Patient Name: Date:

Are you allergic to any medications? NO ☐ YES ☐ Please list:

Past Medical History

	Yes	No		Yes	No		Yes	No
Diabetes	☐	☐	Osteoporosis	☐	☐	Blood Clots	☐	☐
Chest Pain/Angina	☐	☐	Asthma/COPD	☐	☐	Peripheral Vascular Disease	☐	☐
High Blood Pressure	☐	☐	Stroke/CVA/TIA	☐	☐	Tuberculosis	☐	☐
Heart Disease	☐	☐	Seizures	☐	☐	Depression	☐	☐
Heart Attack	☐	☐	HIV/AIDS	☐	☐	Congestive Heart Failure	☐	☐
High Cholesterol	☐	☐	Hepatitis	☐	☐	Thyroid Disease	☐	☐
Pacemaker	☐	☐	Stomach Ulcer	☐	☐	Other (please list below)		
Headaches	☐	☐	Liver Disease	☐	☐			
Kidney Stones	☐	☐	Heart Palpitations	☐	☐			
Kidney Disease	☐	☐	Arthritis	☐	☐			
Cancer	☐	☐	Heart Surgery	☐	☐			

Current Medications

ROS	(-)	Please check all **CURRENT** positive findings
Constitutional		Weight loss ☐ Fevers ☐ Chills ☐ Poor appetite ☐ Fatigue ☐ Weight gain ☐ Insomnia ☐ Night sweats ☐
Eyes		Blurry vision ☐ Eye pain ☐ Eye discharge ☐ Eye redness ☐ Decrease in vision ☐ Dry eyes ☐ Double vision ☐
ENT		Sore throat ☐ Hoarseness ☐ Ear pain ☐ Hearing loss ☐ Ear discharge ☐ Nose bleeds ☐ Tinnitus ☐ Sinus problems ☐
Cardiovascular		Chest pain ☐ Palpitations ☐ Rapid heart rate ☐ Heart murmur ☐ Poor circulation ☐ Swelling in the legs or feet ☐
Respiratory		Shortness of breath ☐ Chronic cough ☐ Coughing up blood ☐ History of Tuberculosis ☐ Excess sputum production ☐
Gastrointestinal		Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Blood in the stool ☐ Frequent heartburn ☐ Trouble swallowing ☐
Genitourinary		Increased urinary frequency ☐ Blood in the urine ☐ Incontinence ☐ Painful urination ☐ Urinary retention ☐ Frequent UTIs ☐
Skin		Rash ☐ Hives ☐ Hair loss ☐ Skin sores or ulcers ☐ Itching ☐ Skin thickening ☐ Nail changes ☐ Mole changes ☐
Musculoskeletal		Joint pain ☐ Muscle aches ☐ Frequent leg cramps ☐ Muscle weakness ☐ Bone pain ☐ Joint swelling ☐ Back pain ☐
Psychiatric		Anxiety ☐ Depression ☐ Alcohol or drug dependence ☐ Suicidal thoughts ☐ Panic attacks ☐ Use of anti-depressants ☐
Endocrine		Goiter ☐ Heat intolerance ☐ Cold intolerance ☐ Increased thirst ☐ Change in skin pigment ☐ Excess sweating ☐
Neurological		Seizures ☐ Tremors ☐ Migraines ☐ Numbness ☐ Dizziness/Vertigo ☐ Loss of balance ☐ Slurred speech ☐ Stroke ☐
Hem/Lymphatic		Low blood count ☐ Easy bruising ☐ Swollen lymph nodes ☐ Transfusions ☐ Prolonged bleeding ☐ Blood clots ☐
Allergic/Immun		Allergic reactions ☐ Hay fever ☐ Frequent infections ☐ Hepatitis ☐ HIV positive ☐ Positive tuberculin skin test (PPD) ☐

Social History: Marital Status _____ Occupation (or most recent job held) _____

Non-Smoker (never smoked) ☐ Ex-Smoker ☐ Current Smoker ☐ How many packs per day? _____

Alcohol consumption: Never ☐ Occasional ☐ Frequent ☐

Family History: (Please list any known medical problems)

Father: _____ Mother: _____

Siblings: _____

Your Children: _____

Additional Information: Use this space to provide any additional information which may be important to your health care.

_____ _____

Signature of Reviewing Physician Date Signature of Patient Date

InstaCare Clinic PLLC.

Atlanta Russell, FNP-BC and Kristin Taylor, FNP-BC

1532 West Andrew Johnson Highway

Morristown TN, 37814

Phone: 423-616-0705 Fax: 423-616-0707

PATIENT INFORMATION

Name_____ Primary Care Physician_____

Address_____ Address_____

City, State, Zip_____ City, State, Zip_____

Home PH: _____CELL_____ Pharmacy

_____Phone_____

SS#_____DOB____/____/___

Sex: __M ___F Marital Status: ___S__D___SEP___W

__African American __Asian __Native Hawaiian___ Latino or Hispanic ___American Indian or Alaska Native ___Caucasian/White ___Non-Latino or Non-Hispanic ___Prefer not to answer

Preferred Language: ___English ___Spanish ___Other

____Yes/ ____No If I am unavailable, I authorize InstaCare to contact me by phone or text to discuss Personal Health Information at the Phone numbers provided.

EMERGENCY CONTACT

Name_____ Home_____ Cell_____

Address_____ Relationship_____

City, State, Zip_____

___I do/ ____do not authorize the disclosure of Personal Health Information to certain designated individuals other than myself as listed above.

INSURANCE

Primary Carrier _____Member ID:_____

Group #_____ Policy Holder_____ Relationship_____

Secondary Carrier _____Member ID: _____

Group #_____ Policy Holder _____Relationship_____

Signature_____ Printed Name _____Date: _____

Consent to Treat a Minor

(If applicable)

Father's Name: _____ DOB: _____

Address:_____ City:_____ State:_____ Zip:_____

Phone: _____ (OK to call Y/N)

Mother's Name: _____ DOB: _____

Address: _____ City: _____ State_____ Zip_____

Phone: _____ (OK to call Y/N)

Guardian's Name: _____ DOB: _____

Address: _____ City_____ State_____ Zip_____

Phone: _____ (OK to call Y/N)

Emergency Contacts:

Name: _____ Relationship: _____ Phone_____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone_____

Please circle all that apply to minor and family:

Divorce, Legal Separation, Custody/Guardianship Restraining Orders, Current Litigation Issues, Probation

Any issues concerning Divorce, Custody, Guardianship, Probation and/ or Restraining Orders will require all documents to be presented on first visit to verify any legal issues and/or custody of child. Copies of these documents will be kept with minor's records

I, (*print name*) _____, am the mother/father/legal guardian (*circle one*) of _____ and I authorize (INSTACARE) to provide medical treatment (*initial here*)_____

I authorize (INSTACARE) to provide medical treatment to said minor. I also agree to be legal responsible for any charges said minor may incur during the treatment with (INSTACARE) (*initial here*) _____

Signature:_____ Date:_____

InstaCare Clinic PLLC.

1532 West Andrew Johnson Highway

Morristown, TN 37814

Notice of Privacy Practices

Patient Acknowledgement

Patient's Name: _____

DOB: _____

I have received and understand this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practices legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice

If changes to the policy occur, this practice will provide me a revised Notice of Privacy Practices upon request.

Printed Name: _____

Signature: _____

Date: _____

Relationship to patient (If signed by a personal representative of patient):

_____

InstaCare Clinic PLLC.

1532 West Andrew Johnson Highway

Morristown, TN. 37814

We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc.)

Co-pays

Patients are expected to present an insurance card at each visit. All co-payments and past due balances are due at time of check-in unless previous arrangements have been made with a billing coordinator. We accept cash, check or credit cards. Absolutely no post-dated checks will be accepted.

Insurance Claims

Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

Leaving against Medical Advice

If our practice sends you for any test outside our facility and needs, you to return to the clinic afterwards and you do not return you will be doing so at your own risk. (INSTACARE) will not be liable for patients that do not return to the clinic when advised to do so by your provider.

Unpaid Patient Balances

If any balances such as co-pays, deductibles due InstaCare go unpaid over 90 days, a final demand for payment letter will be sent to an outside collection agency with an additional 30% added to the account to pay for recovery fees. Patients will be held responsible for any legal and/or attorney fees, with 10% added for late fees to the account.

Patient Printed Name: _____

Patient Signature: _____ Date: _____

Relationship to patient (If signed by a personal representative): _____

InstaCare Clinic PLLC.

Atlanta Russell, FNP-BC and Kristin Taylor, FNP-BC

Phone: 423-616-0705 Fax: 423-616-0707

Medical Records Authorization Release Form

I hereby authorize: InstaCare Clinic PLLC.

1532 W Andrew Johnson Hwy

Morristown, TN 37814

Phone: 423-616-0705

Fax: 423-616-0707

To release photostatic copies of all medical records compiled during office visits.

Patient: _____

Date of Birth: _____

Last 4 numbers of SSN: _____

Purpose or need for information: To continue medical care/treatment

I place no limitations on history of illness or diagnostic and therapeutic information, including any treatment for alcohol, drug abuse, psychiatric-disorders, or HIV infections.

This authorization can be revoked, but not retroactive to the release of information made in good faith.

Signature: _____

Relationship: _____

Date: _____

InstaCare Insurances

BCBS- Blue network P, Network S, Bluecare, Coverkids, Dual Integration, Tenncare Select

AARP Medicare Complete

Medicare Railroad

Medicare

Medicaid

Aetna

Cigna

Amerigroup- No Tenncare pts/Medicaid

United Health Care

Tricare-Urgent Care patients only

Wellcare