Patient Registration Form

(Please Print and Complete Entire Form) Have Insurance Cards and ID ready for Scanning **DATE:**

Last Name:	First:	Preferred Name:	MI:
Sex: ☐Male ☐Female ☐Other	Date of Birth:	SSN#:	
Primary Address:		City, State:	Zip Code:
Mailing Address(if Different from Above):		City, State:	Zip Code:
Home Phone:	Cell Phone:	Work Number:	
How would you like to receive reminders for upcoming appointments: ☐Phone Calls ☐Text Messages ☐None			
Email Address:			
Contact Preference: ☐Home ☐Work ☐Mobile	Would you like to create a Patient Portal account? ☐yes ☐no		
Language:	Race:	Ethnicity: ☐Hispanic ☐Non-Hispanic	Marital Status: ☐Married ☐Single ☐Separated ☐Widowed ☐Partner ☐Divorced

Emergency Contact Name:	Relationship:	Home Phone:	Mobile Phone:

Guardian Last Name:	First:	MI:

Next Of Kin Name:	Relationship:	Phone:

Patient Employer Name:	Employer Phone:	Usual Occupation:

Pharmacy:	Pharmacy Location/City:

INSURANCE INFORMATION

Need to be completed even with card on file

PRIMARY INSURANCE:	SECONDARY INSURANCE:
ID #:	ID#
POLICY/GROUP #:	POLICY/GROUP#:
POLICY HOLDER NAME:	POLICY HOLDER NAME:
POLICY HOLDER ADDRESS:	POLICY HOLDER ADDRESS:
POLICY HOLDER SSN#:	POLICY HOLDER SSN#:
POLICY HOLDER DOB:	POLICY HOLDER DOB:
POLICY HOLDER SEX: ☐Male ☐Female ☐Other	POLICY HOLDER SEX: ☐Male ☐Female ☐Other
EMPLOYER IF DIFFERENT FROM ABOVE:	EMPLOYER IF DIFFERENT FROM ABOVE:

Motley Family Medical
Lucinda Motley, FNP-C

Motley Family Medical

Lucinda Motley, FNP-C

General Consent and Authorization Form

Consent to Treat:

I consent to and authorize the physicians, nurses and other healthcare providers at Motley Family Medical to perform appropriate healthcare examinations, treatment, and diagnostic testing or medication administration as deemed medically necessary by their professional judgment. I know that there are some risks with all medical treatments and procedures and I understand that no one can guarantee how well treatments or procedures will work.

Assignment of Benefits/Payments for Services:

Payment is due at time of service. I authorize payment of any and all benefits to Motley Family Medical. I know that I must pay for any charges for my care that are not covered by my insurance, health plan, or government programs. I realize I must cooperate with Motley Family Medical to get payment for my care. If I am eligible for payment from more than one type of coverage, Motley Family Medical will return any extra payments to the payor. If I have an unpaid bill at Motley Family Medical, any refunds due to me will be put on my unpaid bill. If there is money left over after the bill is paid, I will get a refund from Motley Family Medical

Release of Information:

I consent to the release and use by Motley Family Medical of my protected health information to the extent permitted by law to and for the following:

- To a healthcare provider being advised or consulted in connection with my treatment or care
- To a health plan, insurer, third party payer, third party administrator or other organization providing me with health benefits, for the purposes of claims payment and benefit determinations, fraud investigations, or quality of care studies or reviews,
- To a person or organization in connection with Motley Family Medical's healthcare operations. These operations may include interdisciplinary care conferences, quality improvement activities, performance evaluations, business management and other related activities.
- To leave medical, billing or scheduling information on this voice mail/answering machine number: ( ) _____ - _____.

Other Individuals Authorized to Release Information:

In addition to myself (if minor any other legal guardians of the patient), the following are authorized to speak to my provider or have access to medical record.

Name: **Relationship to patient:**

- 1._____ _____
- 2._____ _____

Motley Family Medical

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Fees:

I acknowledge there are fees not billable to insurance and agree to pay these fees as below

1. Return check fee - $35.00 plus amount of check
2. Records – Copy fee of $20 flat rate if requested by patient
3. Missed Appointment fee - $25.00 for any appointment not cancelled or changed 24 hours in advance.
4. Paperwork - $20 per item not limited to FMLA paperwork, Short Term Disability paperwork, Loan Forgiveness Paperwork, or any other paper not directly related to the visit.
5. This list is not all inclusive. Other fees may arise

Patient Rights and Privacy Practices:

You and your family's rights and our privacy practices are posted in main areas within Motley Family Medical. Your signature acknowledges receipt of our Notice of Privacy Practices. If you have any questions concerning your rights and/or our privacy practices, please contact your care provider.

Other Individuals Authorized to Consent to Treatment:

In addition to the legal guardians of the patient, the following persons are authorized to consent to recommended medical care for me: name and relationship to patient (e.g., significant other, spouse, grandma, grandpa, daycare provider, etc.)

Name:	**Relationship to patient:**
1._____	_____
2._____	_____

My signature here means I have read this information and understand it. This consent is valid until revoked in writing.

Patient Name: _____ Date of Birth: _____

Signature: _____ Relationship to patient: _____

Print name: _____ Date: _____

Name of Interpreter (if used): _____

Interpreter Phone Number: _____

Motley Family Medical

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PATIENT HISTORY FORM

Date: _____/_____/_____

NAME: _____ Birthdate: _____/_____/_____
Last First M. I.

Age:_____ Sex: ☐ F ☐ M

How did you hear about this clinic?

Describe briefly your present symptoms:

Please list the names of other practitioners you have seen for this problem:

Psychiatric Hospitalizations (include where, when, & for what reason):

Have you ever had ECT? Have you had psychotherapy?

CURRENT MEDICATIONS

Drug allergies: ☐ No ☐ Yes To what?

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of drug	Dose (include strength & number of pills per day)	How long have you been taking this?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

Physician initials _____

PAST MEDICAL HISTORY

Do you now or have you ever had:

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hypothyroidism
- ❑ Goiter
- ❑ Cancer (type) _____
- ❑ Leukemia
- ❑ Psoriasis
- ❑ Angina
- ❑ Heart problems
- ❑ Heart murmur
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Asthma
- ❑ Emphysema
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Cataracts
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Anemia
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Stomach or peptic ulcer
- ❑ Rheumatic fever
- ❑ Tuberculosis
- ❑ HIV/AIDS

Other medical conditions (please list):

PERSONAL HISTORY

Were there problems with your birth? (specify)

Where were your born & raised?

What is your highest education? ❑High school ❑Some college ❑College graduate ❑Advanced degree

Marital status: ❑ Never married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Partnered/significant other

What is your current or past occupation?

Are you currently working? : ❑ Yes ❑ No Hours/week _____ If not, are you ❑ retired ❑ disabled ❑ sick leave?

Do you receive disability or SSI? ❑ Yes ❑ No If yes, for what disability & how long?_____

Have you ever had legal problems? (specify)

Religion:

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age (s)	Health & Psychiatric	Age(s) at death	Cause
Father				
Mother				
Siblings				
Children				

EXTENDED FAMILY PSYCHIATRIC PROBLEMS PAST & PRESENT:

Maternal Relatives:

Paternal Relatives:

Physician initials _____

SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL
- ❑ Recent weight gain; how much____
- ❑ Recent weight loss: how much____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

MUSCLE/JOINTS/BONES
- ❑ Numbness
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

Where?

EARS
- ❑ Ringing in ears
- ❑ Loss of hearing

EYES
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness

THROAT
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing
- ❑ Pain in jaw

HEART AND LUNGS
- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Swollen legs or feet
- ❑ Cough

NERVOUS SYSTEM
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss

STOMACH AND INTESTINES
- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Yellow jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools

SKIN
- ❑ Redness
- ❑ Rash
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet

BLOOD
- ❑ Anemia
- ❑ Clots

KIDNEY/URINE/BLADDER
- ❑ Frequent or painful urination
- ❑ Blood in urine

Women Only:
- ❑ Abnormal Pap smear
- ❑ Irregular periods
- ❑ Bleeding between periods
- ❑ PMS

PSYCHIATRIC
- ❑ Depression
- ❑ Excessive worries
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep
- ❑ Difficulties with sexual arousal
- ❑ Poor appetite
- ❑ Food cravings
- ❑ Frequent crying
- ❑ Sensitivity
- ❑ Thoughts of suicide / attempts
- ❑ Stress
- ❑ Irritability
- ❑ Poor concentration
- ❑ Racing thoughts
- ❑ Hallucinations
- ❑ Rapid speech
- ❑ Guilty thoughts
- ❑ Paranoia
- ❑ Mood swings
- ❑ Anxiety
- ❑ Risky behavior

OTHER PROBLEMS:

WOMENS REPRODUCTIVE HISTORY:

Age of first period:
Pregnancies:
Miscarriages:
Abortions:
Have you reached menopause? Y / N At what age?
Do you have regular periods? Y / N

Physician initials _____

SUBSTANCE USE					
DRUG CATEGORY (circle each substance used)	Age when you first used this:	How much & how often did you use this?	How many years did you use this?	When did you last use this?	Do you currently use this?
ALCOHOL					Yes ☐ No ☐
CANNABIS: Marijuana, hashish, hash oil					Yes ☐ No ☐
STIMULANTS: Cocaine, crack					Yes ☐ No ☐
STIMULANTS: Methamphetamine—speed, ice, crank					Yes ☐ No ☐
AMPHETAMINES/OTHER STIMULANTS: Ritalin, Benzedrine, Dexedrine					Yes ☐ No ☐
BENZODIAZEPINES/TRANQUILIZERS: Valium, Librium, Halcion, Xanax, Diazepam, "Roofies"					Yes ☐ No ☐
SEDATIVES/HYPNOTICS/BARBITURATES: Amytal, Seconal, Dalmane, Quaalude, Phenobarbital					Yes ☐ No ☐
HEROIN					Yes ☐ No ☐
STREET OR ILLICIT METHADONE					Yes ☐ No ☐
OTHER OPIOIDS: Tylenol #2 & #3, 282'S, 292'S, Percodan, Percocet, Opium, Morphine, Demerol, Dilaudid					Yes ☐ No ☐
HALLUCINOGENS: LSD, PCP, STP, MDA, DAT, mescaline, peyote, mushrooms, ecstasy (MDMA), nitrous oxide					Yes ☐ No ☐
INHALANTS: Glue, gasoline, aerosols, paint thinner, poppers, rush, locker room					Yes ☐ No ☐
OTHER: specify)_____ _____ _____					Yes ☐ No ☐

Physician initials _____

Motley Family Medical
Lucinda Motley, FNP-C

NARCOTIC CONTRACT

The purpose of this contract is to maintain a safe, controlled treatment plan. I am asking for narcotic medication because other treatments and medications I have received have not provided adequate relief of symptoms. It is unlikely that any medication will completely resolve my symptoms, but for humane reasons, narcotic medication will be given to me as long as my pain continues, provided that I follow the terms of this contract.

I understand that the possible complications of chronic narcotic therapy include: • chemical dependence (addiction) • constipation, which could be severe enough to require medical treatment • difficulty with urination • drowsiness • nausea • itching • slowed respiration

If I take more medication than what is prescribed, a dangerous situation could result, such coma, organ damage, or even death. I understand that if I run out of my medication too soon, or if my medication is stopped suddenly, I could have narcotic withdrawal symptoms which can be very uncomfortable or dangerous. If I become pregnant, there are known or unknown risks to the unborn child which include narcotic addiction and the possibility of the baby experiencing narcotic withdrawal at birth. I am obligated to let my doctors know if I am pregnant, and they will help me find ways of controlling my pain without narcotics.

The terms of this contract include the following:

1. Only one pharmacy will be used for filling narcotic prescriptions. The pharmacy you have selected is: _____ Phone #. _____

2. If it is found that I received a prescription for narcotic medications from a source other than Motley Family Medical, I will be discharged from Motley Family Medical, and any prescriptions for narcotic medication will be discontinued.

3. It is necessary to schedule an appointment to refill medications. It is important to make sure that I have enough medication to get through the weekend or after hours

4. The provider on call or after hours and on weekends **WILL NOT** fill my medications. They do not have charts available for review to make decisions regarding medications.

5. I agree and will sign a release to allow Motley Family Medical providers to communicate with any of my past or consulting providers and any pharmacists regarding my use of medications.

6. I will contact and communicate with Motley Family Medical about narcotic and other pain related medications and side effects. I **WILL NOT** contact providers who do not work at Motley Family Medical regarding the above concerns. If I have a significant side effect that occurs after hours or during the weekend, it is appropriate to go to the emergency room at the nearest hospital.

7. I agree to take the narcotic medication exactly as instructed by Motley Family Medical providers. I am NOT allowed to change dosage amounts or alter the time schedule of taking the medication without talking to a Motley Family Medical staff member.

8. I agree that Motley Family Medical **WILL NOT** replace any lost, stolen, or inaccessible narcotic medications or narcotic prescriptions for any reason.

9. I must keep all regular follow-up appointments as recommended by Motley Family Medical providers. Failure to comply may cause discontinuation of narcotic prescriptions and possible discharge from Motley Family Medical.

10. Motley Family Medical **WILL NOT** accept telephone requests for narcotic prescriptions or refills.

11. All narcotic prescriptions must be picked up by me. If I am too disabled or sick, an exception may be allowed at Motley Family Medical's discretion.

12. I understand that the benefits of narcotic pain medications will be evaluated regularly using the following criteria of pain relief: a. -increase in general functions b. -increase in life activities c. -improvement in pain intensity levels d. -absence of unacceptable side effects e. -if appropriate, possible return to work and maintenance of a job .

13. I agree to periodic urine screens for other medications and drugs if Motley Family Medical providers deem appropriate.

14. I have been given information about the use of narcotic medications and possible risks of side effects including development of tolerance, dependence, addiction, and withdrawal problems due to the medications, and I agree to undergo narcotic administration,

15. I agree to NOT hoard medication or alter the narcotic prescription. These behaviors and other unacceptable behaviors will result in the discontinuation of narcotic prescriptions and possible discharge from Motley Family Medical.

16. I agree to the following: A. that I am **NOT** currently abusing illicit or prescription drugs and that I am not undergoing treatment for substance dependence or abuse. B. That I have never been involved in the sale, illegal pot session, or transport of any drugs. C. For women only: That 1 am not pregnant and that I will inform the physician if I become pregnant.

This form has been fully explained to me, I have read it or have had it read to me, and I understand and agree to the terms of this contract. If any part of this contract as outlined above is broken, I understand that it will result in the immediate discharge from Motley Family Medical and discontinuation of narcotic prescriptions.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

Motley Family Medical
Lucinda Motley, FNP-C

Office Policies

Thank you for choosing Motley Family Medical for your healthcare needs. In order for us to give you our undivided attention, the following policies will be followed.

1. Payment is due at time of service. If you have a deductible, the self pay office visit amount will be collected at time of service.
2. If you are more than 15 minutes late for your appointment, you may be asked to reschedule.
3. If you miss your appointment or fail to reschedule of cancel your appointment 24 hours in advance, you will be charged a $25 missed appointment fee due before your next visit will be scheduled.
4. If you NO SHOW – or fail to arrive for without rescheduling or canceling – 3 appointments, Motley family medical reserves the right to decline to schedule any further appointments for you.
5. If a personal check is returned for insufficient fund, a $35.00 fee will be charged. This fee and the value of the returned check must be paid by another method of payment before any other appointments will be made. No other checks will be accepted once one has been returned for insufficient funds.
6. There is $20 paperwork fee for any paperwork that needs to be completed by the provider. This includes Short term Disability, Loan Forgiveness, and any other paperwork requiring extended time to complete.
7. There is a $20 copy fee for medical records given directly to the patient per their request. Signed medical records release is required.
8. If a referral or test is ordered for you by the provider, please give the offices 5 business days to get that scheduled. If you have not heard anything after that time, please call us back to let us know so we can resolve the issues.
9. If you call the office and no one answers, please leave a message. We will call you back be end of business or on the next business day.
10. The provider has 24 hours to review any messages, refill requests, or any other patient correspondence.
11. After hours call. As always if you feel like your issues is an emergency, do not call the office. Call 911 or proceed to the nearest emergency room. Only Urgent Calls will be answered after hours. Urgent Call are defined as any call that the provider feels cannot wait until the next business day.
12. Refill for controlled substances will only be complete by appointment. Please refer to Narcotics Agreement for additional information.
13. Schedule II Narcotic Pain Medication (ex Norco, Percocet) nor Benzodiazepines (ex. Xanax, Valium will not be written for patient newly establishing with Lucinda Motley, FNP-C.
14. Additional Policies may be added and the need arises.

I have read the above Motley Family Medical Policies. I am aware that I can request a copy of these policies at any time.

Patient Name _____ Date _____

Signature _____

Motley Family Medical
Lucinda Motley, FNP-C

Release of Information

I hereby authorize: Lucinda Motley, FNP-C

301 Wolverine Trail, Ste 201 * Smyrna, Tn 37167
P 615 768 5511 F 615 768 5519

To: Release information to:
Obtain information from:
Exchange information with:

Name: _____
Address: _____
_____
_____
Telephone: _____

The information requested or authorized for release or exchange pertains to:

Primary Health Care
Mental Health Care
HIV/AIDS
Sexually transmitted diseases
Drug or alcohol abuse

This authorization is valid for 90 days from the date below or _____, whichever is earlier. I may cancel this authorization by signing, dating, and writing "CANCEL" on this original form or by sending a written, signed and dated request to the doctor above indicating my desire to cancel. I understand that once my information has been released, the recipient might re-disclose it, my doctor has no control over it and privacy laws may no longer protect it. The purpose of this authorization is to improve the quality of my mental health evaluation or treatment.

_____ _____
Patients Name Date of Birth

_____ _____
Patients Signature Date

_____ _____
Guardian's Signature (if patient is a minor) Date