8906 Kingston Pike
Knoxville, TN 37923
Phone – 865-690-4200
Fax – 865-531-9018

2905 Tazewell Pike
Knoxville, TN 37918
Phone – 865-686-1600
Fax – 865-686-3380

New Patient Intake Form

To provide you with the most appropriate treatment, please complete the following questionnaire. All information is strictly confidential.

First Name: _____ MI ___ Last Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (H) _____ (C): _____ (W): _____ Can we call work □ Yes □ No

Email Address: _____ Date of Birth: _____

Sex: □ Male □ Female SS#: _____ Marital Status: □ Single □ Married □ Widowed

Race: □ Caucasian □ African American □ Asian □ Native American □ Latin American □ Other

Occupation: _____ Employer: _____

Employer Phone: _____

How did you hear about our practice? _____
(If referred, by whom?) _____

Emergency Contact:

Name: _____ Relationship: _____ Phone: _____

Accident Information
Is this visit due to an accident? □ Yes □ No If yes, what type? □ Auto □ Work □ Other

Has it been reported? □ Yes □ No If yes, to whom? _____

Signature: _____ Date: _____

Health History

Please check to indicate you have previously been diagnosed with any of the following:

- ☐ Aids/HIV
- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Anorexia/Bulimia
- ☐ Anxiety
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Breast Lumps
- ☐ Cancer _____
- ☐ Chemical Dependency
- ☐ Chicken Pox/Shingles
- ☐ COPD
- ☐ Deep Vein Thrombosis
- ☐ Depression
- ☐ Diabetes
- ☐ Eczema/Dermatitis
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hernia
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Migraines/Cluster
- ☐ Headaches
- ☐ Multiple Sclerosis
- ☐ Ovarian Cysts
- ☐ Pacemaker
- ☐ Parkinson's disease
- ☐ Pinched Nerve
- ☐ Planta Fasciitis
- ☐ Polio
- ☐ Prostate Cancer
- ☐ Pulmonary Embolism
- ☐ Rheumatoid Arthritis
- ☐ Stroke/TIA
  - ☐ Stomach Ulcers
  - ☐ Thyroid Problems
- ☐ Tuberculosis
  - ☐ Uterine Fibrosis
  - ☐ Other:

_____

_____

ORTHOPEDIC HISTORY:

- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Degenerative Joint Disease
- ☐ Bulging Disc
- ☐ Herniated Disc
- ☐ Degenerative Disc Disease
- ☐ Carpal Tunnel
- ☐ Scoliosis
- ☐ Broken Bones/Fractures:

_____

_____

Surgical History:

- ☐ Appendectomy
- ☐ Gallbladder Removal
- ☐ Coronary Bypass
- ☐ Hysterectomy
- ☐ Carpal Tunnel Surgery
- ☐ Fusion _____
- ☐ Laminectomy _____
- ☐ Discectomy _____
- ☐ Other: _____

Medications:

Are you on any blood thinners including Coumadin (Warfarin), Pradaxa, Xarelto? ☐ *Yes* ☐ *No*

Please list below any medications or supplements that you are taking (include dose/frequency)/

_____ _____

_____ _____

_____ _____

Allergies: Please list any medication allergies: _____

Social History. What is your occupation? _____

Approximate your intake of the following: Alcohol _____ drinks/week Cigarettes _____ packs/day

Who is your family /primary physician? _____

What pharmacy do you use? _____

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE: _____ DATE: _____

Allergy Questionnaire – Intake Questions

To Be Filled Out by Patient

Patient Name: Birthdate:

Reviewed by: Date:

1. Do you experience any of these symptoms more than twice per year: Cough, Cold, Congestion, Difficulty breathing, headaches, wheezing, runny nose, sore throat, itchy/irritated eyes, sinus pain, ear pain, unexplained fatigue, skin irritation, snoring? ☐ Yes ☐ No

1. Have you ever been diagnosed with asthma or bronchitis? ☐ Yes ☐ No

2. Do you experience symptoms of allergies? ☐ Yes ☐ No

3. Regarding possible food allergies, do you experience any of the following: (check all that apply)
   - ☐ Bloating
   - ☐ Constipation
   - ☐ Stomach Pain
   - ☐ Nausea
   - ☐ Tingling of the mouth or any other unusual sensation
   - ☐ Diarrhea
   - ☐ Upset Stomach
   - ☐ Indigestion
   - ☐ Vomiting

Optimal Health, PLLC

Informed Consent to Care

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not provide specific healthcare if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from, such as latent pathological defects, illness, or deformities, which would otherwise not come to the attention of the physician.

The patient agrees to settle any claim/ dispute he/she may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitrations under the current malpractice terms which can be obtained by written request.

All forms of health care, while offering considerable benefit may also provide some level of risk. Prior to receiving medical care, it may be necessary to perform a health history and physical examination. These procedures are performed to assess the patient's specific conditions and overall health. These procedures will assist Optimal Health in determining if medical care is needed or if any further examinations or studies are needed. In addition, they will help Optimal Health determine if there is any reason to modify the patient's care or provide the patient with a referral to another health care provider. All relevant findings will be reported to the patient, along with a care plan prior to beginning care. Patient understands and accepts that there are risks associated with medical care and gives consent to the examination that the doctor deems necessary and to the medical services, as reported following the assessment.

This notice is effective as of (today's date) _____ *and will expire 7 years after the date on which you last received* services from Optimal Health.

Patient Signature: _____ Date: _____

To Our Patients

Regarding patient right to make advanced healthcare decisions.

Federal law requires that Optimal Health gives the patient's information about their rights to make advanced health care decisions. The patient may make healthcare decisions for themselves, however if the patient is unable to make healthcare decisions, advance directions are required. If the patient becomes unable to do so, the patient appoints another person to accept or refuse treatment on their behalf.

The patient may leave advance directions about withdrawal of life support executing a "Living Will". A Living Will authorizes the patient's healthcare provider and family to withdraw or withhold medical care which artificially prolongs life, in the event Optimal Health determines the patient to have a terminal condition from which there is no reasonable expectation of recovery. The patient can also name a person to make medical treatment decisions by appointing someone to have "Durable Power of Attorney for Healthcare" for the patient. This person is allowed to make healthcare decisions for the patient, including life support decisions. It may also direct the attending physician with respect to donations of the patient's organs.

It is Optimal Health's policy to honor the patient's healthcare decisions to the full extent required or allowed by law. The patient is NOT required to give advance healthcare directions in order to receive care at this facility.

Do you have a living will? Yes____ No____

Do you have Durable Power of Attorney for healthcare? Yes____ No____

If you answered YES to either of the questions, we need to put a copy of the document in your medical chart in order to ensure that your wishes are honored.

Patient Signature: _____ Date: _____

Acknowledgment of Receipt of Notice of Privacy Practices

Patient Name: _____ Date: _____

I acknowledge that I have received the Notice of Privacy Practices of Optimal Health, PLLC. I acknowledge that it is the policy of Optimal Health, PLLC to send a text message or leave reminder messages on my answering machine or with another person in my home. I will make a request of an alternative means of communication (within reason) in writing. I acknowledge that if I should have a problem or question in regards to my rights, I may speak with a privacy officer about my concerns.

Patient Signature: _____ Date: _____

X-Ray Questionnaire for Women

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____

- □ There is a possibility that I may be pregnant at this time
- □ Yes, I am definitely pregnant
- □ No, I am definitely not pregnant
- □ I request that x-rays not be taken because _____

_____

Date of last menstrual cycle: _____

Patient Signature: _____ Date: _____

Optimal Health, PLLC

Authorization to Treat Specific and Irrevocable Assignment of Benefits and Healthcare Lien

Pertinent Data

Date of Injury (if applicable) : _____

Liable Party: _____

Second Party if Applicable: _____

Second Insurance Company: _____

To Optimal Health PLLC, Access Healthcare PC here forward known as *Providers.*

1. I hereby testify that my sole purpose for coming to this office is for healthcare.
2. I hereby authorize providers and its staff and doctors to examine and treat my condition.
3. I hereby authorize providers to release any information you deem appropriate concerning my health condition to any insurance company, attorney, or adjuster in order to process claims for reimbursement of charges incurred at the *Providers* clinic by me.
4. I authorize and assign direct payment to *Providers* if any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to reimburse me for the charges for your services or otherwise obligated to payment to me or you based in whole or part upon the charges made for *Providers'* services.
5. I give assignment and lien against any claim against a third party whose negligence may have caused my injury, up to the amount of the bill for treatment.
6. I understand that I am financially responsible for all charges for services rendered by *Providers* and you may investigate my credit, employment, income records and credit references. You may report to the credit reporting agencies and other creditors the status of payment of my account.
7. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for *Provider* services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that in my favor against any such company the name(s) of which is believed to be correctly set forth under pertinent data above and authorize you to prosecute said action either in my name or your name as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sum(s) due from the insurance company or companies contractually obligated, you will refrain from attempts and efforts to collect the amounts you do not collect from insurance proceeds (whether it is all or part of what is due) I personally owe you.
8. I waive the statute of limitations regarding *Providers* right to recovery.
9. I hereby authorize and direct you, my attorney, to pay directly to said *Provider(s)* such sums as may be due and owing him for professional services rendered me both by reasons of this accident and by reasons of any other bill(s) that ae due his office and to withhold such sums from any settlement, judgment, or verdict as may be necessary adequately to protect said P*roviders*. I hereby further give a lien on my case to said *Provider* against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, or myself as a result of the injuries for which I have been treated or injuries in connection therewith.

Patient Signature: _____ Date: _____

Assignment of Health Plan Benefits and Right
As well As an
Appointment and/or Designation as My Personal Representative and An ERISA/PPACA Representative and Beneficiary

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay ***Optimal Health PLLC***, as well as all employees, employers, representatives, and agents, thereof, (herein collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided.

I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been or will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially pain claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same.

I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA (*Employee Retirement Income Security Act*)
Governed plan/insurance contract, PPACA (*Patient Protection and Affordable Care Act*) governed plan/insurance contract) rights that I (or my child, spouse or dependent) may have under my/our applicable health plan(s) or health insurance policy (ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and purse appeals and/or legal action to obtain (or protect) benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan.

This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 20 _____

_____ _____

Patient Signature or Signature of Guardian if a Minor Date

_____

Please Print Name

OPTIMAL HEALTH PLLC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

Optimal Health PLLC, is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Healthcare Information

Treatment:
Our treatment are is an open environment. You may be treated alongside other patients and your health information discussed. In addition audio and video recording will take place in our office which is for the purpose of maintaining a high level of patient care, integrity, and security purposes.

We may disclose your healthcare information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations (example):

> *"On occasion, it may be necessary to seek consultation regarding your condition from other healthcare providers associated with Optimal Health PLLC.*
>
> *"It is our policy to provide a substitute healthcare provider, authorized by Optimal Health PLLC to provide assessment and/or treatment to our patients, without advanced notice, in the event of you primary healthcare provider's absence due to vacation, sickness, or other emergency situation."*

Payment:
We may disclose your health information to your insurance provider for the purpose of payment or healthcare operations (example).

> "As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Optimal Health PLLC for your healthcare services rendered. If you pay for your healthcare services personally, we will, as a courtesy, provide an itemized billing statement to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the healthcare services received."

Workers' Compensation
We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency of your health.

Public Health
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings
We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement
We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Person
We may disclose your health information to coroners or medical examiners.

Organ Donation
We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research
We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies
We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing
We may contact you for marketing purposes or fundraising purposes, as described below:

"As a courtesy to our patients, it is our policy to call your home or send you a text message on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

"It is our practice to participate and or market upcoming events, new services, and, charitable events. During these times, we may send you a letter, email, text message, post card, invitation or call your home to invite you to participate. We will provide you with information about the type of activity, the dates and times and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of Optimal Health PLLC sponsored events."

Change of Ownership
In the event that Optimal Health PLLC is sold or merged with another organization, your health information/record will become property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Optimal Health PLLC is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to request that Optimal Health PLLC amend your protected health information. Please be advised, however, that Optimal Health PLLC is not required to agree to amend your health information. If your request to amend your health information has been denied, you will be provided with and explanation of your denial reason(s) and information about how you can disagree with the denial.
- You have the right to an accounting of disclosures of your protected health information made by Optimal Health PLLC.
- You have the right to a paper copy of this Notice of Privacy Practices at any time upon request,

Changes to this Notice of Privacy Practices
Optimal Health PLLC reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Optima Health PLLC is required by law to comply with this notice.

Optimal Health PLLC is required to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: Cathy Humphrey by calling 865-691-9055. If they are not available, you may make an appointment for a personal conference in person or by telephone within two working days.

Complaints
Complaints about your Privacy Rights, or how Optimal Health PLLC has handled your health information should be directed to Cathy Humphrey by calling 865-691-9055. If they are not available, you may make an appointment for a personal conference in person or by telephone within two working days.

Office Address is:
8874 Kingston Pike, Ste. 202
Knoxville, TN 37923

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

Privacy Practice Acknowledgement of Receipt:

Patient Signature

Date