OPTIMAL HEALTH
REGENERATIVE AESTHETICS MEDICAL

11668 Parkside Dr.
Knoxville, TN 37934
Ph# (865)288-4200 Fax# (865)392-1029

# 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: _____

Phone: (Mobile/Home)_____ (Work)_____

Email Address: _____

Date of Birth: _____/_____/_____ Sex: □ Male □Female

SS#: _____ Marital Status: □ Single □ Married □ Widowed

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

Which service are you here for?
□ Regenerative Therapy □ Hair Restoration □ Medical Weight Loss
□ Women's Health □ Men's Health □ IV Therapy □ Other

Emergency Contact:
Name: _____ Relationship: _____ Phone Number: _____

Social History: *(please circle all that apply)*

| | | | |
|---|---|---|---|
| Caffeine: | Occasional | Often | Never |
| Drink Alcohol: | Occasional | Often | Never |
| Exercise: | Occasional | Often | Never |
| Cigarettes: | Occasional | Often | Never |

Other: _____

Family History: *(please circle all that apply)*

| | | | |
|---|---|---|---|
| Arthritis: | Parent | Sibling | Grandparent |
| Cancer: | Parent | Sibling | Grandparent |
| Diabetes: | Parent | Sibling | Grandparent |
| Heart Disease: | Parent | Sibling | Grandparent |
| Hypertension: | Parent | Sibling | Grandparent |
| Stroke: | Parent | Sibling | Grandparent |
| Thyroid: | Parent | Sibling | Grandparent |

Other: _____

Medical Conditions: *(please check all that apply)*

□ Arthritis □ Cancer □ Diabetes □ Heart Disease □ Hypertension

□ Psychiatric Illness □ Skin Disorder □ Stroke □ Thyroid disorder □ Blood Disorder

Surgeries: *(please list all)*

_____

_____

_____

_____

Current Prescribed Medications: *(Please list all)*

_____

_____

_____

_____

Supplements and Over the Counter Medications: *(please list all)*

_____

_____

_____

_____

Allergies: *(please list all)*

_____

_____

_____

_____

*Patient Signature:* _____ *Date:* _____

**Optimal Health, PLLC**
**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 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 regard to my rights, I may speak with a privacy officer about my concerns.

Patient Signature: _____ Date: _____

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**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: _____

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## Free Service Receipt

I understand that my initial consultation and free
x-rays (if needed) may be of no charge to me.

I also understand that any other services rendered by this office today or any day here after, will be charged to me.

I have read and understand the above FREE SERVICE RECEIPT.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

## 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 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 to ensure that your wishes are honored.

Patient Signature: _____ Date: _____

# 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 area 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 your 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 during 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 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 in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. 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 fund-raising events."*

Change of Ownership
If 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: _____

# COVID-19 Liability Release Waiver

Due to the 2020 outbreak of the Coronavirus (COVID 19), our business is taking extra precautions with the care of our patients to include health history and enhanced sanitation/disinfecting procedures in compliance with CDC guidance.

Symptoms of COVID-19 include:

- Fever
- Fatigue
- Dry Cough
- Difficulty Breathing

I agree to the following:

- I understand the above symptoms and affirm that I, as well as all household members, do not currently have, nor have experienced the symptoms listed above within the last 14 days.
- I affirm that I, as well as all household members, have not been diagnosed with COVID-19 within the past 30 days.
- I affirm that I, as well as all household members, have not knowingly been exposed to anyone diagnosed with COVID-19 within the last 30 days.
- I affirm that I, as well as all household members, have not traveled outside of the country or to any city considered to be a "hot spot" for COVID-19 infections within the past 30 days.
- I understand that Optimal Health PLLC, cannot be held liable for any exposure to the COVID-19 virus caused by misinformation on this form or the health history provided by each patient.

Our business is following, these enhanced procedures to prevent the spread of COVID-19:

- Provide mask at entrance of facility for all patients
- Provide gloves at entrance of facility for all patients
- Disinfecting in between patient use of equipment
- Hand sanitizer available all throughout clinic
- Maintain social distancing
- Staff and patient education

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE AND REPRESENT THAT I have read the foregoing Waiver of Liability, understand it and sign it voluntarily as my own free act and deed, no oral representations, statements, or inducements, apart from the foregoing written agreement, have been made. I am at least eighteen (18) years of age and fully competent; and I execute this agreement for full, adequate and complete consideration fully intending to be bound by same

Signature: _____ Date: _____

Printed Name: _____

Name of Minor Children: _____