APEX HEALTH & WELLNESS
104 W. Court Avenue • Selmer, TN 38375
731-437-2720 • Fax: 731-434-0388

Patient Information Sheet

Welcome to our Practice

Please complete and sign: (attach copy of **insurance ID** card {and **drivers license** as required})

PATIENT INFORMATION (please print)

First Name _____ MI _____ Last Name _____

Address _____ Appt # _____ City _____ State _____ Zip _____

Home Phone _____ Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Social Security # _____ Sex ☐ M ☐ F Date of Birth ___/___/_____ Age _____

Employer _____ Work Phone _____

Employer's Address _____ City _____ State _____ Zip _____

Pharmacy: _____ City & Zip Code: _____

Emergency Contact: Name _____ Relationship _____

Phone Number: _____

RESPONSIBLE PARTY INFORMATION

If you are the responsible party, mark "self" and move down to "Insurance Information".

Patient's relationship to responsible party: ☐ Self ☐ Spouse ☐ Dependent SSN _____

First Name _____ MI _____ Last Name _____

Address _____ City _____ State _____ Zip _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated Sex ☐ M ☐ F

Date of Birth ____/____/_____ Age _____ Work Phone _____

Employer _____ Job Title _____

Employer's Address _____ City _____ State ____ Zip _____

INSURANCE INFORMATION (Attach copy of insurance card)

Primary Insurance _____ Telephone number _____

Group / Policy Number _____ Subscriber / I.D. Number _____

Name of Card Holder _____ Card Holder Date of Birth _____

Effective Date _____ Deductible $ _____ Co-Pay $ _____

Secondary Insurance _____ Telephone number _____

Group / Policy Number _____ Subscriber / I.D. Number _____

Name of Card Holder _____ Card Holder Date of Birth _____

Effective Date _____ Deductible $ _____ Co-Pay $ _____

Signature of Patient or Guardian: _____ Date: _____

Printed Name of Representative: _____

Relationship to Patient: _____

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT NAME (PLEASE PRINT):	Birth Date:	SS No.:
	Phone No:	
	Address:	
	E-Mail Address:	

Information Being Released by:
(**Provider name or Clinic name/address/phone #)**

Release Records To:	Address:	City, State, Zip
Apex Health & Wellness	**104 W Court Ave**	**Selmer, TN 38375**
	Phone No.: **731-437-2720**	Fax No**: 731-434-0388**

Purpose of Disclosure**:** ☐ Medical Care ☐ Insurance ☐ Other

Method of Disclosure**:** ☐ Paper ☐ Facsimile ☐ Email: frontdesk@apexselmer.com

DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED: (Choose from the following please initial beside)

_____ Last 3 Encounters
_____ Radiology Reports
_____ Pathology Reports
_____ Labs
_____ Immunizations

I understand that:

1. ***I may revoke this authorization in writing at any time, but if I do so, it will not have any effect on any actions taken by the facility releasing the information (hereafter referred to as "the facility") prior to the facility's receiving the revocation. Further details regarding the way this authorization may be revoked may be found in the facility's Notice of Privacy Practices.***
2. ***This authorization allows the facility to release the above indicated documents in my medical record, including those copies from other health care facilities and providers as requested. The released information may no longer be protected by federal privacy regulations and may be redisclosed.***
3. ***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.***
4. ***The facility is hereby released from any liability and the undersigned will hold the facility harmless for complying with this authorization.***
5. ***The facility will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization, except for research related purposes and as otherwise permitted under applicable law.***
6. ***My signed (written) authorization will expire in one year from date of signature unless I provide an alternate expiration date or event. This authorization will not apply to any dates of service that occur after the date this authorization is signed.***

I have read and understood this authorization. I hereby authorize the release, use, and disclosure of the above-requested protected health information about me.

Signature of Patient: _____ **Date**_____

Signature of Representative of Patient: _____ **Date**_____

Printed name of Representative_____

Relationship to Patient:_____

Witness (office staff) _____ **Date**_____

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Patient Authorization:

1. I consent to treatment necessary for the care of the below named patient.
2. I authorize the release of all medical records to the referring and family physicians and to my insurance company if applicable.
3. I allow fax transmittal of my medical records if necessary.
4. I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.
5. In the event the charges incurred are not paid in full when due and collection action is instituted whether by collection agency, or attorney, or both; I agree to be responsible for and to pay in addition to the charges for services and treatment received all costs associated with such collection activity including but not limited to, reasonable collection agency fees, attorney fees, and court costs. In addition to unpaid balances being referred to a collections agency the balance will also be subject to a 25% fee that is automatically added when the account is referred.
6. I further authorize and request that insurance payments be made directly to the provider.
7. I have read and fully understand the above consent for treatment and financial responsibility, release of medical information, and insurance authorization.
8. I acknowledge full responsibility for services rendered by Apex Health & Wellness, PLLC.

Please Initial:

1. _____ Apex Health & Wellness, PLLC has my permission to send e-mail reminders for upcoming appointments and to message me regarding my health concerns. No e-mail will be collected.
2. _____ Apex Health & Wellness, PLLC has my permission for SMS mobile text reminders and messaging regarding upcoming appointments and my health concerns.
3. _____ Apex Health & Wellness, PLLC has my permission for voice reminders and messaging regarding upcoming appointments and my health concerns.

Advanced Directives:

Do you have a Living Will or Durable Power of Attorney? ____ Yes No___

If you have a durable power of attorney, please identify: _____

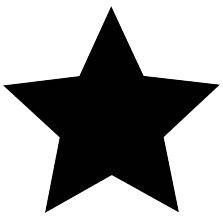
Would you like a packet of information on Advanced Directives? ____Yes No____
(Please Check Yes or No)

Signature _____ Date_____

Witness_____ Date _____

Portal Access: This will be how you get your labs and communicate with Apex

EMAIL:_____



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Financial Policy

INSURANCE INFORMATION
The patient is expected to present the insurance card at each visit. Insurance claims are filed to participating insurance companies. The patient is responsible for notifying our office of any changes in insurance coverage.
PLEASE NOTE THERE WILL BE A $50 DUE IF DEDUCTIBLE IS NOT YET FULLY MET.

NON-PARTICIPATING INSURANCE PLANS
Verification of participation with the patient's specific insurance plan is the responsibility of the patient. Patients are encouraged to contact our office at 731-437-2720 or their insurance carrier to ensure participation with the insurance plan prior to arriving for an appointment.

WORKERS COMPENSATION
Patients covered with workers compensation must contact their employer and assigned caseworker prior to treatment. Some of our providers do not participate with workers compensation plans. The patient must inform the office prior to the appointment if the visit is related to a work injury.

LAB PROGRAMS
APEX HEALTH & WELLNESS, PLLC uses Quest Labs for processing of all our labs. You may receive a bill after services rendered from them for any balances due.

SELF-PAY ACCOUNTS
Payment in full is expected at the time of service for uninsured patients.

RETURNED CHECKS
Checks returned for insufficient funds there will be a $50.00 fee. After which the patient to include any guarantor on other accounts will not be permitted to give check for payment for up to 6 months following.

DIVORCE CASES
In cases of divorce, the individual who receives the care is responsible for payment of any patient balance at the time of service. We will not bill a divorced spouse for the patient's services. The responsibility for payment of services for minor children belongs to the guarantor. Statements will be mailed to the guarantor address. We cannot send statements to multiple addresses.

COLLECTION ACCOUNTS
Unpaid patient balances may be sent to a third party collection agency at the provider's discretion.

PATIENT REFUNDS
Refunds are issued to patients when a patient over-payment has occurred and there are no outstanding claims to insurance and/or no current patient balances which they are guarantor on other accounts.

QUESTIONS/PAYMENT OPTIONS
We accept cash, money orders, Visa, MasterCard, American Express and Discover. ***There will be a 3.3% fee for any debit or credit card transactions payable by the patient.*** For specific billing inquiries or to pay by phone with a credit or debit card, please call 731-798-5065.

_____ _____
Printed name of Patient Patient Date of Birth

_____ _____
Patient Signature Date

_____
Printed Name and Relationship of Representative to Patient (if not signed by patient)

_____ _____
Witness Date

Notice of Privacy Practice Acknowledgement

The health insurance portability & Accountability act of 1996 ("HIPPA") is a federal program that requires that all medical records and other individually health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPPA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.
Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers.
Payment means such activities as obtaining reimbursement for service, confirming coverage, billing or collection activities, and utilization review.
Health care options include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders of information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorizations. You may revoke such authorization in writing and we are required to honor and abide by the written request, except to the extent that we have already taken actions relying on your authorization.
You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
The right to inspect and copy your protected health information.
The right to amend your protected health information.
The right to receive an accounting of disclosures of protected health information.
The right to obtain paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

Acknowledgement of Privacy Practices

Patient/Guardian Signature_____Date_____

APEX CLINIC & SPA
HEALTH & WELLNESS

Medical Information Release Form HIPPA Release Form

NAME:_____DATE of BIRTH_____

We are unable to discuss your treatment with anyone unless you give us written permission.

[ ] I authorize the release of information including the diagnosis, records, images, examination rendered to me and claims information. This information may be released to:

[ ] Spouse Name:_____ph#_____

[ ] Parent Name:_____ph#_____

[ ] Child Name:_____ph#_____

[ ] Other Name:_____ph#_____

[ ] Information is NOT to be released to anyone.

MESSAGES

Please call my [ ] home [ ] work [ ] cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] I prefer text messages

I have received a copy of this office's Notice of Privacy Practices and agree to all the above information.

SIGNED:_____DATE:_____