Bluegrass Legacy Healthcare
105 Glen Oak Blvd, 202
Hendersonville, TN 37075

PATIENT INFORMATION SHEET

Legal Name (print): _____ Date: _____

M ____ F____ Marital Status: M S W D Do you have a living will? Y ____ N ___ (if yes, please provide to the office)

Address: _____ City/State/Zip: _____

(___) _____ (___) _____ _____
Contact Phone Number Work Phone Number Patient Employer

_____ _____ _____
Social Security Number (Reg) Date of Birth Referred By

_____ (____) _____ _____
Spouse's Name Spouse's Contact Number Spouse's Date of Birth

_____ (___) _____ _____
Emergency Notification Phone Number Relationship

Insurance (Primary): _____ ID# _____ Group# _____

(Secondary): _____ ID# _____ Group#_____

_____ _____ _____
Insured Name Relationship Date of Birth

I hereby acknowledge that I have carefully read and understand the "Financial Policy"'' "Office Guidelines" and "Notice of Privacy Practices for Health Information" describing how my medical information may be used and disclosed by the office of Bluegrass Legacy Healthcare as well as how I may obtain access to the information.

I agree to the terms and conditions of the "Financial Policy" and "Office Guidelines" a copy of which is available upon my request.

_____ _____
Signature Date

I hereby authorize the office of Bluegrass Legacy Healthcare to release information concerning my medical history including insurance information, payments and billing in inquires solely to the person(s) listed below. ***Other than myself.***

_____ _____
Name Address/Phone

PATIENT HISTORY

Date:

First Name _____ Middle _____ Last _____

SSN: ___-___-_____ Occupation _____ Date of Birth: ___/___/_____

Gender: ___M ___F ___Other Marital Status _____ Number of Children _____

Medications – (List ALL medications you are currently taking, including Over-the-Counter ones)

Drug Name	Dosage	Freq.

Allergies – (List your allergies including any medications that caused an allergic reaction)

List ALL Allergies	**Allergic Reaction**

PAST MEDICAL HISTORY – *Please provide a complete history including all illnesses, injuries, hospitalizations and operations.*

List ALL Illnesses, Injuries & Operations	**Date**	**Hospital**	**Treatment**	**Physician**	**Response**

Immunizations/Vaccinations/Dates

___DPT ___/___/_____ ___Measles ___/___/_____

___Smallpox ___/___/_____ ___Polio ___/___/_____

___Typhoid ___/___/_____ ___Mumps ___/___/_____

___Tetanus ___/___/_____ ___MMR ___/___/_____

Pneumoccocal ___/___/_____

Influenza ___/___/_____

Blood Type _____

No. of Transfusions _____

Date(s) _____

_____

Reason(s) _____

_____

_____

Last Chest X-ray: _____

___Normal ___Abnormal

Last TB Skin Test: _____

___Positive ___Abnormal

Last EKG: _____

Last Eye Exam: _____

FAMILY HISTORY – *(Please list all **Blood Relatives** with their current health status and any illnesses they have had or now have.*

List Blood Relatives	***Health Status***	***Age (if living)***	***Age at death***	***Cause of Death***	***Illnesses***
Father					
Mother					
Brother(s)					
Sister(s)					

SOCIAL HISTORY *(Please check the appropriate boxes and fill in the accurate amounts of standard portions)*

Mental Work ___*Light* ___*Moderate* ___*Heavy* *Hours per day:*_____

Physical Work ___*Light* ___*Moderate* ___*Heavy* *Hours per day:*_____

Exercise ___*Light* ___*Moderate* ___*Heavy* *Hours per week:*_____ *Type of Exercise:* _____

Diet ___*Low Sodium* ___*Diabetic* ___*Low Fat* ___*Vegetarian* ___*Low Cholesterol* *Other:* _____

Alcohol ___*Never* *Beer(s)* ____*per week* *Liquor* ____*per week* ____*Wine per week How many years?* _____
Smoking ___*Never* ____*Current* _____*Previous* *Packs per day:* ___ *How many years?* _____
Caffeine: ____*None* _____ *Cups per day:* ____ *How many years?* ____ *Other:* _____
Aspirin: ___*None* *Qty per day:* ____ *How many years?* ____ *Other:* _____
Misc. Drugs: ___*Amphetamines* ___*Antacids* ___*Cocaine* ___*Diet Pills* ___*Laxatives* ___*Marijuana* ___ *Nutrasweet*
___*Pain Pills* ___*Saccharin* ___*Sleeping Pills* ___*Vitamins* *Other:*_____

REVIEW OF SYMPTOMS – CHECK ONLY THE ONES YOU NOW HAVE OR HAVE HAD RECENTLY

GENERAL
- o WEAKNESS
- o FATIGUE
- o FEVER
- o MALAISE
- o CHILLS
- o NIGHT SWEATS
- o FAINTING
- o DIZZINESS
- o NONE

SKIN
- o COLOR CHANGES
- o NAIL CHANGES
- o HAIR CHANGES
- o MOLES
- o RASHING
- o ITCHING
- o SORES
- o DRYNESS
- o NONE

HEAD
- o HEADACHES
- o INJURIES
- o BUMPS
- o NONE

EYES
- o CONTACTS
- o CATARECTS
- o BLURRED VISION
- o GLAUCOMA
- o REDNESS
- o ITCHING
- o BURNING
- o SWELLING
- o PAIN
- o DRYNESS
- o TEARING
- o NONE

EARS
- o HARD OF HEARING
- o DEAFNESS
- o RINGING
- o DISCHARGE
- o EARACHE
- o ITCHING
- o LOSS OF BALANCE
- o DIZZINESS
- o ROOM SPINS
- o NONE

NOSE
- o DECREASED SMELL
- o BLEEDING
- o PAIN
- o OBSTRUCTION
- o POST NASAL DRIP
- o DEVIATED SEPTUM
- o RUNNY NOSE
- o SINUS CONGEST
- o NONE

MOUTH
- o BLEEDING GUMS
- o SORES
- o DENTAL PROBLEMS
- o PAIN
- o BAD BREATHE
- o LOSS OF TASTE
- o DRYNESS
- o ULCERS
- o BLISTERS
- o NONE

THROAT
- o SORE THROAT
- o BAD TONSILS
- o HOARSENESS
- o PAIN
- o HARD TO SWALLOW
- o RECURRENT INFECTIONS
- o WHITE SPOTS
- o NONE

NECK
- o ENLARGEMENT
- o STIFFNESS
- o SORENESS
- o PAIN
- o LUMPS
- o MASSES
- o NONE

BREASTS
- o DISCHARGE
- o NODULES
- o PAIN/TENDERNESS
- o CHANGES
- o SKIN
- o BLOATEDNESS
- o MASSES
- o BLEEDING
- o NONE

LUNGS
- o COUGH
- o PHLEGM
- o COUGHED BLOOD
- o SHORTNESS OF BREATHE
- o WHEEZING
- o PAIN IN LUNGS
- o CHEST CONGESTION
- o INHALANT EXPOSURE
- o NONE

HEART
- o MURMUR
- o PALPITATIONS
- o RAPID HEARTBEAT
- o SWOLLEN EXTREMITIES
- o TIGHTNESS/PRESSURE
- o CHEST PAINS
- o VARICOSE VEINS
- o BLOOD CLOTS
- o BLUE EXTREMITIES
- o NONE

BLOOD
- o BROKEN BLOOD VESSELS
- o ANEMIA
- o EASY BRUISING
- o PROLONGED BLEEDING
- o SWOLLEN NODES
- o PAINFUL NODES
- o RED DOTS/SPOTS
- o NONE

GASTROINTESTINAL
- o ABDOMINAL PAIN
- o NAUSEA
- o VOMINTING
- o BLOATEDNESS
- o BELCHING
- o HEARTBURN
- o INDIGESTION
- o IRREGULAR BOWELS
- o CONSTIPATION
- o DIARRHEA
- o GAS
- o HEMORRHOIDS
- o HERNIA
- o POOR APPETITE
- o FOOD INTOLERENCE
- o BLOODY STOLLS
- o BLACK TARRY STOOLS
- o EXCESSIVE APPETITE
- o RECTAL BLEEDING
- o NONE

GENITOURINARY
- o URGENCY
- o INCONTINENCE
- o STRAINING
- o FLANK PAIN
- o STONES
- o BURNING
- o BED WETTING
- o BLOODY
- o SMALL STREAM
- o URETHRAL DISCHARGE
- o DRIBBLING
- o CLOUDY URINE
- o UNUSUAL COLOR
- o URINATION AT NIGHT
- o HESITANCY
- o NONE

GYNECOLOGICAL
- o BREAKTHROUGH BLEEDING
- o MENSTRUAL CRAMPS
- o POST MENOPAUSAL
- o VAGINAL DISCHARGE
- o VAGINAL ITCHING
- o LABIAL SORES
- o LABIAL LUMPS/NODULES
- o IRREGULAR MENSES
- o PAINFUL INTERCOURSE
- o HOT FLASHES
- o PAIN BETWEEN MENSES
- o LOSS OF LIBIDO
- o MOOD SWINGS
- o NIGHT SWEATS

(GYN. DATES)
MENSTRUAL FLOW
O LIGHT O MODERATE O HEAVY
DATE OF LAST MENSES ___/____
LAST PAP SMEAR ____/____
LAST MAMMOGRAM ___/____
DURATION OF CYCLE _____(21-30 days)
DURATION OF FLOW _____(3-7 days)
AGE AT 1ST PERIOD_____
AGE AT MENOPAUSE _____
CONTRACEPTION O NO O YES
TYPE _____
NO. OF PREGNANCIES _____
NO. OF STILL BIRTHS _____
NO. OF LIVE BIRTHS _____
NO. OF MISCARRIAGES _____
NO. OF ABORTIONS _____
NONE

MUSCULOSKELETAL
- o PAIN
- o WEAKNESS
- o CRAMPS
- o TWITCHING
- o JOINT STIFFNESS
- o JOINT DEFORMATIES
- o JOINT PAIN
- o JOINT SWELLING
- o INJURIES
- o CURVATURE OF SPINE
- o BACK PAIN
- o HOT JOINT
- o NONE

NEUROLOGICAL
- o SEIZURES
- o VERTIGO
- o HAND TREMBLING
- o LOSS OF SENSATION
- o INCOORDINATION
- o LOSS OF FACIAL EXPRESSIONS
- o WEAK GRIP
- o PARALYSIS
- o SLURRED SPEECH
- o TINGLING/BURNING/NUMBING
- o LOSS OF MEMORY
- o LACK OF CONCENTRATION
- o DISORIENTATION
- o GAIT SHUFFLING
- o NONE

PSYCHIATRIC
- o HYPERTENSION
- o INSECURITY
- o DEPRESSION
- o INSOMNIA
- o IRRITABILITY
- o ANXIOUSNESS/STRESS
- o INDECISIVENESS
- o TIMID/SHY/BASHFUL
- o HALLUCINATIONS
- o ALCOHOL ABUSE
- o DRUG USE
- o SUICIDAL THOUGHTS
- o WORRYING
- o OBSESSIVENESS
- o MANIA/DEPRESSION
- o MULTPLE PERSONALITIES
- o SEXUAL DIFFUCULTIES
- o NUMBNESS
- o PANIC ATTACKS
- o COMPULSIVENESS
- o NONE

ENDOCRINE
- o WEIGHT LOSS
- o WEIGHT GAIN
- o HOARSENESS
- o HEAT INTOLERANCE
- o COLD INTOLERANCE
- o BREAST CHANGES
- o LOSS OF HAIR
- o EXTREME THIRST
- o VOICE CHANGES
- o EXCESSIVE HAIR
- o HYPOGLYCEMIA
- o DIABETES
- o NONE

RESPONSBILITY FOR PAYMENT/CONSENT TO TREAT

Patient/guarantor is responsible for all charges incurred. You are responsible for any copayments, deductibles, and/or unpaid percentage of what the insurance company does not pay. Unpaid balances are due and payable within 30 days of notice. Accounts that are 90 days past due will be placed in collections and patient agrees to pay all costs of collection, including, reasonable attorney's fees.

It is responsibility of the patient to assure that the most current insurance cards are presented at the time of service and are on file with this office.

If you're unable to keep your scheduled appointment, you are to notify this office within eight hours prior to the appointment time. Failure your desire will result in a charge of $45 assist gives your account and is not available to your insurance carrier.

I hereby consent to care by all healthcare providers an officer Bluegrass Legacy Healthcare and I authorize to administer search treatment as they may deem necessary for my diagnosis and treatment. I understand that these services are voluntary and that I have the right to refuse these services.

Signature _____ Date_____

Witness _____ Date _____

Do you have a Living Will? Yes ____ No ____. If so, please provide us with a copy.

****

Medicare certification for payment
(If applicable)

An applying for payment under the title XV 11 of the Social Security act is correct and I authorize any holder of my medical information to release to the Social Security administration or its intermediate or carriers any information needed for related Medicare claims. I request the payment of authorized benefits made on my behalf, and I assign the benefits payable for physicians' services to the provider furnishing the service to authorize such provider to submit a claim to Medicare for payment for me.

Signature _____ Date _____

Social Security#_____ Medicare Effective Date _____

BLUEGRASS LEGACY HEALTHCARE, PLLC

Abigail J Eubank, MSN, GNP

AUTHORIZATION TO RELEASE MEDICAL RECORDS/INFORMATION

Physician to release records: _____

Address: _____

_____

Physician phone#: _____ Physician fax#: _____

Patient name: _____

Social Security #: _____ DOB: _____

Facility to receive records: _____ BLUEGRASS *LEGACY HEALTHCARE, PLLC*_____
Address: _____105 Glen Oak Blvd, 202____
City, State Zip*:* _____Hendersonville, TN 37075_____
Phone :_____(615) 826-2265 _____ *Fax*: ____(615) 826-4616_____

IF YOU DO NOT WANT CERTAIN PORTIONS OF YOUR MEDICAL RECORDS RELEASED, PLEASE READ THIS SECTION CAEFULLY AND INITIAL THE BOXES FOR INFORMATION YOU DO NOT WANT ELEASED. OTHERWISE, YOUR RECORDS WILL BE RELEASEED AS SPECIFIED ABOVE.

I authorize the health care provider to release the information specified to the organization, agency, or individual named on this request with the EXCEPTION of:

Initials
_____ Substance abuse, if any
_____ Psychological or psychiatric conditions, if any

Initials
_____ AIDS/HIV, if any

Other (please specify): _____

Expiration or revocation of authorization- I understand that I may revoke this authorization at any time and that unless an earlier date is specified it will automatically expire 12 months after the date affixed below. Use of copies- a copy of this authorization may be utilized with the same effectiveness as an original.

Patient name: _____
Please Print

_____
Patient's signature

Date:_____

Person authorized to sign for patient: _____
Print Name

_____
Signature

_____
Relationship

Date: _____

Office guidelines

Thank you for choosing Bluegrass like to see healthcare as your healthcare provider. We are committed to your pleasant and successful treatment. The rest Legacy healthcare is committed to operating his business based on honesty and integrity. We have developed the following guidelines to sure that patients and staff meet these criteria. **Please initial before each point.**

____***Patient information***-Federal law (HIPAA) requires that no patient information will be given to anyone but the patient unless authorized by the patient in writing. We will follow this law without exception. In addition authorized persons must be prepared by their name and Social Security number and/or date of birth of patient you were calling about. Please inform your authorized person of this policy.

____***Medicine/Refills***-Please bring all medication to your office visit so the doctor can review dates, quantities and resale needs at that time. Some call in refills are permitted no pain, antibiotic the mood altering drugs. It's your responsibility to monitor your prescription refill meds between visits. Please do not wait until you were almost out or have taken your last dosage to get a refill. Except for emergencies please allow five business days for processing prescription refills that you have faxed or phoned in, please inform your pharmacy of this policy to avoid multiple faxing. There will be a $5.00 charge for any prescription refills not obtained at office visits.

____***Physicals***–Our nurse practitioner performs all physicals and all prostate examination. When you call to schedule your physical, please ensure that your insurance will pay for the service. Some insurance companies will not pay for preventative care. As a result, you may are asked to sign a waiver ABN in which will allow our office to bill you directly for the service. Please contact your insurance carrier to confirm coverage will be available.

____***Referrals***–If your insurance requires a referral, we will gladly do so. Due to the many insurance changes regarding the referral policy please keep in mind that there will be an increased demand for referrals and prior authorizations. Depending on your insurance, please allow at least 5 business days to process your referral. You will be contacted by phone when referral is complete, at which time you may call the specialist's office to set-up your appointment at your convenience. Same day referrals can only be done for emergencies or directed by a nurse practitioner. It is patient's responsibility to ensure that all referrals are up-to-date before seeing a specialist. As a policy at the office we do not back date referrals.

____***Calls***–Please give your name and the purpose of your call, so that we may direct you to the correct person in a timely manner. We strive to minimize inconveniences to a patient who are waiting to be seen, except for emergencies, calls for drug refills, and answers to patient concerns are only done after all patients have been seen for the day, which at times can be very late. We asked that you please help us to minimize phone calls and inconveniences to everyone by covering all your questions and medicine needs during your regular office visit.

____***Appointment changes***–Once an appointment is made we require at least an 8 hour notice to change cancel, unless the need is deemed an emergency. After hours, messages can be left for the answering service and still qualify for sufficient time. Patients who change/cancel or fail to keep their appointments under this criteria three times may be discharge from practice. At times, the office schedules appointments 3 to 4 weeks in advance, therefore, it may take several weeks to get you back into the schedule if you change/cancel your appointment.

____***Inappropriate behavior and or verbal abuse***-Including but not limited to, loud and/or vulgar language, sexual or racial comments, making false statements or asking this office to make false statements regarding your health information. This behavior via phone or in person to any member of the office staff is grounds for discharging a patient from his practice. Our staff is here to help and should be treated with respect.

____***Waiting area***–As always we try to see patients as quickly as possible. However; there are times that we have delays, please be patient with us. If this occurs and you want to reschedule your appointment, we will work with you as best we can to get you back into the schedule in a timely manner. We want to give all patients the time and attention they deserve. Please do not call the office and ask for a provider to call back. We do not diagnose or give advice over the phone if you feel that you need to speak with a provider then you will have to make an appointment. The provider is busy and with patients in the office and can't stop to take a call.

Financial Policy

Thank you for choosing Bluegrass Legacy Healthcare as your healthcare provider. We are committed to your pleasant and successful treatment. Please understand paying your bill is considered a part of your treatment. The following is a statement of our financial policy, which we require you to read prior to treatment. Our practice is committed to providing the best treatment for our patients and the charges are based upon usual and customary fees for our area. Thank you for understanding the need for the financial policy. Please let us know if you have questions or concerns.
Please initial before each point*.*

_____***Copayments***- Contracts with your insurance company require the copayment to be collected at time of service. For your convenience we accept checks debit cards Visa MasterCard. We do have a two dollar charge for debit and credit cards. If you're unable to make this payment you will be rescheduled for a different time.

_____***Insurance-*** You are responsible for assuring that this office has the correct insurance information for filing your claims. If you have Medicare as your primary insurance, please contact your secondary insurance through coordination of benefits for them to cross over for payment we will file the claim and will promptly send a statement for the balance. Please keep them on that claim payments are very vital to any medical practice and any remaining balance, after the insurance has paid, will be your responsibility. Patients who are without insurance shall be responsible for payment of charges at the time of service. If you unable to make this payment please make your arrangements in advance of your appointment time.

_____***Account Balances***- Statements will be sent on a monthly basis and are due within 30 days. If you receive a statement that you feel is incorrect, please call our office immediately. Large account balances can be paid by monthly installments but must be approved by the office manager. *Accounts that remain unpaid after 90 days with unsuccessful attempts to work out an acceptable payment plan, will be sent to collections and our healthcare relationship with you will be terminated.* All cost of collections including reasonable attorney fees, will become the responsibility of the patient. Once your account is sent to collections, we cannot reconsider and make arrangements for you to pay through the office. If this becomes necessary, as a courtesy to you we will take care of all of your non-narcotic, non-mood altering drug refills for 30 days to allow time for you to find another healthcare provider. We would prefer to work out of such satisfactory arrangement for you to pay rather than to send your account to collections.

_____***Check*** Privileges- If you pay by check please assure that there are sufficient funds in your account to take care of the transactions we must charge a fee to cover the cost assist against our account for any account checks returned for insufficient funds. To pay off the return check the amount of the check plus the return check fee of $30 must be paid by cash, money order or debit/credit card.

_____***Letters/Forms***- These items require research and documentation of the doctor and are very time-consuming creating additional cost to the office. Therefore a fee of $25-$50 depending on the amount of information requested for any letters or forms requested by patients to be filled out by the provider must be paid in advance before letters or forms are released. The fee for family consultations is $90 payable of time of consult.

_____ _____

Patient name or responsible party Date