Office of Internal Medicine, PC

(901) 726-0843

Hany M. Habashy, MD, MRCP, FACP
Kimberly Polk, FNP-BC
Melissa Reid, NP-C

REGISTRATION FORM

Welcome to our practice! It is an honor to serve your internal medicine needs.
Please present your photo identification card and insurance card(s) to Check-In for scanning.
Please complete the following information:

Patient Information

Patient's Full Name: _____ Sex: ____ Date of Birth: __/__/_____ Marital Status: _____ Race: _____

Patient Address: _____ City State Zip Code

Patient Home Phone Number: _____-_____-_____

Patient Cell Number: _____-_____-_____

Social Security Number: _____-_____-_____

Patient's Employer: _____

Occupation: _____

Employer Address: _____ City State Zip Code

Employer Phone Number: _____-_____-_____

Spouse, Guardian, or Next of Kin Information

Spouse, Guardian or Next of Kin Full Name: _____

Date of Birth: ___/____/_____

Status: Spouse__Guardian__Next of Kin__

Spouse, Guardian or Next of Kin Address: _____ City State Zip Code

Home Phone Number: _____-_____-_____

Cell Phone Number: _____-_____-_____

Social Security Number: _____-_____-_____

Who May We Notify In Case Of Emergency? _____

Relationship: _____ Phone Number(s): _____

I authorize the release of any medical information to process this claim. I also authorize the direct payment of any benefits due me for the described services to Office of Internal Medicine, PC. I understand that I am financially responsible for paying any unpaid balance and will be responsible for the entire bill if claims are not covered by my insurance.

Signature: _____ Date: ____/____/____

Authorization to Leave Message:
I authorize this office to leave a message regarding pending appointments at my place of work, on my voice mail, or with another person answering my phone.

Signature: _____ Date: ____/____/____

Office of Internal Medicine, PC
CONSENTS FORM

CONSENT FOR TREATMENT & CARE

I, the undersigned, do hereby agree and give my consent for The Office of Internal Medicine, PC, to furnish medical care and treatment to myself or _____ which is considered medically necessary and appropriate in diagnosing or treating my/their physical condition.

STATEMENT OF FINANCIAL RESPONSIBILITY

All services rendered are the responsibility of the patient. As a courtesy to our patients, we will file with your insurance carrier. The patient is responsible for all fees, regardless of insurance coverage, or the usual and customary fees provided by your insurance company. In the event your account is placed with a collection agency, a collection fee up to 33.3% may be added to your account and shall become part of the total amount due. In the event your account is placed with an attorney, you will be responsible for reasonable attorney fees and court costs. You agree, that in order for us to service your account or to collect any amounts you may owe, we and our collection agencies may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We and our collection agencies may also contact you by sending text messages and/or emails, using any email address you provide to us. Methods of contact may include pre-recorded/artificial voice messages and/or use of an automatic dialing device, if applicable.

NO SHOWS AND CANCELLATIONS

If an appointment needs to be rescheduled or cancelled, please notify this office within one business day prior to your appointment. If the appointment is not rescheduled in a timely manner, or if the patient is a no show, there will be a fee of $25 added to your account. If the appointment is for a Medicare Annual Wellness Visit, the fee is $50.

INSURANCE AUTHORIZATION & BENEFITS ASSIGNMENTS

I hereby authorize The Office of Internal Medicine, PC, to release all information necessary, including medical records, requested by insurance companies with whom I have coverage or any public agency or its agents to secure payment for myself or my dependents. I hereby authorize payment of benefits to be made directly to The Office of Internal Medicine, P C, for services provided to me or my dependents. I also agree to give Medical Insurance Filing Services, Inc., authorization to file necessary claims to my insurance carrier on behalf of The Office of Internal Medicine, PC.

MEDICARE ONE TIME AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to The Office of Internal Medicine, PC, for any services furnished to me by that provider. I authorize any holder of medical information about me to be released to the Health Care Finance Administration and its agents when needed to determine benefits or benefits payable for related services.

Patient's Signature _____ Date _____

The Office of Internal Medicine, PC
Informed Consent for Opioid Therapy
Revised July 1, 2018

I understand that my physician at The Office of Internal Medicine, PC (OIM), is recommending opioid medication, sometimes called narcotics analgesics, to treat my chronic pain.

I understand that this medication is being recommended because my pain complaints are moderate to severe and other treatments have not sufficiently helped my pain. I understand that many medications can have interactions with opioids that can either increase or decrease their effect. Therefore, I have told my physician about all other medicines and treatments that I am receiving – and that I will promptly advice my physician if I start to take any new medications or have new treatments. Likewise, I have told my physician about my complete personal drug history and that of my family.

I have been informed by my physician that the initiation of a narcotic/opioid medication is a trial. Continuation of the medication is based on evidence of benefit to me from, associated side effects of, and compliance with instructions on, usage of this medication. I have also been informed by my physician that continuation and any changes in dosage of the medication will be determined by pain relief, functional improvement, side effects and adherence to usage restrictions. Lack of significant improvement, the development of adverse side effects, or other considerations may lead my physician to discontinue this treatment or to change dosage.

It has been explained to me that taking narcotic/opioid medication has certain risks associated with it. These include, but are not limited to, the following:

- Allergic reactions
- Overdose (which could result in harm or even death)
- Slowing of breathing rate
- Slowing of reflexes or reaction time
- Sleepiness, drowsiness, dizziness and/or confusion
- Impaired judgement and inability to operate machines or drive motor vehicles
- Nausea, vomiting, and/or constipation
- Itching
- Physician dependence or tolerance to the pain relieving properties of the medication. (This means that if my medication is stopped, reduced in dose, or rendered less effective by other medications I may be taking, I may experience runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body, and a flu-like feeling. These can be very painful but are generally non-life-threatening.)
- Addiction
- Failure to provide pain relief
- Changes in sexual function
- Changes in hormonal levels

In addition, use of these medications poses special risks to women who are pregnant or who may become pregnant. If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetrician and this office to inform them. I have been advised that, should I carry a baby to delivery while taking this medication, the baby will be physically dependent upon opioids. I also understand that birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an opioid. Furthermore, I recognize that the long-term consequence on a child's development that was exposed to opioids is not understood.

Understanding that there are other options I may seek in treatment, I have freely consented to taking the narcotic/ opioid medication.

I will take this/these medications only as prescribed and I will not change the amount or dosing frequency without authorization from my physician. I understand that unauthorized changes may result in my running out of medication early, and early refills will not be allowed. I also understand that if I do not take the medication correctly, I may have withdrawal reactions as described above.

I will obtain all opioid prescriptions from my physician or, during his or her absence, by another physician within the practice of OIM. Requests for pain medications from the on-call physician (nights and weekends) will not be honored. I will not request medications outside of normal business hours.

I understand that I will be dispensed a maximum of a 30-day supply prescription based on my physician's recommendation, and I am required to see the physician by appointment in order to review my condition, treatment and to refill my prescription.

I will submit to random urine and/or blood tests as requested by my physician to monitor my treatment. I understand that the presence of any unauthorized substances in my urine or blood may prompt referral for assessment of addiction or chemical dependency and will result in discontinuation of further opioid prescriptions as well as discharge from the practice.

I will not share, sell or otherwise permit others to have access to these medications.

I HAVE READ THIS FORM OR HAVE HAD IT READ TO ME. I UNDERSTAND ALL OF IT. I HAVE HAD A CHANCE TO HAVE ALL OF MY QUESTIONS REGARDING THIS TREATMENT ANSWERED TO MY SATISFACTION. BY SIGNING THIS FORM VOLUNTARILY, I GIVE MY CONSENT FOR TREATMENT OF PAIN WITH OPIOID MEDICATIONS.

I UNDERSTAND AND AGREE THAT FAILURE TO ADHERE TO THESE POLICIES WILL BE CONSIDERED NONCOMPLIANCE AND MAY RESULT IN CESSATION OF OPIOID PRESCRIBING BY MY PHYSICIAN AND POSSIBLE DISMISSAL FROM THIS CLINIC.

_____ _____

Patient Signature Date

_____

Patient Name (Print)

_____

Witness Initials

HIPAA Notice of Privacy Practices

Office of Internal Medicine, PC
1325 Eastmoreland, Suite 550
Memphis, TN 38104
(901) 726-0843

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment:
We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment:
Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations:
We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, **authorization** or opportunity to object unless required by law. **You may revoke the authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Notice of Privacy Practices Acknowledgment

Office of Internal Medicine, PC
Revised 2/26/18

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

Patient Name or Legal Guardian (print) Date

_____

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date:_____ Attempt:_____

Staff Name:_____

OFFICE OF INTERNAL MEDICINE, PC

HEALTH QUESTIONNAIRE

PLEASE NOTE THAT ALL INFORMATION CONTAINED IN THIS QUESTIONNAIRE IS STRICTLY CONFIDENTIAL AND BECOMES PART OF YOUR MEDICAL RECORD.

NAME: _____ DATE OF BIRTH: _____/_____/_____

◯ MALE ◯ FEMALE MARITAL STATUS: ◯ SINGLE ◯ MARRIED ◯ WIDOWED

PERSONAL HEALTH HISTORY

PAST MEDICAL HISTORY: ◯ HYPERTENSION ◯ DIABETES ◯ STROKE ◯ THYROID ◯ HIGH CHOLESTEROL
◯ HEART DISEASE ◯ OTHER: _____
_____
_____

SURGERIES & PROCEDURES:
_____
_____
_____
_____

TOP 3 COMPLAINTS:
1) _____
2) _____
3) _____

LIST OF YOUR PRESCRIPTION DRUGS AND OVER-THE-COUNTER DRUGS (VITAMINS, FOR EXAMPLE):
DRUG NAME & DESCRIPTION: HOW OFTEN TAKEN?
_____
_____
_____
_____
_____
_____
_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? ◯ YES ◯ NO
IF YES, WHAT MEDICATION(S) AND WHAT REACTION DID YOU HAVE?
_____

PERSONAL HEALTH HABITS

EXERCISE: ◯ NO EXERCISE ◯ MILD EXERCISE (CLIMB STAIRS, WALK 3 BLOCKS, GOLF)
◯ OCCASIONAL VIGOROUS EXERCISE (WORK OR RECREATION, LESS THAN 4 X PER WEEK FOR 30 MINS)
◯ REGULAR VIGOROUS EXERCISE (WORK OR RECREATION, MORE THAN 4 X PER WEEK FOR 30 MINS)

DIET: ARE YOU CURRENTLY DIETING?
IF SO, ARE YOU FOLLOWING A PHYSICIAN PRESCRIBED DIET PLAN? ◯ YES ◯ NO
NUMBER OF MEALS YOU EAT IN AN AVERAGE DAY: _____
SALT INTAKE: ◯ HIGH ◯ MEDIUM ◯ LOW
FAT INTAKE: ◯ HIGH ◯ MEDIUM ◯ LOW
CAFFEINE: ◯ NONE ◯ COFFEE ◯ TEA ◯ COLA # OF CUPS/DAY? _____

ALCOHOL: DO YOU DRINK ALCOHOL? ◯ YES ◯ NO
BEER / LIQUOR / WINE (CIRCLE) HOW MANY DRINKS PER WEEK? _____

TOBACCO: DO YOU USE TOBACCO? ◯ YES ◯ NO
◯ CIGARETTES - # PACKS/DAY: _____ ◯ CHEW - # CANS/DAY: _____
◯ PIPE - #/DAY: _____ ◯ CIGARS - #/DAY: _____

OF YEARS OF TOBACCO USE: _____ AND/OR YEAR QUIT TOBACCO USE: _____

FAMILY MEDICAL HISTORY

PLEASE INDICATE WHETHER MOTHER, FATHER, SIBLINGS, GRANDMOTHER OR GRANDFATHER HAVE HAD:

HEART DISEASE: _____
HIGH BLOOD PRESSURE: _____
DIABETES: _____
CANCER: _____
OTHER DISEASE (PLEASE NAME DISEASE): _____
_____
_____
_____
_____