Family Health Care of Gallatin

New Patient Form

Patient Information

Last Name: _____ First Name: _____

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

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Race: Native Hawaiian or Pacific Islander ☐ Asian ☐ White ☐ Other: _____

Address: _____

City: _____ State: _____ Zip: _____ Email: _____

Home Phone: _____ Mobile Phone: _____

Preferred Phone: ☐ Home ☐ Mobile

Employer Information

Occupation: _____ Employer: _____

Employer Phone: _____

Emergency Contact

Name: _____ Relationship: _____

Phone Number: _____

Preferred Pharmacy

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Address: _____

Person Responsible for Bill (If Different from Patient)

Name: _____ Relationship to Patient: _____

Social Security #: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____

Insurance Information

Primary Insurance Company: _____

Policy Holder: _____ Social Security: _____ DOB: _____

Relationship to Patient: _____

Secondary Insurance Company: _____

Policy Holder: _____ Social Security: _____ DOB: _____

Relationship to Patient: _____

Treating Physicians / Specialists

Please list all active treating physicians.

Physician Name	Specialty

General Medical Questionnaire

Have you ever had any of the following?

Condition	Yes	No
Asthma / Breathing Problems	☐	☐
Arthritis	☐	☐
Bleeding / Clotting Disorder	☐	☐
Blood Pressure Disorder	☐	☐
Cancer	☐	☐
Diabetes	☐	☐
Heart Disease / Disorder	☐	☐
Lung Disorder	☐	☐
Stroke	☐	☐
Thyroid Disorder	☐	☐
Kidney Disorder	☐	☐
Psychiatric Disorder / Illness	☐	☐

Drug Allergies / Sensitivities

Current Medications

Medication Name	Dosage	Frequency

Past Surgical History

Description	Approximate Date

Hospitalizations

Description	Approximate Date

Family Medical History

Relative	Condition / Description	Living?	If Deceased, Age
Mother		☐ Yes ☐ No	
Father		☐ Yes ☐ No	
Sibling		☐ Yes ☐ No	
Other		☐ Yes ☐ No	

Social History

Do you currently smoke? ☐ Yes ☐ No If no, have you smoked previously? ☐ Yes ☐ No

Years Smoked: _____ Packs Per Day: _____ Do you use other tobacco products? ☐ Yes ☐ No

Do you consume alcohol? ☐ Yes ☐ No If yes, drinks per week: _____

Family Health Care of Gallatin Release of Information

Patient Name: _____

I give permission to Family Health Care of Gallatin to discuss my medical condition(s), my treatment, and information regarding my appointments with the following individuals:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

May we leave a message on your voicemail? YES NO

Consent to Treat

I hereby authorize Family Health Care of Gallatin, PLLC and any of its physicians and/or staff to treat my medical condition(s). The risks, benefits, and alternatives will be explained at the time of service. I have the right to questions and/or refuse treatment.

_____ _____

Patient Signature Date

Family Health Care of Gallatin
Consent to Disclose Health Care information

It is important for you to know how your rights concerning your records and how your Personal Health Information (PHI) is used in our office. Before we begin any health care operations, we must require you read and sign this consent form stating you understand and agree with how your records will be used.

1. I understand and agree to allow Family Health Care of Gallatin, PLLC to use my Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care.
2. Family Health Care of Gallatin, PLLC has a document called the "Notice of Privacy Practices" that contains more information about policies and practices used to protect our patients' privacy. I understand that I have the right to read the "Notice of Privacy Practices" before signing this agreement. The notice is posted in the office of Family Health Care of Gallatin, PLLC. A written agreement. The notice is posted in the office of Family Health Care of Gallatin, PLLC may update the "Notice of Privacy Practices" at any time. A copy of the most recent update is available upon request.
3. Under the terms of this consent, I can ask Family Health Care of Gallatin, PLLC to restrict how my personal health information is used or disclosed to carry out treatment, payment or health care operations.
4. I understand that Family Health Care of Gallatin, PLLC does not have to agree to my request. If Family Health Care of Gallatin, PLLC does agree to my request, I understand that agreed limits would be followed.
5. I understand that I have the right to cancel this consent in writing to the Privacy Officer of Family Health Care Gallatin, PLLC. If I do cancel this consent, I understand that Family Health Care of Gallatin, PLLC may have used or disclosed information about me and canceling this consent would not apply to information already used or disclosed.
6. I understand that if I cancel this consent, Family Health Care of Gallatin, PLLC does not have to provide further healthcare services to me.
7. I grant Family Health Care of Gallatin, PLLC permission to view my prescription history from external sources.

I have read and understand how my Patient Health Information (PHI) will be used and I agree to these policies and procedures.

I have been given the opportunity to review a current copy of **Family Health Care of Gallatin's Privacy Policy**.

_____ _____

Patient Signature Date

_____

Printed Name

Family Health Care of Gallatin Financial Policy

It is our policy that all fees including co-pays, deductibles, and non-covered services are due and payable on the date of service unless other payment arrangements have been made.

As a service to our patients, we will file a claim with your insurance company. The filling of insurance does NOT release the patient from responsibility for charges of services which have been provided. Please make sure we have a current copy of your insurance card. **If we do not have the correct insurance information on the date of service and your claim is denied, you are responsible for payment.** It is your responsibility to verify if our office is in network with your plan.

Accounts which are not paid within 90 days, and for which no special arrangements have been made, will be subject to placement with collection agencies following due notice.

Having read and understood the above statements, I agree with the terms set forth:

1. I understand my co-pay, deductible, or non-covered service fee is due and payable at my appointment or I will need to reschedule my appointment.
2. I understand that I am financially responsible for all charges, even if they are not covered by insurance.
3. If my insurance does not pay, I understand that I am responsible for those charges.
4. If I do not pay in accordance with the above policy and my account is sent to collection agency, I agree to pay all costs of collection, including attorney fees.
5. If my account is sent to collections, I understand I will be dismissed from this practice.
6. I understand if I fail to show up for a scheduled appointment, I will receive one courtesy notice. For a second no show appointment, I understand I will receive a bill for the missed appointment. I understand a third missed appointment is grounds for dismissal from the practice.

I, the patient or guarantor/guardian hereby authorize the release of all applicable medical information including, without limitation, copies of all records and test results produced to the designated attending, referral and/or follow-up physicians and such other healthcare practitioners or organizations which will providing subsequent monitoring, care or treatment in connection with care provided by Family Health Care of Gallatin, PLLC. I also authorize the release of information from my medical record to comply with applicable law, to facilitate the performance of utilization review and quality assurance activities and to incurred by the patient and agree to pay all bills at the time of service, unless other arrangements are made. I authorize physician and/or clinic to rend medical treatment and to release information to process insurance claims and to determine Medicare benefits. I also authorize my insurance claim and/or authorized Medicare benefits to be paid directly to Family Health Care of Gallatin, PLLC. I further agree that a photocopy of this document is to be considered as valid as an original.

Signature of Responsible Party: _____ Date: _____

Printed Name: _____ Relationship to patient: _____

Patient Health Questionnaire (PHQ-9)

Name:_____ Date:_____

Rate how often from 0-3, how each statement has bothered you in the past two weeks

STATEMENTS	Not at all	Several days	More than half of the days	Nearly every day
1.) Little interest or pleasure in doing things.	0	1	2	3
2.) Feeling down, depressed, or hopeless.	0	1	2	3
3.) Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4.) Feeling tired or having little energy.	0	1	2	3
5.) Poor appetite or overeating.	0	1	2	3
6.) Feeling bad about yourself, thinking you are a failure or have let yourself or your family down.	0	1	2	3
7.) Trouble concentrating on things, such as reading the newspaper or watching TV.	0	1	2	3
8.) Moving or speaking at a pace that is not normal for yourself , or being fidgety or restless that you move around a lot more than normal.	0	1	2	3
9.) Thoughts that you would be better off dead, or better off hurting yourself.	0	1	2	3

Family Healthcare of Gallatin

Susan Anderson, FNP
Rebecca Parks, FNP
831B Nashville Pike
Gallatin Tn 37066
Phone 615-206-0500 Fax 615-206-0092

Authorization to Release Medical Records:

Patient Information:
Name: _____ DOB: ___/___/____ SSN: ____/___/____
Address: _____
Phone: _____/_____/_____

Information to be Released To/From:
Name of Facility or provider: _____
Phone: ____/_____/_____ Fax: ____/____/_____

Information to be Sent To/From:

Family Healthcare of Gallatin
Phone 615-206-0500
Fax 615-206-0092

___ The most recent 2 years of pertinent information (chart notes, labs, imaging)
_x__ ALL medical records
___ Specific information (Please specify): _____

Patient Authorization:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.
**EXCLUDE the following information from the records released
Please initial: _____Drug/alcohol abuse treatment/diagnosis
_____STD
_____ HIV/AIDS diagnosis/treatment/testing
_____Mental Illness/ diagnosis/treatment

My Rights:

I understand I do not have to sign this authorization in order to obtain health care benefits. I may Revoke this authorization in writing. To view the process for revoking this auth, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which it may no longer be protected under Privacy Laws.

Patient Signature: _____ Date: _____/____/_____
(Patient, guardian, or Auth representative)

This authorization will expire 90 days from the date signed

Family Healthcare of Gallatin

Patient Name: _____ Date of Birth: _____

To enhance the accuracy and efficiency of your medical documentation, Family Healthcare of Gallatin uses ezScribe, an A.I. scribe, during some patient visits. This technology assists your healthcare provider by generating clinical notes in real time based on the conversation during your visit.

How It Works

- The AI scribe listens to and/or processes the conversation between you and your provider.
- It creates a draft of your medical note for your provider to review, edit, and finalize.
- Your provider remains fully responsible for the accuracy and completeness of your medical record.

Privacy and Security

- Any information processed by the AI scribe is treated as protected health information (PHI) under the Health Insurance Portability and Accountability Act.
- We use secure, HIPAA-compliant systems designed to safeguard your information.
- Your information will not be used for purposes outside of your care without your authorization, unless otherwise permitted by law.

Patient Acknowledgment and Consent

By signing below, you acknowledge and agree that:

- You understand that an AI scribe may be used during your visit.
- You consent to the use of AI technology to assist in documenting your care.
- You understand that your provider is responsible for reviewing and finalizing your medical record.

Patient/Guardian Signature: _____

Date: _____

HOW TO SIGN ON TO HEALOW PATIENT PORTAL

DOWNLOAD HEALOW APP

ENTER your FIRST NAME, LAST NAME and DOB

Do you have a practice code??? YES!

EFHIBD

VERIFY PRACTICE: Family Health Care of Gallatin

831B Nashville Pk

Gallatin TN 37066

CLICK "THIS IS MY PRACTICE"

Create a user name and password and WRITE IT DOWN!

YOU KEEP THIS PAGE