Third Circle Medical

PATIENT REGISTRATION FORM

Today's Date:	**Primary Care Provider:**

PATIENT INFORMATION

Patient's Last name:	**First:**	**Middle:**	**Marital status:**

Is this your legal name? ☒ Yes ☐ No	If not, what is your legal name?	Former name:	**Birth date:**	**Age:**	**Sex:** ☐ M ☐ F

Address:	**City:**	**State:**	**Zip:**

Social Security no.:	**Home phone no.:**	**Cell phone no.:**
Your Email:	**Your Employer:**	**Employer phone no.:**

Chose clinic because/referred to clinic by (Please choose one option): ☒ [Doctor's name] ☐ Friend

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different than above):	Home phone no.:
Is this person a patient here?	☐ Yes ☐ No	Is this patient covered by insurance?	☐ Yes ☐ No
Occupation:	Employer:	Employer address:	Employer phone no.:

Please indicate primary insurance Name:
Other:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	Other:

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	Other:

IN CASE OF EMERGENCY WHO WOULD YOU LIKE US TO CONTACT :

Name of local friend or relative:	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Third Circle Medical or insurance company to release any information required to process my claims.

Patient/Guardian Signature

Date

Third Circle Medical
1609 Rosewood Drive
Columbia, TN 38401
Phone: 855-222-7938

CONSENT FOR TREATMENT

I give permission for Third Circle Medical to give me medical treatment. I understand that I have the right to refuse any procedure or treatment and that I have the right to discuss all medical treatments with my clinician.

PRESCRIPTIONS

I give permission for Third Circle Medical to send my prescriptions electronically.

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize Third Circle Medical to apply for benefits on my behalf for covered services rendered. I request that payment from my insurance company be made directly to Third Circle Medical. I certify that the information I have reported with regard to my insurance coverage is correct. This authorization may be revoked by either myself or my insurance company at any time. If my insurance company denies payment for services provided, I authorize Third Circle Medical to initiate an internal appeal, external appeal, and/or arbitration of the denial claim(s) on my behalf. I authorize the release of any medical information necessary to process this claim.

FINANCIAL RESPONSIBILTY

I am aware that I will be responsible for any balance in which my plan indicates is my responsibility on their explanation of benefits (EOB), including, but not limited to, non-covered and non-medically necessary services. I agree that I am responsible for my co-pay, co-insurance and deductible.

NON-PARTICIPATING PLANS

If Third Circle Medical does not participate with my plan, as a courtesy, they will send a claim to the carrier on my behalf. However, should they not pay the claim; I will be responsible for the full amount due.

____________________________________ __________________________

Signature of Patient or Patient Representative (if a minor) **Date**

____________________________________ __________________________

Printed Name of Patient or Patient Representative (if a minor) **Date**

Third Circle Medical
How are you feeling today?

Name ______________________________ **DOB (m/d/y)**____________________

REASON FOR TODAY'S EXAM: ____

Review of Systems:	**Normal**	**Abnormal**	**Describe Abnormal Findings**
Constitution:	☐	☐	☐ Fever ☐ Weight Loss ☐ Other
Cardiovascular:	☐	☐	☐ Heart Attack ☐ Chest Pain ☐ Hypertension ☐ Mitral valve prolapse ☐Claudication ☐ Other: ____________________
Ears/Nose/Throat:	☐	☐	☐ Ear Pain ☐ Sore Throat ☐ Nosebleed ☐ Nose/Sinus Problems
Respiratory:	☐	☐	☐ Asthma ☐Bronchitis ☐ Emphysema☐Cough ☐ SOB ☐ Other: ____________________
Gastrointestinal:	☐	☐	☐ GERD ☐ Peptic Ulcer disease ☐ Diverticulitis ☐ Irritable bowel ☐Hepatitis ☐ Cirrhosis ☐ Hypercholesteremia ☐ Gall Bladder Disease ☐ Other: __________________________
Genitourinary:	☐	☐	☐ Renal Failure ☐ Other: ________________
Musculoskeletal:	☐	☐	☐ Rheumatoid arthritis ☐ Other: ___________
Neurologic:	☐	☐	☐ Stroke ☐ Other: _____________________
Psychiatric:	☐	☐	☐ Depression ☐ Anxiety ☐ Bipolar ☐ Other: ____________________________
Endocrine/Metabolic:	☐	☐	☐ Diabetes ☐ Lupus ☐ Thyroid Disease ☐ Other: ____________________________
Hematologic/Lymphatic:	☐	☐	☐ Anemia ☐ Other: ____________________
Integumentary/Skin:	☐	☐	☐ Abnormal Mole ☐ Jaundice ☐ Rash ☐ Itching ☐ Dry Skin ☐ Growths/Lesions
Substance Abuse:	☐No	☐Yes	Substance: ___________ last used: __/__/___
Smoking:	☐No	☐Yes	When quit: __/__/__ Packs per day: _____
Cancer:	☐No	☐Yes	_________________________________

MEDICAL HISTORY INFORMATION SHEET

NAME: ____ **AGE:** __________ **TODAY'S DATE:** _____________________

DATE OF BIRTH: (m/d/y) _____/_____/__________ **HEIGHT:** _____ **ft** _____ **inches WEIGHT:** _______________ **lbs**

REASON FOR TODAY'S EXAM: ____

HISTORY:

Past Surgical History: Surgery	Date	Past Medical History: Condition	Date

HISTORY OF SERIOUS INJURIES OR ILLNESSES: ☐ YES ☐ NO If yes, please describe: ________________________

____

COVID Vaccine: ☐ YES ☐ NO If yes, which one: ________________________ **Booster:** ☐ YES ☐ NO

Family History: (check all that apply and relationship to patient)

☐ Heart Attack__________ ☐ Cancer ___________ ☐ Colon Problems __________☐ Diabetes ___________

☐ Blood Pressure ________________ ☐ Other: ____

☐ None

SOCIAL HISTORY:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Children How Many? ______

Tobacco Use: ☐ Never ☐ In the Past ☐ Currently: Type? ___________ How much? _________ How long? _________

Alcohol Use: ☐ Daily ☐ Occasional ☐ Never Other substance use or abuse? ☐ Yes ☐ No Type: ________________

Do you have allergies? ☐ Yes ☐ No ☐ Food ☐ Drug ☐ Latex ☐ Other: ___________

ALLERGEN	REACTION

Medications: List of Medications (including over-the-counter medications)

(If you have list, we can make a copy)

Medications	Dosage	Frequency

Your Pharmacy Name and Address: ____

Third Circle Medical

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient:____

Date of Birth: ____________________________ **Social Security Number**:__________________________

I. My Authorization:

I authorize **Third Circle Medical** to use or disclose the following health information:

☐ - All of my health information

☐ - My health information relating to the following treatment or condition:

____

☐ - My health information covering the period from ________________ (date) to ________________ (date).

☐ - Other: ____

The above party may disclose this health information to the following recipient:

Name (or title) and organization: ____

Address: ____

City: __________________________________State: ____________________ Zip Code: ______________

Phone: ____________________ Fax: ___________________ E-mail: ______________________________

The purpose of this authorization is (check all that apply):

☐ - At my request

☐ - To authorize the using or disclosing party to communicate with me for marketing purposes when they receive payment form a third party to do so.

☐ - To authorize the using or disclosing party to sell my health information. I understand that the seller will receive compensation for my health information and will stop any future sales if I revoke this authorization.

☐ - Other: ____

Signature of Patient or Authorized Representative: ____

Date: ____________________________________ **Time:** ____

Third Circle Medical

Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of many medical records or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name:____ Date of Birth: ________________________

The information you may release subject to this signed release form is as follows:

- ☐ Complete Records
- ☐ History & Physical
- ☐ Progress Notes
- ☐ Care Plan
- ☐ Lab Reports
- ☐ Radiology Reports
- ☐ Pathology Reports
- ☐ Treatment Records
- ☐ Operative Reports
- ☐ Hospital Reports
- ☐ Medication Records
- ☐ Other (please specify)__________________

The following person(s) are authorized to make the request for the above information:

☐Spouse: ______________________________

☐Parents: ______________________________

☐Children: Son: ________________________ Daughter: ________________________

☐Other: ____

This authorization shall remain in effect for the above listed person(s) from the date signed below until: _____________

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office at the address above, attention Privacy Officer.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA.
- I may refuse to sign this authorization and that you will not condition treatment or payment on me providing this authorization (except to the extent that the authorization is for research – related treatment, in which case you may refuse to provide that research-related treatment).

Release my protected health information to the following physician/person/facility/entity and/or those directly associated in my medical care:

Name: **Third Circle Medical**
Address: **627 S James M Campbell Blvd #229**
City/State/Zip Code: **Columbia, TN 38401**
Phone: **855-222-7938**

Email : **support@thirdcirclemedical.com**

The purpose/reason for the release of this information is as follows:

____ ________________________

Signature of Patient/Guardian/Power of Attorney Date

____ ________________________

Printed Name of Patient/Guardian/Power of Attorney Relationship (if applicable)