**Dr. Joe Krick**

General Surgeon

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  | |  |  | / |
| Date |  | |  |  | **Referring Physician /Primary Physician** |
|  | | |  |  |
| Last Name |  | | First | MI | Email Address |
|  |  | |  |  |  |
| Address |  | | City | State | Zip |
|  |  | |  |  |  |
|  |  | | |  |  |
| Home Phone | Cell Phone | | | Work Phone | Employer |
|  |  | |  |  |  |
|  | ☐ M ☐ F | | |  |  |
| Date Of Birth | Sex SSN | | |  | Race Ethnicity |
|  |  | | | | M S W D |
| WHO IS INSURANCE SUBSCRIBER? (Please mark a box) | | | | | Marital Status |
| Self  Spouse  Parent (If insurance is not in your name, fill out information below) | | | | | |
|  | | | |  | |
| Primary Insurance Company | | | | Subscriber’s Name (Name of person carrying insurance) | |
|  |  | |  |  |  |
|  |  | |  |  |  |
| Subscriber Date of Birth | Subscriber Social Security # | | | | Subscriber Employer |
|  |  | |  |  |  |
|  | | | |  | |
| Secondary Insurance Company | | | | Subscriber’s Name (Name of person carrying insurance) | |
|  |  | |  |  |  |
|  |  | |  |  |  |
| Subscriber Date of Birth | Subscriber Social Security # | | | | Subscriber Employer |
|  |  | |  |  |  |
|  |  | |  |  |  |
| Subscriber’s Employer |  | |  |  | Employer Phone Number |
|  |  | |  |  |  |
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|  |  | |  |  | ( ) |
| **EMERGENCY CONTACT** | | Relationship | |  | ALTERNATE Phone Number |
|  |  | |  |  |  |
| I hereby assign payment directly to Dr. Joseph G. Krick for all surgical and/or medical benefits otherwise payable to me for its services but not to exceed its charges. Any unpaid deductible, co-pay, or any other balance not paid by insurance is due and payable in full within 90 days from the date of service regardless of any insurance pending. If this account is assigned to an attorney for collection and/or suit, the practice shall be entitled to reasonable attorney’s fees and costs of collection. | | | | | |
|  |  | |  |  |  |
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|  | | | | |  |
| **Patient Signature** (or Parent of Minor/Power of Attorney) | | | | | **Date** |

**PATIENT HISTORY INFORMATION**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| NAME: | | | | | | | | DATE: | | | | | |
| **PHARMACY**: **CITY**: | | | | | | | |  | | | | | |
|  | |  |  | | |  | |  | | | |  |  |
| **LIST ALL MEDICATIONS (CALL PHARMACY FOR LIST IF NECESSARY):** | | | | | | | | | | | | | |
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| DO YOU TAKE **ASPIRIN** DAILY? ☐YES ☐NO: 81 mg OR 325 mg | | | | | | | | | | | | | |
|  | |  |  | | |  | |  | | | |  |  |
| LIST ALL DRUG **ALLERGIES**: | | | | | |  | |  | | | |  |  |
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| **PLEASE CIRCLE YES OR NO** HAVE YOU EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS? | | | | | | | | | | | | | |
| HIGH BLOOD PRESSURE | YES | | | NO |  | | SICKLE CELL | | | YES | NO | | |
| ANGINA, HEART ATTACK | YES | | | NO |  | | HEPATITIS, CIRRHOSIS | | | YES | NO | | |
| COPD, EMPHYSEMA | YES | | | NO |  | | TRANSFUSIONS | | | YES | NO | | |
| ASTHMA, SLEEP APNEA | YES | | | NO |  | | KIDNEY STONES | | | YES | NO | | |
| SEIZURES, EPILEPSY | YES | | | NO |  | | PROSTATE TROUBLE | | | YES | NO | | |
| STROKE, TIA | YES | | | NO |  | | COLON POLYPS | | | YES | NO | | |
| GLAUCOMA OR CATARACTS | YES | | | NO |  | | CROHN’S DISEASE | | | YES | NO | | |
| THYROID PROBLEMS | YES | | | NO |  | | ULCERATIVE COLITIS | | | YES | NO | | |
| DIABETES | YES | | | NO |  | | BLOOD CLOTS | | | YES | NO | | |
| HIATAL HERNIA | YES | | | NO |  | | VASCULAR DISEASE | | | YES | NO | | |
| STOMACH ULCERS | YES | | | NO |  | | ARTHRITIS | | | YES | NO | | |
| REFLUX/GERD | YES | | | NO |  | | HIGH CHOLESTEROL | | | YES | NO | | |
|  |  | | |  |  | |  | | |  |  | | |
| |  |  |  |  | | --- | --- | --- | --- | | HAVE YOU EVER HAD **CANCER**? IF SO, SPECIFY TYPE AND DATE. | | |  | |  |  |  |  |   PLEASE LIST ALL **SURGERIES** THAT YOU HAVE HAD, **INCLUDING** GASTROSCOPY (EGD) AND COLONOSCOPY WITH DATES: | | | | | | | | | | | | | |
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|  |  | | |  |  | |  | |  | |  | | |
| DO YOU SMOKE? YES NO | | | | | HOW MUCH PER DAY? | | | |  | |  | | |
| DO YOU DRINK ALCOHOL? YES NO | | | | | HOW MUCH PER DAY? | | | |  | |  | | |
|  | | | | |  | | | |  | |  | | |
| HAS ANYONE IN YOUR **IMMEDIATE** FAMILY HAD: | | | | |  | | | |  | |  | | |
| HYPERTENSION | YES | | | NO |  | | HEART DISEASE | | | YES | NO | | |
| STROKE | YES | | | NO |  | | DIABETES | | | YES | NO | | |
|  | | | | |  | | | |  | |  | | |
| IF ANYONE IN YOUR FAMILY HAS HAD **CANCER**, PLEASE STATE WHO AND WHAT TYPE: | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |

**Advance Directive for Health Care**

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself**

**Agent:** I want the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**When Effective (mark one):**  I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself.  I do not give such permission (this form applies only when I no longer have capacity).

**Mark all that apply to you**: Surrogate Decision Maker No Advanced Directive on File Power of Attorney Living Will Organ Donor

Do Not Intubate Do Not Resuscitate

Other than the purposes listed previously, disclosure of your protected health information requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization.

**Individual Rights**

While the health and billing records we maintain are the physical property of Dr. Krick, you have the following rights with respect to your protected health information:

* the right to receive a printed copy of this notice;
* the right to inspect and copy your protected health information and billing record;
* the right to amend or submit corrections to your health information;
* the right to request restrictions on the use and disclosure of your health information. We are not required to grant the request but will comply with any request granted;
* the right to receive an accounting of how and to whom your protected health information has been disclosed;
* the right to receive confidential communications concerning your medical condition and treatment.

If you want to exercise any of the above rights, please contact our Office Manager for assistance.

With your consent, we may disclose your health information or test results to your spouse, family members, caregivers, or other persons involved in your care as indicated by initialing each item below:

**(Initial if agreeable)** **Print Name(s)**

|  |  |  |
| --- | --- | --- |
|  | My Spouse |  |
|  | My Caregiver |  |
|  | Other |  |

**I give Dr. Krick/his office staff permission to:**

**(Initial if agreeable)**

\_\_\_\_\_\_\_ Leave a message on my voicemail (or with whomever may answer my phone).

\_\_\_\_\_\_\_ Text me at the cell phone number given on previous page.

\_\_\_\_\_\_\_ Contact me at my employer (including leaving a message to return a call if I am unavailable).

**Dr. Krick’s Duties**

We are required by law to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Standards and abide by the terms of this notice. We will accommodate your request for an accounting of disclosures and the method by which we communicate health information to you. We will notify you if we cannot accommodate a requested restriction or request. We reserve the right to amend or modify our privacy policies and practices as required by law. Upon request, we will provide you with the most recently revised notice on any office visit.

**To Request Information or File a Complaint**

If you have any questions, would like to inspect or copy your health care information, or want to report a problem regarding the handling of your information, you may contact our Office Manager and Privacy Official at 931-563-7675. We cannot retaliate against you for filing a complaint.

I acknowledge that I can request a copy of Dr. Joseph G. Krick’s **Notice of Privacy Practices.** This **Notice** describes how Dr. Joseph G. Krick may use and disclose my protected health information, certain restrictions on the use and disclose of my healthcare information, and rights I may have regarding my protected health information.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature (**or Parent of Minor/Power of Attorney)** Effective Date

**AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Patient Birth Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address City, State, Zip Code

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient (or Legal Representative) Date

If signed by Legal Representative:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient (authority to act on patient’s behalf) Date

**I understand that I have the right to:**

→ **Receive Copy of This Authorization**.

→ **Refuse to Sign This Authorization** and that treatment, payment, enrollment in a health plan or eligibility for

health care benefits may not be contingent on my signing this authorization.

→ **Revoke This Authorization**, except to the extent that the person(s) and or organization(s) listed above have

already made in reference to this authorization.

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

**FOR OFFICE USE ONLY**

**I hereby authorize: To disclose my protected health**

**Information, as described below to**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dr. Joseph G. Krick, MD\_\_\_\_\_\_\_\_\_\_\_

Name Name of Individual or Entity

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 1805 N. Jackson St Ste 14\_\_\_\_\_\_\_\_\_\_

Street Address Street Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tullahoma, TN 37388\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip Code City, State, Zip Code

Phone: 931-563-7675 FAX: 877-409-2636

This authorization will remain in effect until the following date(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Information to be released:**

\_\_\_\_ Medical History, Examination Reports \_\_\_\_Surgical Reports

\_\_\_\_ Treatments or Tests \_\_\_\_Hospital Records Including Reports

\_\_\_\_ X-ray Reports \_\_\_\_Developmental Disabilities

\_\_\_\_ Laboratory Reports \_\_\_\_Prescriptions

\_\_\_\_ HIV Test Results \_\_\_\_Consultations

\_\_\_\_ Mental Health \_\_\_\_Allergy Records

\_\_\_\_ Sexually Transmitted Disease \_\_\_\_Drug Abuse

\_\_\_\_ Alcoholism \_\_\_\_Other (Please specify)

\*A listing of the statutory exceptions to release of HIV test results without consent is available.

**Purpose for Need of Disclosure**

\_\_\_\_ At the request of the individual