FAMILY MEDICAL
ASSOCIATES & PEDIATRICS

PATIENT REGISTRATION

Name: _____
FIRST MIDDLE LAST

If minor, parent's name (s): _____

Date of Birth: _____ Social Security Number: _____ Gender: _____

Mailing Address: _____
STREET CITY STATE ZIP

Cell Phone: _____ Home Phone: _____
Which number is primary? *CELL or HOME* **Are we allowed to leave detailed messages? *YES or NO***

E-Mail Address: _____
Providing your e-mail will opt you in for e-mailed appointment reminders and office newsletters. You may opt out by calling our office or within the e-mail by clicking the Unsubscribe link.

Preferred method for appointment reminders? (circle all that apply): **phone call** **text** **e-mail**

Will you allow medical related calls such as test results as early as 7am? **YES** **NO**

PRIMARY INSURANCE INFORMATION

Insurance Carrier: _____ Policy #: _____

Subscriber Name: _____ Date of Birth: _____

Social Security #: _____ Relationship: _____

SECONDARY INSURANCE INFORMATION

Insurance Carrier: _____ Policy #: _____

Subscriber Name: _____ Date of Birth: _____

Social Security #: _____ Relationship: _____

RESPONSIBLE PARTY (Required for all minors)

Name: _____ Date of Birth: _____ Relationship: _____

Address: _____

Social Security #: _____ Home Phone: _____ Cell Phone: _____

Employer: _____ Employer Phone: _____

Marital Status: ***(circle)*** Single Married Partnership Separated Divorced Widowed

(Continue On Back Page)

Name of Spouse/Partner: _____

Race: ***(circle)*** American Indian Alaska Native Native Hawaiian African American White
Asian Pacific Islander Other: _____

Ethnicity: ***(circle)*** Not Hispanic or Latino Hispanic/Latino Unknown Decline to Specify

Language: ***(circle)*** English Spanish Other: _____

Advanced Medical Directive? YES or NO

Do you have an advance medical directive? (Living will and/or durable power of attorney for healthcare?)

Emergency Contact: _____ Relation: _____ Phone: _____

Preferred Pharmacy: _____ Address: _____

E-PRESCRIBING PBM CONSENT

e-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care.

Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an e-Prescribe program. These include:

- Formulary and benefit transactions-- Gives the prescriber information about which drugs are covered by the drug benefit plan.
- Medication history transactions--Provides the physician with information about medications the patient is already taking prescribed by any provider, to minimize the number of adverse drug events.

If you change insurance carriers or you are issued a new insurance card, it is your responsibility to provide the new card to our office. After your visit today, you will have access to an online Patient Portal where your complete medical record can be viewed. If you provide your e-mail address, you can ask any staff member to activate your portal.

Please review and sign: I authorize Family Medical for treatment. I also authorize the release of any information acquired during the examination and treatment to secure payment of claims and benefits. I authorize payment directly from my insurance company (if applicable) to Family Medical. I have received and reviewed a copy of the Authorization for Billing & Treatment and I agree to be responsible for any deductibles, copays, coinsurances and services rendered that are not covered by my insurance plan.

_____

Signature of Patient or Patient Representative Date

FAMILY MEDICAL
ASSOCIATES & PEDIATRICS

PATIENT HISTORY FORM

TODAY'S DATE _____/_____/_____ DATE OF LAST PHYSICAL EXAM _____/_____/_____

LAST NAME _____ FIRST NAME_____ MIDDLE _____

SOCIAL SECURITY NO. _____ DATE OF BIRTH _____

CHIEF COMPLAINT WHAT IS THE MAIN REASON FOR YOUR VISIT TODAY? (DESCRIBE YOUR PROBLEM IN DETAIL)

_____

_____

_____

HISTORY OF PRESENT ILLNESS

Please answer the following questions

Location of the problem

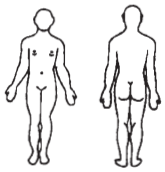
Abdomen Back Leg

Other _____

_____

_____

FRONT BACK



On a scale of 1-10, with 10 being the most severe, circle the number that best describes the problem?

1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?

2 days ago 2 weeks ago 1 month ago

Other _____

Does anything help or make the problem worse?

Moving around Standing up Lying on my side

Other _____

How long does the problem last?

30 minutes 1 hour It is alway there

Other _____

Is anything else occurring at the same time?

YES NO If yes, please explain.

Nausea Rash Headaches

Other _____

Is the problem constant or variable?

Dull then sharp Very sharp then leaves Always there

Other _____

Does the problem interfere with your normal functions?

YES NO If yes, please explain. _____

_____

PHYSICIAN USE ONLY: (COMMENTS / NOTES)

# of Answers	Level of Service
1 - 3	1 or 2
4 +	3 - 5

PAST MEDICAL AND SOCIAL HISTORY

List all serious illnesses in your immediate family. (Example: diabetes, tuberculosis, breast cancer, heart disease, etc.)

_____ _____ _____ _____

_____ _____ _____ _____

List any personal past illnesses and/or surgeries and when they occurred.

Illness or Surgery Date

_____

_____

_____

Do you smoke? ❑ **Y** ❑ **N** If yes, how much? _____

Do you drink? ❑ **Y** ❑ **N** If yes, how much? _____

Are you on any medications? ❑ **Y** ❑ **N** If yes, list all.

_____

_____

Are you on a special diet? ❑ **Y** ❑ **N** If yes, please explain.

_____

Do you have allergies? ❑ **Y** ❑ **N** If yes, please explain.

_____

_____

REVIEW OF SYSTEMS

Do you now of have you had any problems related to the following systems. Mark YES or NO.
Please explain any yes answers in the space provided.

Constitutional Symptoms

Fever	❑ Y	❑ N
Chills	❑ Y	❑ N
Headache	❑ Y	❑ N

Other _____

Eyes

Blurred Vision	❑ Y	❑ N
Double Vision	❑ Y	❑ N
Pain	❑ Y	❑ N

Other _____

Allergic/Immunologic

Hay Fever	❑ Y	❑ N
Drug Allergies	❑ Y	❑ N

Other _____

Neurological

Tremors	❑ Y	❑ N
Dizzy Spells	❑ Y	❑ N
Numbness/tingling	❑ Y	❑ N

Other _____

Endocrine

Excessive Thirst	❑ Y	❑ N
Too Hot/Cold	❑ Y	❑ N
Tired/Sluggish	❑ Y	❑ N

Other _____

Gastrointestinal

Abdominal Pain	❑ Y	❑ N
Nausea/Vomitting	❑ Y	❑ N
Indigestion/Heartburn	❑ Y	❑ N

Other _____

Cardiovascular

Chest Pain	❑ Y	❑ N
Vericose Veins	❑ Y	❑ N
High Blood Pressure	❑ Y	❑ N

Other _____

Integumentary

Skin Rash	❑ Y	❑ N
Boils	❑ Y	❑ N
Persistent Itch	❑ Y	❑ N

Other _____

Musculoskeletal

Joint Pain	❑ Y	❑ N
Neck Pain	❑ Y	❑ N
Back Pain	❑ Y	❑ N

Other _____

Ear/Nose/Throat/Mouth

Ear Infectin	❑ Y	❑ N
Sore Throat	❑ Y	❑ N
Sinus Problems	❑ Y	❑ N

Other _____

Genitourinary

Urine Retention	❑ Y	❑ N
Painful Urination	❑ Y	❑ N
Urinary Frequency	❑ Y	❑ N

Other _____

Respiratory

Wheezing	❑ Y	❑ N
Frequent Cough	❑ Y	❑ N
Shortness of Breath	❑ Y	❑ N

Other _____

Hematologic/Lymphatic

Swollen Glands	❑ Y	❑ N
Blood Clotting Problem	❑ Y	❑ N

Other _____

Psychologic

Are you generally satisfied with your life?	❑ Y	❑ N
Do you feel severely depressed?	❑ Y	❑ N
Have you considered suicide?	❑ Y	❑ N

Other _____

PHYSICIAN USE ONLY: (COMMENTS / NOTES)

# of Answers	Level of Service
0-1	1 or 2
2-9	3
10+	4 or 5

Physician: _____

Family Medical Associates & Pediatrics
Narcotic/Controlled Substance Agreement

I have read and understand the following agreement and will abide by it if I am prescribed controlled substance (Narcotics, benzodiazepine, ADD/ADHD medications, Soma, and certain muscle relaxers.)

1. I understand that the narcotic prescriptions are my responsibility. Once they are placed in my hands, anything that happens to the prescription (i.e. It is lost or stolen, etc.) is my personal responsibility. The Family Medical Providers will not rewrite the prescription until the designated times that it is to be written.
2. I Promise to stick with my time contingent schedule. If my medications are prescribed every eight hours, I will take the medication every eight hours. I understand that if I use up my medication before my appointment date no more will be prescribed until the given appointment date.
3. I understand that controlled prescriptions will not be phoned into the pharmacy.
4. I understand that controlled prescription appointments will generally be given on a one-to-three-month schedule. Only on rare occasions will this time period be altered. I understand that I am to return to see the physician on the schedule appointment date. If I come early for an appointment, additional medication will not be given.
5. I understand that if I develop another painful condition; i.e. abdominal pain, chest pain, etc., I will make a separate appointment with my primary care doctor for evaluation and treatment.
6. I understand that I am to obtain designated controlled substances only from a Family Medical provider. If I violate this contract, this practice will thereafter cease and potentially terminate all treatment.
7. I understand that I am not to use narcotics for the purpose of alleviating emotional stress. They are to be used only as prescribed.
8. I understand that narcotics are to be used as a short-term solution and may then be tapered off. The Family Medical Providers may consider chronic narcotic therapy only in very unusual circumstances; therefore, it should not be expected.
9. I have informed the Family Medical Providers of all past drug usage, including narcotics, street drugs, and alcohol; as well as any problems associated with their use.
10. I understand that there is a low risk of psychological dependence but a greater risk of physical dependence and tolerance to these medications.
11. I understand that there is a possibility of impairment of thought processes, especially if this narcotic is combined with a sedative, sleeping pill, tranquilizer, or alcohol.
12. *WOMEN ONLY* I understand that if I become pregnant, my child will likely by physically dependent at birth if I continue these medications.
13. I understand that the Tennessee Controlled Substance or Kentucky KASPER database available at Family Medical Associates will be accessed at my appointments to verify my prescription habits.
14. If a new condition develops such as trauma or surgery and narcotics or other controlled substances are prescribed, I will notify my primary care physician within 48 hours.
15. I will submit a urine and/or oral fluid on request for testing at any time without prior notification to detect use of non-prescribed drugs/medicine and confirm the use of prescribed ones. I will also submit to unannounced pill counts.

I further understand that if I do not abide by this agreement Family Medical PC may discontinue providing any or all medication prescriptions. I also understand that if I have a problem with any portion of this contract, I can make an appointment to talk with the physician to receive clarification before a problem or crisis situation arises.

Under HIPPA regulations, this shall be considered the patient's authorization to share information regarding patient's use of narcotics under this agreement with other treating physicians.

Family Medical Provider Date

Patient Name Printed Patient Signature Date

Witness Date

Family Medical Associates & Pediatrics

O F F I C E F I N A N C I A L P O L I C Y

We would like to share the following policies with you so that you understand your responsibility regarding the charges for services rendered to you by this office. It is necessary that you provide accurate and updated information when you are seen for services that can be billed to your insurance**. If your insurance requires any authorizations prior to treatment, it is your responsibility to make sure that has been completed.** This information must be in this office prior to your being seen. If you arrive for an appointment and have an insurance that requires such paperwork, you will not be seen if it is not present.

- On the day of your appointment, you will be responsible for the following:
  - **Co-Payments, Co-Insurance, Insurance Deductibles**
  - **Charges for non-covered services or cosmetic procedures**
  - **Payment in full if you are Self-Pay or have an Out of Network insurance**
- If your deductible has not been met or you have an out of network insurance carrier, we will collect payment in full and process a refund, if applicable, once the claim processes.
- **It is your responsibility to make sure your primary insurance is aware of your secondary insurance and that it is set up to cross over automatically. WE CANNOT DO THIS FOR YOU.**
- All charges are your responsibility whether your insurance company pays or not. Not all services are a covered benefit in all contracts. It is your responsibility to provide accurate and current insurance information and to keep your file updated with that information. If you fail to provide correct insurance information at the time of your appointment and it results in a claim denial, you are responsible for payment of these services. If you attempt to provide insurance information at a later date, it may or may not be accepted. Most insurances have a time limit of filing claims. **If we are unable to collect from your primary or secondary insurance within three (3) months the balance will be turned over to you the patient.**
- Billing statements are mailed after your claim processes and the balance is due within 30 days of receipt.
- Unpaid balances will receive a late notice and will be turned over to a collection agency if not paid within 30 days of the late notice. Once an account is turned over to collections, all communications will be with the collection agency. After your balance is paid with the collection agency, you will be required to pay in full at every visit thereafter. Once your insurance processes, we will issue a refund for any credit on the account. Patients who are in collection status and do not bring their account current may be discharged via certified letter from Family Medical with availability only for emergency care 30 days following dismissal.
- We will not accept insurance cards that have been altered or tampered with in any way.
- **We will ask to scan and verify your insurance cards once a year. If you have changes to your insurance coverage you must inform the registration staff and provide a copy of the new card.**
- We accept the following forms of payment: Cash, Check, Visa, MasterCard, American Express and Discover. Returned Checks will be subject to a $20.00 fee which will be added to the balance due. Once a patient balance is determined, a statement will be mailed to the address which was provided to us.

You will be asked to sign this document every three (3) years.

_____ _____

PATIENT SIGNATURE DATE

Bill Robertson, M.D. ♣ Samuel Crutcher, M.D. ♣ Bernard Sy, M.D. Roger McKinney, M.D. ♣ George Robertson, M.D. ♣ James Reed, D.O. Richard Kincaid, FNP-C ♣ Kelly Louvin, PA-C ♣ Benita Qualls, PA-C Carrie Forhetz, PA-C ♣ Stormiee Eldred, FNP-BC

AUTHORIZATION FOR TREATMENT AND BILLING

AUTHORIZATION FOR MEDICAL TREATMENT

I authorize the physicians and physician extenders at Family Medical, PC to conduct and direct my medical care. I also authorize Family Medical, PC staff, directed by my physician, to give medications, perform diagnostic procedures, and provide other care which, in the judgment of my doctor, is required for my best care and treatment.

ASSIGNMENT OF BENEFITS

I direct and authorize payment directly to my physician for all monetary benefits available to me. It is expressly understood and agreed that acceptance by the said hospital, of benefits under this policy, shall in no way operate to release the person responsible for payment of the services referred to herein from his/her obligation to pay for all charges not covered by my insurance policy or excess of said policy limits.

GUARANTEE OF PAYMENT

For value received, the undersigned hereby unconditionally guarantees the prompt payment of all its charges, hereby agreeing to pay all cost and expenses incurred in enforcing this guarantee. In the event the patient or guarantor fails to comply with their obligation herein, each consents to the disclosure of their identity and the preferred method of contact (provided by the patient to Family Medical, PC on the registration paperwork) and any other necessary information relating to service rendered to the patient by the attending physician to any collection agency or attorney at law, for the purpose of enforcing the patient's or guarantor's obligation to the health group and the re-disclosure of such information by the collection agency or attorney. Such disclosure or re-disclosure shall not be deemed to be a breach of the patient confidentiality by the health group. **Cell Phone Calls/Text and Emails.** By providing your cell phone number and/or email address, you consent to receiving such calls or electronic communications at the number or email address provided, including but not limited to, communication attempts (calls, text messages, emails or other electronic means) made by automated telephone dialing system, prerecorded messages or artificial voice. This consent is for Provider and any affiliates, including any and all third-party entities hired by Provider for billing, collections, or customer care services.

RELEASE OF WRITTEN AND/OR VERBAL INFORMATION FOR BILLING AND UTILIZATION REVIEW PROCESS

I authorize my physician to release written and/or verbal information from my medical record, as necessary, to process my insurance claims and for utilization review when justification for treatment or continued treatment is required.

MEDICARE ASSIGNMENT AND AGREEMENT TO PAY MEDICARE NON-COVERD CHARGES

I certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my physician to release to the Social Security Administration and/or its intermediaries and/or carriers any information needed for this or any related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician organization furnishing these services, or authorize the above to submit a claim to Medicare for payment to me. I understand Medicare Participating Physicians have been advised by the Centers for Medicare & Medicaid Services (CMS) that services provided to Medicare Beneficiaries, which are determined by CMS to be unnecessary, will not be paid for by Medicare. The physician may not collect for these services from the patient, unless an Advanced Beneficiary Notification (ABN) has been signed by the patient at the time services were rendered.

FAMILY MEDICAL
ASSOCIATES & PEDIATRICS

Bill Robertson, M.D. ▪ Samuel Crutcher, M.D. ▪ Bernard Sy, M.D.
Roger McKinney, M.D. ▪ George Robertson, M.D. ▪ James Reed, D.O.
Richard Kincaid, FNP-C ▪ Kelly Louvin, PA-C ▪ Benita Qualls, PA-C
Carrie Forhetz, PA-C ▪ Stormiee Eldred, FNP-BC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

** You May Refuse to Sign This Acknowledgement **

I have read and understand Family Medical's Notice of Privacy Practices. I acknowledge that I may request and will be provided a copy at any time from the office. I also understand that I am able to take the copy with me that I read prior to signing this notice.

_____
Signature of Patient or Patient Representative

_____
Print Name of Patient or Patient Representative *Patient Date of Birth*

_____
Today's Date

Who are we allowed to talk to about your medical treatment?

↓ TELL US HERE ↓

I authorize the disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):

Name: _____ **Relationship:** _____

Phone: _____

Name: _____ **Relationship:** _____

Phone: _____

This authorization shall be in force and effect for thirty-six (36) months at which time this authorization expires.

I understand that I have the right to revoke this authorization, in writing, at any time prior to the planned expiration date.

OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

❒ Individual Refused to sign ❒ Communication barriers prohibited obtaining the acknowledgement

❒ An emergency situation prevented us from obtaining acknowledgements

❒ Other (Please Specify) _____

Notice of Health Information Privacy Practices

(PATIENT COPY)

Effective Date: May 19, 2023
Updated: 05/19/2023

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We are required by law to provide you with this notice that explains our privacy practices with regard to your medical information and how we may use and disclose your protected health information for treatment, payment, and for health care operations, as well as for other purposes that are permitted or required by law. You have certain rights regarding the privacy of your protected health information and we also describe them in this notice.

Ways in Which We May Use and Disclose Your Protected Health Information:

The following paragraphs describe different ways that we use and disclose your protected health information. We have provided an example for each category, but these examples are not meant to be exhaustive. We assure you that all of the ways we are permitted to use and disclose your health information fall within one of these categories.

Treatment. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. We will also disclose your health information to other physicians who may be treating you. Additionally, we may, from time to time, disclose your health information to another physician who we have requested to be involved in your care. For example -- we would disclose your health information to a specialist to whom we have referred you for a diagnosis to help in your treatment.

Payment. We will use and disclose your protected health information to obtain payment for the health care services we provide you. For example -- we may include information with a bill to a third-party payer that identifies you, your diagnosis, procedures performed, and supplies used in rendering the service.

Health Care Operations. We will use and disclose your protected health information to support the business activities of our practice. For example -- we may use medical information about you to review and evaluate our treatment and services or to evaluate our staff's performance while caring for you. In addition, we may disclose your health information to third party business associates who perform billing, consulting, or transcription services for our practice.

Other Ways We May Use and Disclose Your Protected Health Information:

Appointment Reminders. We will use and disclose your protected health information to contact you as a reminder about scheduled appointments or treatment.

Treatment Alternatives. We will use and disclose your protected health information to tell you about or to recommend possible alternative treatments or options that may be of interest to you.

Others Involved in Your Care. We will use and disclose your protected health information to a family member, a relative, a close friend, or any other person you identify that is involved in your medical care or payment for care.

Research. We will use and disclose your protected health information for research provided the research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

As Required by Law. We will use and disclose your protected health information when required to by federal, state, or local law. You will be notified of any such disclosures.

To Avert a Serious Threat to Public Health or Safety. We will use and disclose your protected health information to a public health authority that is permitted to collect or receive the information for the purpose of controlling disease, injury, or disability. If directed by that health authority, we will also disclose your health information to a foreign government agency that is collaborating with the public health authority.

Worker's Compensation. We will use and disclose your protected health information for worker's compensation or similar programs that provide benefits for work-related injuries or illness.

Inmates. We will use and disclose your protected health information to a correctional institution or law enforcement official if you are an inmate of that correctional institution or under the custody of the law enforcement official. This information would be necessary for the institution to provide you with health care; to protect the health and safety of others; or for the safety and security of the correctional institution.

Your Health Information Rights

Although your health record is the physical property of the health care practitioner or facility that compiled it, the information belongs to you. You have the right to:

A Paper Copy of This Notice. You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking our receptionist at your visit or by calling and asking us to mail you a copy.

Inspect and Copy. You have the right to inspect and copy the protected health information that we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medical and billing records as well as any other records we use for making decisions about you. Any psychotherapy notes that may have been included in records we received about you are not available for your inspection or copying by law. **We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request.**

If you wish to inspect or copy your medical information, you must submit your request in writing to our practice manager at Family Medical, 1407 W Baddour Pkwy, Lebanon, TN 37087. You may mail in your request, or bring it to our office. We will have 30 days to respond to your request for information that we maintain at our practice site.

Request Amendment. You have the right to request that we amend your medical information if you feel that it is incomplete or inaccurate. You must make this request in writing to our practice manager, stating exactly what information is incomplete or inaccurate and your reasoning that supports your request. We are permitted to deny your request if it is not in writing or does not include a reason to support the request. We may also deny your request if:

(1) the information was not created by us, or the person who created it is no longer available to make the amendment;
(2) the information is not part of the record which you are permitted to inspect and copy;
(3) the information is not part of the designated record set kept by this practice; or if it is the opinion of the health care provider that the information is not accurate and complete.

Request Restrictions. You have the right to request a restriction or limitation of how we use or disclose your medical information for treatment, payment, or health care operations. For example -- you could request that we not disclose information about a prior treatment to a family member or friend who may be involved in your care or payment for care. Your request may be made in writing to our practice manager. We are not required to agree to your request if we feel it is in your best interest to use or disclose that information. However, if we do agree, we will comply with your request unless that information is needed for emergency treatment.

An Accounting of Disclosures. You have the right to request a list of the disclosures of your health information we have made outside of our practice that were not for treatment, payment, or health care operations. Your request must be made in writing and must state the time period for the requested information. You may not request information for any dates prior to April 14, 2003 (the compliance date for the federal regulation) nor for a period of time greater than six years (our legal obligation to retain information).

Request Confidential Communications. You have the right to request how we communicate with you to preserve your privacy. For example -- you may request that we call you only at your work number, by mail at a special address or postal box. Your request must be made in writing and must specify how or where we are able to contact you. We will accommodate all reasonable requests.

File a Complaint. If you believe we have violated your medical information privacy rights, you have the right to file a complaint with our practice manager or directly to the Secretary of Health and Human Services. To file a complaint with our manager, you must make it in writing within 180 days of the suspected violation. Provide as must detail as you can about the suspected violation and send it to Family Medical, 1407 W Baddour Pkwy, Lebanon, TN 37087. You should know that there would be no retaliation for your filing a complaint.

Uses or Disclosures Not Covered

Uses or disclosures of your health information not covered by this notice or the laws that apply to us may only be made with your written authorization. You may revoke such authorization, in writing, at any time and we will no longer disclose health information about you for the reason stated in your written authorization. Disclosures made in reliance on the authorization prior to the revocation are not affected by the revocation.

For More Information

If you have questions or would like additional information, contact our practice manager at (615) 444-6203.

FAMILY MEDICAL ASSOCIATES & PEDIATRICS
1407 W Baddour Pkwy, Lebanon, TN 37087

FAMILY MEDICAL ASSOCIATES & PEDIATRICS

Bill Robertson, M.D. • Samuel Crutcher, M.D. • Bernard Sy, M.D. • Roger McKinney, M.D.
George Robertson, M.D. • James Reed, D.O. • Richard Kincaid, FNP-C
Kelly Louvin, PA-C • Benita Qualls, PA-C • Carrie Forhetz, PA-C
Stormiee Eldred, FNP-BC
1407 W Baddour Pkwy, Lebanon, TN 37087
Phone: (615) 444-6203
MAIN FAX: (615) 444-6252

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name: _____

Last Four of Social Security #: _____ Date of Birth: _____

Reason for Release: (circle) New PCP Seeing Specialist FMLA Legal

Other: _____

_____

I authorize Family Medical Associates & Pediatrics to:

⬇ (Circle One) ⬇

RELEASE TO or **OBTAIN FROM**

Doctor & Office / Name: _____

Address: _____

_____

Phone: _____ Fax: _____

E-Mail: _____

****

I request a copy or summary of the following medical records:

□ Most Recent Labs & Office Notes

□ Other _____

For dates of service from _____ to _____

****

Expiration Date: This authorization shall automatically expire six (6) months after the date of signature and covers information only prior to that date. I understand that I may withdraw this consent at any time but the revocation shall not be retroactive to the release of information made in good faith. I also understand that any disclosure of records concerning diagnosis and/or treatment of alcohol and/or drug abuse is covered by Title 42 CFR, and if there is any such information, I hereby authorize the release of information. This authorization also includes any information related to diagnosis and/or treatment of any psychiatric or mental illness or any state of infection with the HIV (AIDS) virus.

_____ _____

Patient (or person authorized to consent for minor) Date