



Patient Information:

Last Name _____ First Name _____ Middle _____
Male/Female _____ SS# _____ Marital Status _____ Date of Birth _____
Race _____ Ethnic Group _____ Primary Language Spoken _____
Street Address _____ City/State _____ Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____
Email Address _____ Preferred Reminder Method _____ Text _____ Email
Preferred Pharmacy _____

Emergency Contact:

Name _____ Relationship _____ Phone _____

Responsible Party Information (If not Self)

Full Name _____
Street Address _____ City/ State _____ Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____
Date of Birth _____ Marital Status _____ SS# _____ Relationship _____

* How did you hear about us? _____ Source Magazine _____ Facebook _____ Instagram
_____ Internet _____ Billboard _____ Family/ Friend: _____
_____ Other: _____

I hereby authorize and direct payment to better weighs to better health for medical benefits. I understand that I am financially responsible for the charges of services. I understand that checks returned for nonpayment will result in a \$30.00 fee. I Understand that regardless of my insurance status I am solely responsible for payment of any services rendered to me, or on my behalf.

Patient/ Responsible Party Signature: _____

Date: _____

Inclement Weather Policy

In the event of inclement weather, please call our office to confirm we are open.

Appointment No Show Policy

It is the policy of better weighs to better health to monitor and manage appointment no shows. Any patient who fails to arrive for a scheduled appointment without cancelling the appointment less than 24 hours prior to the scheduled time is considered a “no show.” The no-show patient fee is \$50.00, as set by better weighs to better health, for failure to show.

_____ Please Initial Here

Medication Refill Policy

It is the responsibility of each patient to bring all their medications, in the original bottle, to each visit.

Lists of medication are not acceptable due to possible error and lack of information.

It is imperative to notify the nurse if there is a need for any refills at the time of each visit. Calling at a later time for refills may cause a delay in receiving your medications.

Please allow at least 24-48 hours for medication refills that are requested by call in.

_____ Please Initial Here

Forms Requests

There will be a \$30.00 charge for certain forms that require the doctor to complete. Please Allow 5-7 business days to complete.

Patient Signature

Date

HIPPA Notice of Privacy Practices

Better Weighs to Better Health

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

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment of 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 or condition and relates 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 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, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For Example, your protected health information may be provided to a physician 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.

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 activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities.

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 and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required uses and Disclosures: Under the law we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with YOUR consent, Authorization or opportunity to object unless required law.

You may revoke this 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.

Patient Signature

Date



725 W. Market Street Suite B
Athens, AL 35611
Phone: 256-777-4965 Fax: 833-714-2128

DUE TO THE PRIVACY CONFIDENTIAL ACT, please list the people that you approve to have access to your information as stated below:

Billing Information: _____ **Relationship:** _____
_____ **Relationship:** _____
Medical Information: _____ **Relationship:** _____
_____ **Relationship:** _____

Authorization to Leave Messages:

I hereby authorize **better weighs to better health** staff to leave messages regarding my medical condition, such as lab reports, other test results, medications, and appointment reminders on my home answering machine. This authorization will be in effect until I have given written notice to **better weighs to better health**.

Check one of the following:

Agree _____

Disagree _____

We are required by law to maintain privacy of and provide individuals with a notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our Office Manager.

Signature below is acknowledgement that you have received this Notice of our Privacy Practices and agree to all the information listed above. Signature below also indicates that you have received a copy of the HIPPA agreement.

Print Patients Name: _____

Patients Date of Birth: _____

Signature of Patient or Patient's Representative

Date

Better Weighs to Better Health

Name _____

Patient Health Assessment

Telephone _____

D.O.B _____

Life Habits:

Yes No

_____ Do you live alone? If no, with whom do you live? _____

_____ Have you ever used nicotine? (Circle Cigarettes, Cigar, Pipe) How much per day? _____
For how many years? _____

_____ Do you currently use nicotine? If yes, what do you use?(Cigarettes, Cigar, Pipe, Smokeless tobacco)
How much per day? _____ For how many years? _____

_____ Do you currently use alcohol? If yes how much per day? _____ How often? _____
Past use? _____

_____ Do you currently use any illicit drugs? If yes, How often? _____
Past use? _____

_____ Do you have problems sleeping? _____ If yes,
explain _____

Domestic Violence:

Yes No

_____ Are you being abused, injured or frightened by anyone at home or in another area of your life?

Beliefs, Rights, & Values

Yes No

_____ Do you have ethnic, religious, spiritual, or cultural practices that need to be a part of your care?

_____ Do you have financial concerns related to your medical care? Please List: _____

_____ Do you have children? How Many? Adult _____ Minor _____

_____ Do you have a guardian? If yes, whom? _____

_____ Do you have an Advanced Directive (e.g living will or durable power of attorney) If yes, bring a copy
with you to the office upon your admission. If not, information is available upon request.

_____ Are you an organ/tissue donor?

Please provide a list of **ALL** specialist you currently see below:

Better Weighs to Better Health

Name: _____

Date of Birth: _____

Check the box if the condition pertains to you and write comments if necessary.

Respiratory

Comment

- _____ Asthma _____
- _____ COPD _____
- _____ Emphysema _____
- _____ Sinus Problems _____
- _____ Sleep Apnea _____
- _____ TB _____
- _____ Other _____

Gastrointestinal

Comment

- _____ Constipation _____
- _____ Diarrhea _____
- _____ Diverticulitis _____
- _____ GERD _____
- _____ Heartburn _____
- _____ Hepatitis _____
- _____ Hiatal Hernia _____
- _____ Jaundice _____
- _____ Other _____

Genitourinary

Comment

- _____ Kidney Disease _____
- _____ Kidney Stone _____
- _____ Prostate Disease _____
- _____ UTI _____
- _____ Other _____

Other Conditions

Comment

- _____ Anxiety _____
- _____ AIDS/HIV _____
- _____ Cancer _____
- _____ Cataracts _____
- _____ Depression _____
- _____ Diabetes _____
- _____ Eye Problems _____
- _____ Glaucoma _____
- _____ Hearing Problems _____
- _____ Peripheral Artery DZ _____
- _____ Rheumatic Fever _____
- _____ STD _____
- _____ Thyroid Disease _____
- _____ Other _____

Neurological

Comment

- _____ Dementia _____
- _____ Fibromyalgia _____
- _____ Osteoarthritis _____
- _____ Osteopenia _____
- _____ Osteoporosis _____
- _____ Other _____

Musculoskeletal

Comment

- _____ Arthritis _____
- _____ Chronic Headaches _____
- _____ Faint/Dizziness _____
- _____ Migraines _____
- _____ Numbness/Weakness _____
- _____ Seizures _____
- _____ Stroke _____
- _____ Other _____

Previous Surgeries

| DATE | Reason |
|-------|--------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Cardiovascular

Comment

- _____ Anemia _____
- _____ Angina _____
- _____ Heart DZ _____
- _____ CHF _____
- _____ Heart Attack _____
- _____ High Blood Pressure _____
- _____ High Cholesterol _____
- _____ Pacemaker _____ Valve _____
- _____ Problem _____
- _____ Other _____

Are there any other Medical Conditions not listed above? Please list them on the back of form.



Release for Medical Records

Date: _____

Patient's Name: _____ DOB: _____

I hereby authorize **Better Weighs to Better Health, LLC** to use, disclose, and/or obtain my health information.

**To Include: Most Recent Office Notes and Labs - All Medical Records and Labs
(Please circle which applies)**

From: _____

Physician's Name or Facility Name

Street Address

City State Zip

I hereby request that my medical records be released to:

Better Weighs to Better Health, LLC
725 W. Market St. Ste. B Athens, AL 35611
Phone: (256)787-2924
Fax: (256)408-9971
Email: info@betterweighs.com

Melissa Gray, MD
Barrett Teeples, CRNP, FNP-BC
Savannah Pointer, CRNP, FNP-C
Sherry Clouch, AGACNP-BS

Signature of Patient: _____ Today's Date: _____