Betty Jo Dulaney M.D., P.C.

Patient Information Sheet
Please complete all blanks

PATIENT'S INFORMATION

LAST NAME: _____ FIRST: _____ MIDDLE INITIAL:___ D/O/B: _____

ADDRESS: _____ ZIP: _____ S/S/N: _____ RACE: _____

HOME PHONE: _____ CELL: _____EMAIL _____
PREFERRED CONTACT: HOME CELL WORK (CIRCLE ONE)

MARITAL STATUS: _____ ARE YOU PREGNANT? _____ WHO REFFERRED YOU TO US?_____

EMPLOYMENT

[IF STUDENT CHECK HERE_____]

EMPLOYER: _____ ADDRESS: _____ ZIP: _____ PHONE: _____

OCCUPATION: _____ CHECK ONE: FULL TIME: ___ PART TIME: ___

SPOUSE OR PARENT'S INFORMATION

LAST NAME: _____ FIRST: _____ MIDDLE INITIAL:___ D/O/B: _____

ADDRESS: _____ ZIP: _____ S/S/N: _____ RACE: _____

EMPLOYER: _____ OCCUPATION: _____ Cell PHONE: _____

IN CASE OF AN EMERGENCY

NAME: _____ DAYTIME PHONE: _____RELATIONSHIP TO PT: _____

NAME (NOT LIVING WITH YOU): _____ PHONE: _____ RELATIONSHIP TO PT: _____

PRIMARY INSURANCE

PLEASE NOTE-THE INSURED IS THE POLICY HOLDER. IF YOU ARE NOT THE POLICY HOLDER, PLEASE LIST THEIR INFORMATION*

INSURANCE: _____ INSURED NAME: _____ D/O/B: _____ INSURED'S EMPLOYER: _____

INS ADDRESS: _____ ZIP: _____ PHONE NUMBER: _____ RELATION TO PT: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

SECONDARY INSURANCE

INS CO: _____ INSURED NAME: _____ D/O/B: _____ INSURED'S EMPLOYER: _____

INS ADDRESS: _____ ZIP: _____ PHONE NUMBER: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

PLEASE READ AND SIGN

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO DR. DULANEY AND I AUTHORIZE DR. DULANEY TO RELEASE ANY INFORMATION AQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT AS REQUIRED BY MY INSURANCE COMPANY. I UNDERSTAND THAT I AM FINACIALLY RESPONSIBLE FOR THE PAYMENT OF ALL CHARGES AT THE TIME SERVICES ARE RENDERED INCLUDING ANY CHARGES IN EXCESSOF MY INSURANCE RESONABLE AND CUSTOMARY, WHETHER OR NOT THEY ARE COVERED BY MEDICARE OR ANY OTHER INSURANCE. I UNDERSTAND THAT I AM RESPONSIBLE FOR VERIFY MY INSURANCE COVERAGE AND PRE-CERTIFYING MY BENEFITS WITH MY INSURANCE COMPANY. I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR ANY COLLECTION COST AND/OR ATTORNEY FEES INCURRED IN THE COLLECTION OF THIS ACCOUNT. I GIVE PERMISSON TO DR. BETTY JO DULANEY M.D., P.C. FOR MEDICAL TREATMENT INCLUDING, BUT NOT LIMITED TO, EXAMINATION, INJECTIONS, BLOOD TEST, DIAGNOSTIC TESTING OR MEDICAL PROCEDURES DEEMED NECESSARY FOR DIAGNOSIS AND TREATMENT. I HAVE ALSO READ AND UNDERSTAND THE PATIENT RIGHTS AND RESPONSIBILITIES, AS WELL AS THE HIPPA GUIDELINES AND I UNDERSTAND THAT A COPY IS READILY AVAILABLE UPON MY REQUEST. FURTHERMORE, I VERIFY THAT THE ABOVE INFORMATION PROVIDED IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE: X _____ **DATE:** _____

***SIGNATURE OF PARENT IF PATIENT IS A MINOR*: X** _____ **DATE:** _____

BETTY JO DULANEY, M.D., PC

ASSIGNMENT FORM/HIPAA/ACCOUNT PERMISSION

Assignment and release

I assign directly to Betty Jo Dulaney, MD, PC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid by insurance as well as collection fees or interest that may be added if the account should be placed with an outside collection agency. I authorize the use of my signature on all insurance submissions. Betty Jo Dulaney, MD, PC may use my health care information and may disclose such information to the named insurance company/companies (as listed on the patient registration form) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. Furthermore, I authorize Dr. Dulaney to release my records to other physicians as needed to provide assistance in the course of my care/treatment.

Initial _____

HIPAA I am verifying that I have seen the privacy regulation form (HIPAA) posted on the clip board which provides me with the information of how my Protected Health Information (PHI) can be used and I understand that a copy will be made available to me upon my request.

Initial_____

*****Leave a message on your Answering Machine** _____**Accept** _____**Decline**

Discuss your account/payments/test results

We cannot discuss your account/payment details/or test results with anyone without your written permission (this includes your spouse or any other family member) unless they have a power of attorney letter on file. By your initial (above) and signature (below), you are giving us permission to discuss your account/payment details/or test results with the listed person(s).

Name of approved person we may talk to:

Name:_____ Relationship: _____

Name:_____ Relationship: _____

PHARMACY INFORMATION (Where would you like prescriptions sent?)

_____	(_____)_____	_____	_____
Pharmacy Name	Phone #	Address	Cross Street

Communications:

Dr Dulaney now sends <u>all lab results</u> as a PDF copy for you to view/save/print.
This is sent as a message in the Portal at MyHealthRecord.com
You will receive an email requesting you register for myhealthrecord.com please click on link and create the user name and password. Information regarding the security of the portal is available during registration

I understand that <u>all lab results</u> will be sent as a message in the secure portal

Initial_____

Dr. Dulaney does NOT participate in any TennCare or other Medicaid plans. We are unable to see you if you have any TennCare or Medicaid plans as Primary insurance or **<u>Secondary</u>** insurance. These plans will not cover Dr. Dulaney to write prescriptions or cover hospital care.

By initialing you are certifying **one** of the following:

_____**NO**, **I do NOT have** active or pending TennCare or Medicaid coverage

_____*YES, I DO have* active or pending TennCare or Medicaid coverage

Initial _____

I have read, understand, and give my permission to the above statements including statements that have been initialed.

Patient name: _____ Date: _____

Signature: _____
(Signature of patient, parent, guardian, or personal representative)

Betty Jo Dulaney, M.D., P.C.
2157 Judicial Drive
Germantown, TN 38138
Ph#901-309-6745

Patient Agenda Form

Name _____Date _____

Please take a moment to answer the questions below in order to best use the time spent today with your provider.

1. What do you want to discuss/have done at today's appointment?

_____

2. What symptoms do you want your provider to be aware of?

_____

3. What providers (hospital, ER, Urgent Care , Specialist, etc.) have you seen since your last visit?

_____

4. Please list **ALL** your medications (including what we prescribe or any other providers)
please include over the counter meds/vitamins *(add on back if needed)*

Drug Name	Dose	how often taken?	Refill needed? (30 or 90 days)

_____

_____

_____

_____

5. ***Please circle below***

Do you drink alcoholic beverages? Yes No

Do you use recreational drugs? *example* (Marijuana/Cocaine/Heroin etc.) Yes No

Do you smoke cigarettes or use tobacco? Yes No

Do you vape? Yes No

Do you request a staff member (Chaperone) in room during sensitive exams (Pelvic/Breast)? Yes No

6. **Please list all**

Drug allergies:_____

7. Do you have specific requests for:
   - New medications/Tests/Referrals/Completion of forms/Work or School Forms

_____