All About Health Medical, PLLC
2759 Hwy 31w Suite 2 White house, TN USA 37188
PH 615-672-3568 Fax 615-672-5049

Patient Name_____ Date: _____

Email: _____ SS #/SIN_____ DOB_____

Check the appropriate box: ☐ Male ☐ Female

Home phone:_____ Cell phone:_____

Would you like appointment Reminders via Text?_____ Cell phone Provider:_____

Check appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's Address _____City _____ State_____ Zip_____

Employer Name:_____

Whom may we thank for referring you?_____

Person to contact in case of an emergency_____Phone_____

In case of a medical emergency, if the patient is of school age 15+, is ok to treat in my absence.

_____ _____ _____

Parent or Guardian Signature Relationship to Patient Date

Responsible Party

Person responsible for this account _____ Relationship to Patient _____

Address _____

City_____ State_____ Zip_____

Home Phone _____ Cell Phone _____

E-Mail _____ Birthdate:_____

Driver's License # _____ License State:_____

Is the person currently a patient at our office? ☐ Yes ☐ No

Do you have any Medical insurance? ☐ Yes ☐ No if yes, complete the following:

Name of the insured_____ Relationship to patient_____

Birthdate_____ SS#/SIN_____ Name of Employer_____

Work Phone _____ Cell Phone _____

Address of Employer_____State _____Zip_____

Insurance Company_____ Group #_____

Union or local # _____

Ins. Co. Address _____

City _____ State _____ Zip_____

Health History

Patient Name: _____ DOB: _____ Date: _____

Chief Complaint: _____

History of Present Illness:

Location: _____ **Quality:** _____
(Where is the pain/problem?) (Example: normal vs abnormal color, activity, etc..)

Severity: _____ **Duration:** _____
(How severe is the pain/problem on a scale of 1-10 with 10 being the most severe?) (How long have you had this pain/ problem? When did it start?)

Timing: _____ **Context:** _____
(Does the pain/problem occur at a specific time?) (Where were you at the onset of this pain/problem?)

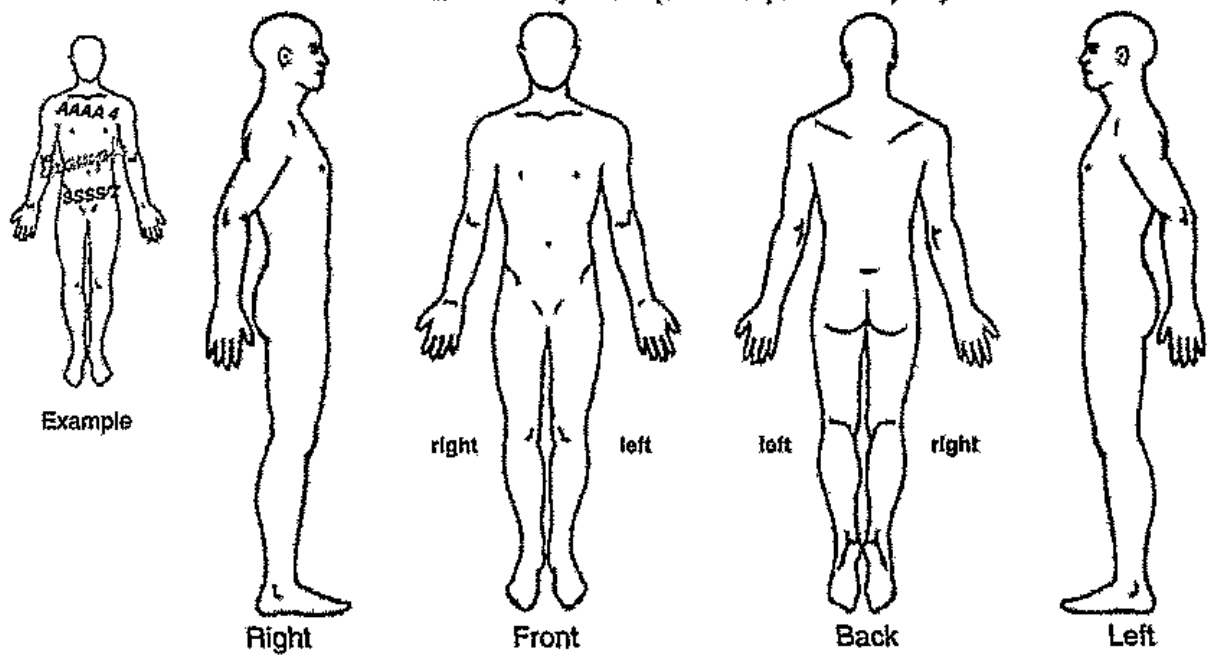
Associated Signs/Symptoms _____ **Modifying Factors** _____
(What other associated problems have you been having?) had previous episodes?) (What makes the pain/problem worse or better? Have you

SHOW US WHERE IT HURTS

Please mark area(s) of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

Description →	Numbness	Pins & Needles	Burning	Aching	Stabbing
Symbol →	NNNN	PPPP	BBBB	AAAA	SSSS

○ Circle any area of pain not represented by a symbol.



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I understand that my health information is private and confidential. I understand that the staff of All About Health work hard to protect my privacy and preserve the confidentiality of my personal health information.

I understand that signing this document means that All About Health may use and disclose my personal health information to help provide my healthcare, to handle my billing and payments and to take care of other healthcare operations.

All About Health has a document called "Notice of Privacy Practices". It contains more information about policies and practices used to protect their patient's privacy. I understand that I have the right to read the "Notice of Privacy Practices" before signing this agreement. A written copy will be provided upon request.

Under the terms of this consent, I can ask All About Health to restrict how my personal health information is used or disclosed to carry out treatment, payment or other healthcare operations. I understand that All About Health does not have to agree with my request. If All About Health does agree with my request, I understand that agreed limits would be followed.

I understand that I have the right to cancel this consent in writing to All About Health. If I do cancel the consent, I understand that All About Health may have used or disclosed information about me and canceling this consent would not apply to information already used or disclosed.

I understand that if I cancel this consent, All About Health does not have to provide further healthcare services to me.

To be completed by the patient: Authorized patient representative:

X _____ X _____

Signature - Patient or Authorized Agent | Print Name

Date: _____

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ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS 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 All About Health Medical, PLLC as well as all employees, employers, representatives, and agents thereof, (hereinafter 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 paid 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 governed plan/insurance contract, PPACA 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 pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/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____.

X_____
(patient signature)

X_____
(signature of Guardian if applicable)

X_____
(please print patient name)

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Suggested Provider Statement of Patient/Client Rights and Responsibilities

- Patients/Clients have the **right** to be treated with dignity and respect.
- Patients/Clients have the **right** to fair treatment, regardless of race, ethnicity, creed, religious belief, sexual orientation, gender, age, health status, or source of payment for care.
- Patients/Clients have the **right** to have their treatment and other patient information kept private. Only by law may records be released without patient permission.
- Patients/Clients have the **right** to access care easily and in a timely fashion.
- Patients/Clients have the **right** to a candid discussion about all their treatment choices, regardless of cost or coverage by their benefit plan.
- Patients/Clients have the **right** to share in developing their plan of care.
- Patients/Clients have the **right** to the delivery of services in a culturally competent manner.
- Patients/Clients have the **right** to information about the organization, its providers, services, and role in the treatment process.
- Patients/Clients have the **right** to information about provider work history and training.
- Patients/Clients have the **right** to information about clinical guidelines used in providing and managing their care.
- Patients/Clients have a **right** to know about advocacy and community groups and prevention services.
- Patients/Clients have a **right** to freely file a complaint, grievance, or appeal, and to learn how to do so.
- Patients/Clients have the **right** to know about laws that relate to their rights and responsibilities.
- Patients/Clients have the **right** to know of their rights and responsibilities in the treatment process, and to make recommendations regarding the organization's rights and responsibilities policy.

I have read and understood my rights and responsibilities.

- Patients/Clients have the **responsibility** to treat those giving them care with dignity and respect.
- Patients/Clients have the **responsibility** to give providers the information they need, in order to provide the best possible care.
- Patients/Clients have the **responsibility** to ask their providers questions about their care.
- Patients/Clients have the **responsibility** to help develop and follow the agreed-upon treatment plans for their care, including the agreed-upon medication plan. • Patients/Clients have the **responsibility** to let their provider know when the treatment plan no longer works for them.
- Patients/Clients have the **responsibility** to tell their provider about medication changes, including medications given to them by others.
- Patients/Clients have the **responsibility** to keep their appointments. Patients should call their providers as soon as possible if they need to cancel visits.
- Patients/Clients have the **responsibility** to let their provider know about their insurance coverage, and any changes to it.
- Patients/Clients have the **responsibility** to let their provider know about problems with paying fees.
- Patients/Clients have the **responsibility** not to take actions that could harm others.
- Patients/Clients have the **responsibility** to report fraud and abuse.
- Patients/Clients have the **responsibility** to openly report concerns about quality of care.
- Patients/Clients have the **responsibility** to let their provider know about any changes to their contact information (name, address, phone, etc).
- Patients/Clients have the **right** and the **responsibility** to understand and help develop plans and goals to improve their health.

_____ _____

Patient Signature Date