NASHVILLE FAMILY MEDICAL CLINIC

Date: _____ Sex: M____ F____ DOB: ___/____/_____

First Name: _____ Last Name_____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Cell #_____-_____-_____ Home #_____-_____-_____

Race: _____ Language: _____ Ethnicity:_____

Marital Status: M__S__D__W__ SS#_____/_____/_____

Employer: _____ Work #_____-_____-_____

Email: _____

Emergency Contact: _____ Cell #_____-_____-_____

Relationship to Patient: _____

Do you have a Living will? Yes___ No____ Unknown___

Fill the space below If patient is under 18 years of age.

Parent/guardian Name:_____
DOB:_____/____/_____ SS#:_____/____/_____

Authorization to pay benefits and release information:

I hereby authorize my insurance company to make payment directly to Nashville Family Medical Clinic for medical and/or surgical services rendered. The physician may also release medical information obtained during the course of treatment of any labs, hospital, physician and responsibility regardless of insurance coverage or third-party liability. If my account must be placed judgments in courts of law bear interest at the legal rate allowed.

Signature of patient or responsible party: _____ Date: _____

Insurance Information

Name: _____

Date of Birth: _____

Name of Insurance: _____

_____

ID# _____

Group # _____

Hipaa Privacy Authorization For Use And Disclosure Of Personal Health Information

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104 -191), 42 U.S.C. Section1320d, et. seq., and regulations promulgated thereunder, as amended from time to time (collectively referred to as "HIPAA").

This authorization affects your rights in the privacy of your personal health care information (PHI). Please read it carefully before signing.

Nashville Family Medical Clinic, will not condition treatment payment, enrollment in a health plan, or eligibility for benefits, as applicable, on your providing authorization for the requested use or disclosure. YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

By signing this authorization you acknowledge and agree that Nashville Family Medical Clinic may use or disclose your personal health care information for the purpose of continuation of care.

By signing this authorization you agree that Nashville Family Medical Clinic or its Business Associates may disclose your personal health care information to other doctors or health care ficilities for continuation of care.

Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand Nashville Family Medical Clinic's HIPAA Privacy Notice containing a complete description of your rights, and the permitted use and disclosure, under HIPAA. While Nashville Family Medical Clinic has reserved the rights to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available from Nashville Family Medical Clinic in the office or by sending a written request with return address to 476 Harding Place, Nashville,TN, 37211.

In accordance with your rights under,and subject to certain restrictions imposed by, HIPAA, you may inspect or copy your personal health information in the designated record set maintained by Nashville Family Medical Clinic for as long as personal health information is maintained in the designated record set.

You have the right to revoke this authorization, in writting, at any time, except to the extent that Nashville Family Medical Clinic has taken action in reliance on it. A revocation is effective upon receipt by Nashville Family Medical Clinic of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.

This authorization shall expire upon the earlier occurrence of: (a) revocation of the authorization: (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with

requirements of HIPAA ;(c) complete satisfaction of the purpose for which this authorization was originally obtained, to be determinded in the reasonable discretion of Nashville Family Medical Clinic ; or (d) six years from this date this authorization was executed.

By signing this authorization you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for redisclosure by the recipient and no longer protected under HIPAA.

Nashville Family Medical Clinic will provide

_____(patients name) with a copy of this signed authorization.

Acknowledge and agreed to by:

PATIENT:

BY_____

Date _____

Print Name_____

Address_____

_____

_____

or, ON BEHALF OF PATIENT

BY_____

Date_____

Print Name_____

As_____

Address:_____

_____

_____

Translation Services

Blue Care of TN
Hotline: 1-888-418-0008

Amerigroup of TN
Hotline: 1-877-227-6138

United Healthcare Community Plan
Hotline: 1-800-690-1606

Catholic Charities of TN
615-352-3087
2806 McGavock Pike
Nashville, TN 37214
Hrs: Monday through Friday 8-12 and 1-7:30

Bridges for the Deaf and Hard of Hearing
615-248-8828
bridgesfordeafandhh.org
935 Edgehill Ave, Nashville, TN 37203
Hrs: Monday through Friday 8-5

Additional Languages Spoken in House
Arabic
French
Kurdish
Nepali
Farsi
Pashto
Dari

Nashville Family Medical Clinic

NonDiscrimination Policy/Procedures

We obey federal and state civil rights laws. We do not treat people differently based on their race, religion, color, language, beliefs, birthplace, age, sex or disability of any kind.

We do not refuse care to any patient unless it meets the following criteria:

- If a patient has been dismissed from this practice, then they will receive a letter of termination and be given a grace period of 30 days to find a new PCP.
- For Medicaid patients who are not assigned to Dr. Attoussi and who do not wish to change their PCP, we will refer them to the physician they are assigned to.