals to have access to protected information, and procedures in place to ensure the integrity of our information and for the timely correction of incorrect information.

Further Information
Prohealth may find it necessary to revise and update its HIPAA Privacy Policy from time to time as changes to the privacy regulations emerge, and will communicate any such changes to our customers and business partners.

HIPAA and Privacy Information was provided to me and I was given the opportunity to ask questions about these policies:
Patient/Responsible Party Name: ______________________________
Signature: _________________________________Date: ___________

Prohealth Community Health Center
Family History

Family History: Circle the following

Diabetes: Y/ N Who:	Drug/ Alcoholism: Y/ N Who:	Heart Disease: Y/ N Who:	Stroke: Y/ N Who:
Arthritis: Y/ N Who:	Epilepsy: Y/ N Who:	High Blood Pressure: Y/ N Who:	Thyroid Disease: Y/ N Who:
Asthma: Y/ N Who:	Glaucoma: Y/ N Who:	Kidney Disease: Y/ N Who:	Tuberculosis: Y/ N Who:
Cancer: Y/ N Who:	Gout: Y/ N Who:	Mental Illness: Y/ N Who:	Depression: Y/ N Who:
HIV/AIDS: Y/ N Who:	Osteoporosis: Y/ N Who:	Other: Y/ N Who:	

Check what applies:

Tobacco Use	**What Kind:**	**Do you drink?**
Never ______	Cigarettes ______	Never ______
Sometimes ______	Chewing Tobacco ______	Sometimes ______
Always ______	E-vape______	Always _______

ProHealth Community Health Center
Social History

Sexual Activity: Check what applies

Sexually Active ______

Safe Sex Practice ______

Not Sexually Active _____

Safety: Answer Yes or No

Do you wear Seatbelts? ___________

Do you have a gun at home? __________

Do you have a household smoke detector? ___________

Do you eat healthy meals? __________

Do you exercise regularly? __________

Do you take aspirin daily? __________

Pregnancies:

Have you been pregnant before? No _____ Yes _____

If yes please answer the following:
How many pregnancies? ________

How many full-term? __________

How many premature? _________

How many living? __________

1325 West Main St

Franklin, TN 37064

Phone (615)591-4750 / Fax (615) 7940081

Authorization to release Health Care information

Print Name

___________________________________ SS#____________________ DOB_____________

Previous Name ___________________________

I request and authorized ____ to release health care information of

patient name above to: ____

This request and authorization applies:

Health care information relating to the following treatment, condition or dates

____

All health care information

Other____

Sexually Transmitted Disease (STD) as defined by law, RCA 70.24 et seq includes Herpes Simplex, Human Pappilloma Virus, Genital Wart, Condyloma, Chlamydia, non specific Urethritis Syphilis, VDRL, Cancroids, Lymphogranuloma, Venerrum, HIV, AIDS, and Gonorrhea.\

YES___ NO___ I authorize the release of my STD results, HIV/AIDS testing, whether negative and positive to the person(s) listed above. I understand that the person(s) listed above will not be notified that I must give specific written permission before disclosure of these tests to anyone.

YES___ NO___ I authorize the release of any records regarding drugs, alcohol, or mental health treatment to the person(s) listed above.

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Patient Signature____Date__________________