Masters Family Medical, PLLC
Patient Demographics Form

234 West Central Ave
Jamestown, TN 38556
(931) 879-8139

117 West Commercial Ave
Monterey, TN 38574
(931) 310-2900

Name: _____
Last First MI

Address: _____
Street City State Zip

Home Phone :_____ Cell phone:_____ Email:_____

DOB: _____ Social Security # _____

Circle what applies:
Male or Female Single Married Divorced Widowed Student

Employer: _____ Phone: _____

Spouse's Name:_____ Phone:_____

Spouse's birthday: _____ Social Security #:_____

Spouse's employer: _____ Phone:_____

Who is responsible for this account?:_____

Relationship to patient: _____ Phone: _____

In case of Emergency who should be notified?:_____

Relationship to patient : _____ Phone: _____

Insurance Information

Name of Primary Insurance _____ Name on Card_____

Group #_____ Subscriber #_____

Name of SecondaryInsurance _____ Name on Card_____

Group #_____ Subscriber#_____

I confirm that the above statements are true and correct.

Signature of patient/guardian:_____ Date_____

MASTERS FAMILY MEDICAL
MFM
Family Practice
www.MastersFamilyMedical.com

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PATIENT INFORMATION

NAME_____ DOB_____
LAST FIRST INITIAL

DENTIST_____ OPTOMITRIST_____ PHARMACY_____

CURRENT MEDICATIONS (PLEASE LIST BY NAME, DOSE AND FREQUENCY TAKEN DAILY):_____

_____

_____

_____

_____

ALLERGIES: _____

PLEASE LIST ANY SPECIALISTS YOU FOLLOW UP WITH (i.e. HEART, LUNG, KIDNEY, ARTHRITIS DOCTORS etc.):_____

_____

_____

_____

PLEASE LIST ALL MAJOR SURGERIES AND DATES PERFORMED: _____

_____

_____

_____

CHECK WHETHER OR NOT YOU HAVE HAD THE LISTED PREVENTATIVE PROCEDURES:

	YES	NO	DATE		YES	NO	DATE
COLONOSCOPY	☐	☐	_____	MAMMOGRAM	☐	☐	_____
PAP SMEAR	☐	☐	_____	DEXA SCAN	☐	☐	_____

SOCIAL HISTORY

OCCUPATION:_____
DAILY CAFFEINE INTAKE:_____ TOBACCO USE TYPE/AMOUNT:_____
ALCOHOL USE TYPE/AMOUNT:_____ DRUG USETYPE/AMOUNT:_____

IMMUNIZATIONS

PLEASE CHECK WHICH APPLIES TO YOU AND LIST THE DATE IF APPLICABLE

YES	NO	DATE		YES	NO	DATE	
☐	☐	_____	TETANUS	☐	☐	_____	COVID-19
☐	☐	_____	PNEUMONIA	☐	☐	_____	SHINGLES
☐	☐	_____	INFLUENZA	☐	☐	_____	HEPATITIS B SERIES

MEDICAL HISTORY

PLEASE CHECK ALL THAT APPLY TO YOU

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	ARTHRITIS	☐	☐	COPD/EMPHYSEMA	☐	☐	HIV/AIDS	☐	☐	ADD/ADHD
☐	☐	DEPRESSION	☐	☐	KIDNEY DISEASE	☐	☐	ALLERGIES	☐	☐	DIABETES
☐	☐	KIDNEY STONES	☐	☐	ALCOHOLISM	☐	☐	CANCER	☐	☐	MIGRAINES
☐	☐	ANEMIA	☐	☐	GOUT	☐	☐	MULTIPLE SCLEROSIS	☐	☐	ANXIETY
☐	☐	HTN	☐	☐	PACEMAKER	☐	☐	DEFIBRILLATOR	☐	☐	ANOREXIA
☐	☐	HEART DISEASE	☐	☐	PROSTATE DISEASE	☐	☐	ASTHMA	☐	☐	HEART FAILURE
☐	☐	HYPOTHYROID	☐	☐	HYPERTHYROID	☐	☐	BLOOD DISORDER	☐	☐	HEART ATTACK
☐	☐	STROKE/CVA/TIA	☐	☐	BLOOD TRANSFUSION	☐	☐	HIGH CHOLEST.	☐	☐	STD/HERPES
☐	☐	BRONCHITIS	☐	☐	HEPATITIS	☐	☐	SEIZURES	☐	☐	CATARACTS

FAMILY HISTORY

PLEASE CHECK ALL THAT APPLY TO YOU

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	ARTHRITIS	☐	☐	COPD/EMPHYSEMA	☐	☐	LUPUS	☐	☐	HEART ATTACK
☐	☐	ASTHMA	☐	☐	KIDNEY DISEASE	☐	☐	GOUT	☐	☐	HEART DISEASE
☐	☐	ALCOHOLISM	☐	☐	CANCER	☐	☐	HTN	☐	☐	DIABETES
☐	☐	HYPOTHYROID	☐	☐	HYPERTHYROID	☐	☐	HIGH CHOLESTEROL			

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOT HOLD MY HEALTHCARE PROVIDER OR ANY MEMBERS OF HIS/HER STAFF RESPONSIBLE FOR ANY ERROR OR OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM.

_____

PRINTED NAME

_____

SIGNATURE DATE

Masters Family Medical, PLLC
Consent to Treat

224 West Central Ave
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Insurance Authorization and Assignment: I hereby authorize the release of any medical or other information (necessary to process claims) on my insurance carrier. I also request payment of government benefits (if applicable) either to myself or the party who accepts the assignment. Furthermore, I authorize payment of medical benefits directly to the medical provider(s) who have treated me or rendered services or materials.

Medicare/Medicaid Patients: I authorize any holder of medical or other information about me to release to Centers for Medicare/Medicaid Services and its agents any information needed to determine benefits for this or related Medicare/Medicaid claim. I request that payment of authorized Medicare/Medicaid benefits be made either to me or to the party who accepts the assignment.

Authorization for Release of Information to Email Address (if one is provided) : We collect email addresses for the purpose of notifying patients of business announcements. We may collect and use personal data for the additional purpose of sending advertisements pertaining to specific medical conditions. We do not disclose your personally identifiable information to any outside businesses or organizations, other than for the purposes mentioned in the paragraph above regarding insurance claims.

Treatment Consent: I consent to medical treatment by Alisha Masters, FNP and other healthcare providers employed by Masters Family Medical, PLLC. I understand this could include but not limited to lab tests, x-rays immunizations, medications/prescriptions and/or administration, education, other diagnostic tests, or behavioral health interventions. I understand that my provider is available to explain the treatment and I have the right to refuse treatment.

By signing this form I am agreeing to the above information.

_____ _____

Print Name **Date**

_____

Signature

Masters Family Medical, PLLC

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Financial Policy

Welcome to Masters Family Medical. The following is a statement of our financial policy. All patients must complete our patient information packet before seeing the provider. You must provide proof of insurance if you fail to provide us with correct insurance information you may be responsible for the balance of your claim.

Unless previous arrangements have been made, all payments are due at the time of the appointment. Payment may be made by CASH, CHECK, CREDIT or DEBIT CARD. Any credit card charges will have a 3.5% interest added to total. We only bill insurance carriers with whom we participate (have a signed agreement with). For those who have not met their deductible, an $85.00 charge will be collected at time of service and any remaining deductible will be billed at a later date.

Regarding Managed Care Insurance with which we participate:
You are responsible to provide our staff with your primary and secondary insurance identification card (s) at the time of your appointment. If your insurance requires a copay it must be paid at the time of your appointment.

Regarding Non-participating Insurances:
If we do not participate with your insurance, the bill will be your responsibility and is due at the time of service/appointment.We accept CASH, CHECK, CREDIT and DEBIT CARDS. Your insurance policy is a contract between you and your insurance company. Our office is not a party to your contract. It is your responsibility to know what your insurance will or will not cover.

Return Check Fee- $30.00
Our bank charges us a fee for any check that is returned for "insufficient funds" and this will be added to the patient's bill if this occurs.

Missed appointments: If you are unable to keep an scheduled appointment, 24 hours notice of cancellation is required. Failure to do so may result in a $25.00 charge.

Outstanding Balance:Any outstanding balance for which the patient is responsible is due within 30 days of billing. Any account that has gone greater than 60 days without payment will be subject to immediate collection process. Accounts that go into collections will be subject to a 25% charge.

Discharge: There are certain situations in which we will be forced to discharge you from our practice. These include but not limited to failure to pay after reasonable attempts to collect balance due, refusal to follow your doctor's advice, and excessive cancellations/no shows. These situations are rare but we must make you aware of them. If this were to occur, you will be notified by certified mail that you have 30 days to find alternative medical care.

Thank you for your cooperation in understanding our financial policy. If you have any questions or concerns, please feel free to ask. If you cannot pay in full at the time of service, please let us know before you see the doctor. We are happy to work out a payment plan.

I have read the above financial policy for Masters Family Medical, PLLC and agree to it's terms.

_____ _____
(print name) (date)

_____ _____
Patient signature Guardian Signature if applicable

Masters Family Medical, PLLC

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Authorization to Release Information

Please Print Clearly

Name: _____
Last First Middle

Address: _____
(Street) (City) (State) (Zipcode)

Phone: _____ Date of Birth:_____

Name of Healthcare provider/Doctor/Hospital etc:_____

Address:_____

City.State/Zipcode:_____

For the purpose of review/examination, I further authorize you to release any and all information, including HIV/AIDS status related information, substance abuse and psychiatric/mental health information that my be contained in my medical records, including copies of all or any portion; hereby waiving there as to any privilege of communication conferred on myself, my personal representative or heirs of any amendments thereto.

Information requested:

- ☐ Office visit notes dates:_____
- ☐ Lab results
- ☐ Imaging
- ☐ Entire chart

Reason for request:_____

This authorization will expire one year from the date signed. I understand that I may revoke this consent at any time except that action has been taken and reliance thereon.

Signed _____ _____
Relationship to patient if signed by other than patient

Witness _____ _____
Date

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Notice of Privacy Practices

Name: _____ Date of Birth: _____/_____/_____

Acknowledgment:

☐ I, the undersigned, acknowledge that I have received a copy of the Masters Family Medical Notice of Privacy Practices. I understand that this notice describes how my medical information may be used and disclosed, and how I can access my medical information.

☐ I understand that I have the right to review the Notice of Privacy Practices prior to signing this acknowledgment and that the clinic has answered all my questions regarding these practices.

By signing below, I confirm that I have read and understand the contents of the Notice of Privacy Practices.

Release of Information

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

☐ Spouse _____

☐ Child(ren) _____

☐ Other _____

☐ Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call ☐ my home ☐ my work ☐ my cell number: _____

If unable to reach me:

☐ you may leave a detailed message

☐ please leave a message asking me to return your call

The best time to reach me is (day) _____ between (time) _____

Signed: _____ **Date**:_____/_____/_____

Witness: _____ **Date**:_____/_____/_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CANGET ACCESS TO THIS INFORMATION. PLEASE REVIEW THE INFORMATION DESCRIBED IN THIS NOTICE CAREFULLY.

Our Responsibilities

We are committed to protecting the privacy of your health information. We are required by state and federal law to maintain the privacy of protected health information, provide you with notice of our legal duties and privacy practices with respect to protected health information, and notify affected individuals following a breach of unsecured protected health information. We reserve the right to change our privacy practices provided law permits the changes, before we make significant change, this notice will be amended to reflect the changes and we will make the new notice available upon request. We reserve the right to make any changes in our privacy practices and the terms of our notice effective for all health information maintained, created and/or received by us before the date changes were made.

This Notice of Privacy Practices is effective as of September 4, 2024.

Uses and Disclosures of Health Information

We may use and disclose your health information for treatment, payment, and healthcare operations. We may also use and disclose your information for other purposes with your written authorization.

Treatment: Healthcare providers may use and disclose your health information to provide, coordinate, or manage your healthcare and any related services. This includes sharing information with other healthcare providers involved in your treatment, such as specialists, laboratories, and pharmacies. These professionals will have a privacy and confidentiality policy similar to this one.

Payment: Providers may use and disclose your health information to bill and receive payment for the treatment and services you receive. This may involve sharing information with your insurance company, Medicare, Medicaid, or other third-party payers.

Required by Law: We may use and disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other process.)

National Security: The health information of Armed forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for intelligence. Counter intelligence or other national security activities, we may disclose it to authorized federal officials.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic abuse.

Public Health Risks: Healthcare providers may use and disclose health information to public health authorities for activities such as:

- Disease Control and Prevention: Sharing information with public health agencies to track and control the spread of diseases or outbreaks, such as COVID-19, influenza, or other communicable diseases.
- Reporting: Reporting certain diseases, injuries, births, and deaths as required by law to public health authorities for surveillance and monitoring purposes.
- Health Oversight Activities: Providing information to government agencies responsible for overseeing the healthcare system to ensure compliance with laws and regulations.
- Emergency Situations: Sharing information in emergency situations to prevent or lessen a serious and imminent threat to public health and safety.
- Research and Surveillance: Using de-identified information for public health research, surveillance, and statistical reporting to improve population health outcomes.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so. We are required to obtain authorization for marketing purposes if communication about a product or service is provided and we receive financial remuneration (getting pain in exchange for making the communication). Not authorization is required if communication is made face-to-face or for promotional gifts.

Fundraising: We may use certain information such as name, address, telephone number or e-mail information, age, date of birth, gender, health insurance status, dates of service, department of service information, treating physician information, or outcome information to contact you for the purpose of raising money and you will have the right to opt out of receiving such communications with each solicitation.

Sale of PHI: We are prohibited to disclose information without an authorization if it constitutes remuneration (getting pain in exchange of PHI). "Sale of PHI" does not include disclosures for public health, certain research purposes treatment and payment, and for any other purpose permitted by the Privacy rule, where the only remuneration received is "a reasonable cost based fee" to cover the cost to prepare and transmit the PHI for such purpose of a fee otherwise expressly permitted by law. Corporate transactions (i.e., sale, transfer, merger, consolidation) are also excluded from the definition of "sale."

Other Purposes with Authorization: In addition to treatment, payment, and healthcare operations, providers may use and disclose your health information for other purposes with your written authorization. This could include research, marketing, fundraising, or sharing information with family members or other individuals involved in your care.
It's important to note that healthcare providers must follow HIPAA regulations when using and disclosing patient information, ensuring that it is only shared for permissible purposes and with appropriate safeguards in place to protect patient privacy and confidentiality. Patients have the right to request restrictions on certain uses and disclosures of their health information and must give authorization for certain types of disclosures not covered under treatment, payment, and healthcare operations.

Your Rights Regarding Your Health Information
- You have the right to request restrictions on certain uses and disclosures of your health information.
- You have the right to receive confidential communications of health information.
- You have the right to inspect and copy your health information for a fee.
- You have the right to request an amendment to your health information.
- You have the right to receive an accounting of disclosures of your health information.
- You have the right to obtain a paper copy of this Notice from us upon request.

Breach Notification Requirements
It is presumed that any acquisition, access, use of disclosure of Protected Health Information not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

Questions and Complaints
If you believe your privacy rights have been violated, you have the right to file a complaint with us or with the Secretary of the Department of Health and Human Services. We will not retaliate against you for filing a complaint.

Contact Information
If you have any questions, concerns, or complaints about our privacy practices, please contact:
Practice Name: Masters Family Medical Alisha Masters, FNP
Privacy Officer: Tammy Stephens

Monterey:
1117 West Commercial Avenue
Monterey, Tn, 38753

Jamestown:
224 West Central Avenue
Jamestown, Tn, 38556