PAREKH MEDICAL CLINIC-PATIENT RIGHTS

As a patient, you have the right:

- To have your personal dignity respected
- To the confidentiality of your identifiable health information
- To enjoy personal privacy and a safe, clean environment and to let us know if you would like to restrict your visitors and phone calls
- To be informed (or your support person to be informed, where appropriate) of your visitation rights, including any clinically necessary restriction or limitation on such rights
- To be free from all forms of abuse or harassment
- To have your cultural, psychosocial, spiritual, and personal values, beliefs and preferences respected
- To receive care regardless of your age, race, color, national origin, culture, ethnicity, language, socioeconomic status, religion, physical or mental disability, sex, sexual orientation, or gender identity or expression
- To know the rules regulating your care and conduct
- To be informed and involved of decisions that affect your care, health status, services or treatment
- To understand your diagnosis, condition, and treatment and make informed decisions about your care after being advised of material risks, benefits, and alternatives
- To knowledgeably refuse any care, treatment and services
- To be informed of unanticipated adverse outcomes
- To receive information you can understand

As a patient, it is your responsibility:

- To give us complete and accurate information about your health, including your previous medical history and all the medications you are taking
- To inform us of changes in your conditions or symptoms, including pain
- To let us know if you do not understand the information we give you about your condition or treatment
- To follow our instructions and advice, understanding that you must accept the consequences if you refuse
- To pay your bills and make arrangements to meet financial obligations arising from your care
- To follow our rules and regulations
- To keep your scheduled appointments, or let us know if you are unable to keep them in advance
- To be considerate and cooperative and to respect the rights and privacy of other patients in the clinic

PAREKH MEDICAL CLINIC-REGISTRATION FORM

Patient Name: _____ Social Security #: _____ - _____ - _____

Date of Birth: _____ / _____ / _____ Sex: M/F (Circle one) Married/Singled/Divorced/Widow

Home Mailing Address: _____
(Street) (City/State/Zip)

Phone: (____) _____ - _____ (Home/Work/Mobile) Phone: (____) _____ - _____ (Home/Work/Mobile)

Email Address: _____ Primary Physician: _____

Employer Name: _____ Employer Phone: (____) _____ - _____ Occupation: _____

Fluently Spoken Language: _____ Race/Ethnicity: _____

Pharmacy: _____ Who is your primary care giver: _____

List of any other doctors you see: (1) _____ (2) _____

(3)_____ (4) _____

What is your preferred way to be contacted: Phone Mail Email

Parent/ Person responsible for bill (Complete only if different from patient)

Guarantor Name: _____ Social Security #: _____ - _____ - _____

Relationship to Patient: (please check): ( ) self, ( ) spouse, or ( ) parent DOB: ____ / _____ /_____

Who to call for an emergency

Name: _____ Address: _____

Phone: (____) _____ - _____ (Home/Work/Mobile) Relationship: _____

PRIMARY INSURANCE

Plan Name: _____ I.D. Number: _____ Group Number: _____

Card Holder's Name: _____ SSN #: _____ - _____ - _____ Sex: ( ) M ( ) F

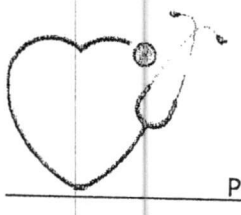
Card Holder's Date of Birth: _____/ _____/_____ Relationship to Patient: _____

SECONDARY INSURANCE

Plan Name: _____ I.D. Number: _____ Group Number: _____

Card Holder's Name: _____ SSN #: _____ - _____ - _____ Sex: ( ) M ( ) F

Card Holder's Date of Birth: _____/ _____/_____ Relationship to Patient: _____



Patient Record of Disclosure

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by means such as sending correspondence to an address other than home.

You must INITIAL next to the acceptable means for Parekh Medical Clinic to contact you.

HOME TELEPHONE or MAIN CONTACT PHONE NUMBER - __(_____)_____

_____ok to leave message with detailed information

_____ok to leave a message with call back number only

_____ok to fax to the following number: _____

_____ok to leave a message with detailed information

_____ok to leave a message with call back number only

Written Communications:

_____ok to mail to home address provided at time of registration

_____ok to mail to work/office

_____ok to EMAIL to the following address: _____

Signature of Patient_____ **Date**_____

Printed Name of Patient_____ **Date of Birth**_____

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization by the individual. Uses and Disclosures for Lifetime Health Center may be permitted without prior consent in an emergency. Healthcare entities must keep records of PHI disclosures. Information provided below will constitute this record. Please list who we may disclose information to such as appointment times, lab results or medication information.

Disclose information to	Address or Phone #	Disclose this information

Signature of Witness: _____ *Date:* _____

(to be signed by Parekh Medical Clinic office Staff requesting information)

PAREKH MEDICAL CLINIC

NOTICE OF PRIVACY PRACTICES AND CONSENT FORM

300 Main Street Plaza, Senatobia, MS 38668
1-662-562-8278 Office
1-662-562-8279 Fax

Patient Name: _____

In the course of providing services to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The Notice of Privacy Practices you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow up care from another health care professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor processing claims or obtaining payment; (2) our submission of claims to third party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third party payers and insurers; and (4) other aspects of payment described in our Notice of Privacy Practices. Our Notice of Privacy Practices will be updated whenever our privacy practices change.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our Notice of Privacy Practices.

You have the right to ask us to reject the use or disclosure made for purposes of treatment, payment or healthcare operations, but as described in our Notice of Privacy Practices, we are not obligated to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our Notice of Privacy Practices describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the Notice of Privacy Practices from Parekh Medical Clinic.

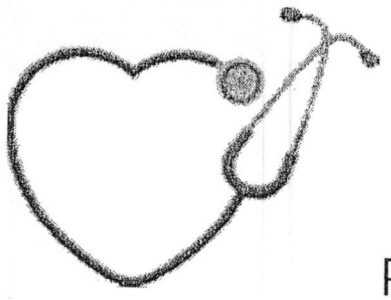
_____ _____

Signature Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

_____ _____

Relationship to patient Date



PAREKH MEDICAL CLINIC

Notice of Patient Responsibility

I understand that Parekh Medical will file a claim with my insurance company for my medical care. I also understand that I will be responsible for any money owed by me as the patient or guarantor such as copays, deductibles, coinsurance and non-covered services including denials for any and all of my care as a patient at Parekh Medical Clinic.

I understand that it is my responsibility to make Parekh Medical Clinic aware of changes to my insurance in a timely manner.

I understand that as long as I am a patient of Parekh Medical Clinic this notice of responsibility is effective and will remain effective until terminated by either party.

Patient Name: _____

Guarantor/Responsible party: _____

Date: _____

Witness: PMC Staff _____

PAREKH MEDICAL CLINIC

PATIENT MEDICAL HISTORY

Patient Name: _____

What is the purpose of your visit today?_____

_____

Past Medical History: High Blood Pressure, Asthma, Cholesterol, Heart Disease, Stroke, Cancer, Hepatitis, HIV, Kidney Disease, Chronic Pain, Diabetes, COPD, Psychiatric Illness, other_____ (please circle all that apply)

Significant Family History: _____

Surgical History and Dates: _____

Social History- please include whether you are employed, retired, or disabled.

If you are employed please include your place of work and title: _____

Married, Single, Divorced, or Widowed (please circle one)

Number of children: ____ Do you live alone? _____if not, who do you live with?_____

Do you need any assistance with your daily activities? _____Do you drink alcohol? _____

if so, how often per week? _____

Do you use any pain medications? _____ if so, what do you take? _____

Do you smoke? _____ how much per day? _____ when did you start smoking? _____

Do you have any other doctors that provide medical care for you? _____ if so, what is the doctor's name an specialty?

_____

Have you had a flu vaccine? _____ Pneumonia vaccine?_____ tetanus vaccine? _____

Are you currently on oxygen? _____ Are you currently on Home Health? _____

Have you ever had a colonoscopy? If so, when and what were the results?

_____

When was your last Pap smear and mammogram? _____

Have you ever had a bone mineral density test which checks for Osteoporosis? _____If so, when?

_____

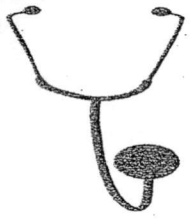
What is the best way to contact you? By phone? By email? Or by mail? _____

Please give us your correct phone numbers and address. Please be willing to give us more than one contact number:

1. Phone: _____

2. Phone: _____

Revised 12-2014



Parekh Medical Clinic-Home Medication Form for Your Safety

Patient Name: _____

****please include any of the following medications you are presently taking at home: Prescription medications, over the counter medications, herbal medications, patches, ointments, injections, eye drops, inhalers, etc...*****

MEDICATION NAME	DOSE	MEDICATION TIMES	REASON

**** if you are unable to complete this list, bring your home medications with you****

PAST MEDICAL HISTORY: please check any of the following conditions that YOU have a history of

Please choose all that apply:

- ☐ ADD
- ☐ ADHD
- ☐ Anemia
- ☐ Angina Pain
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune disease
- ☐ Severe Birth Asphyxia
- ☐ Blood disorder
- ☐ Taking blood thinners
- ☐ bronchitis
- ☐ coronary artery disease
- ☐ cancer
- ☐ cataract
- ☐ CHF (heart failure)
- ☐ COPD
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Ear Infection
- ☐ Eczema
- ☐ Environmental Exposure
- ☐ Emphysema
- ☐ Febrile Convulsion
- ☐ fibromyalgia
- ☐ gastric ulcer
- ☐ GERD (GI Reflux)
- ☐ Glaucoma
- ☐ Gout
- ☐ Head Injury
- ☐ Headaches
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ HIV
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Irritable Bowel Syndrome
- ☐ Kidney disease
- ☐ Liver Disease
- ☐ Meningitis
- ☐ Menstrual Complaints
- ☐ mental disorder
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Multiple Environment Allergy
- ☐ Palpitations
- ☐ Peripheral Vascular Disease
- ☐ Personality Changes
- ☐ Pneumonia
- ☐ Pregnancy how many_____
- ☐ Heart Attack
- ☐ Prostate problems
- ☐ Psoriasis
- ☐ PUD (peptic ulcer)
- ☐ renal disorder
- ☐ rhythm disorder
- ☐ sexual disorder
- ☐ shortness of breath
- ☐ sinusitis
- ☐ skin rash
- ☐ stroke
- ☐ thyroid disease
- ☐ TIA
- ☐ traumatic back
- ☐ traumatic neck
- ☐ tuberculosis
- ☐ ulcerative colitis
- ☐ upper GI bleed
- ☐ urinary tract disorder

SURGERY

- ☐ Neuro surgery
- ☐ nerve block
- ☐ neck surgery
- ☐ lymphatic surgery
- ☐ lymphadenectomy
- ☐ ENT surgery
- ☐ Tonsillectomy
- ☐ adenoidectomy
- ☐ appendectomy
- ☐ gastrointestinal surgery
- ☐ heart valve replacement
- ☐ cardiovascular surgery
- ☐ pacemaker placement
- ☐ gynecological surgery
- ☐ tubal ligation
- ☐ hysterectomy
- ☐ orthopedic surgery
- ☐ musculoskeletal surgery
- ☐ eye surgery
- ☐ endocrine surgery
- ☐ thyroid surgery
- ☐ other surgery
- ☐ _____
- ☐ _____

FAMILY HISTORY CHECK ALL THAT APPLY AND LIST FAMILY MEMBER

- ☐ ADD OR ADHD
- ☐ History of alcoholism
- ☐ Anxiety Disorder
- ☐ asthma
- ☐ atrial fibrillation
- ☐ autistic disorder
- ☐ autoimmune disorder
- ☐ blood disorder
- ☐ cancer
- ☐ CHF (heart failure)
- ☐ copd
- ☐ coronary artery disease
- ☐ dementia
- ☐ depression
- ☐ diabetes
- ☐ epilepsy
- ☐ GI Disorders
- ☐ Glaucoma
- ☐ headache
- ☐ heart disease
- ☐ high cholesterol
- ☐ hypertension
- ☐ involuntary shaking/tremors
- ☐ kidney disease
- ☐ learning disorder
- ☐ mental illness
- ☐ migraine headache
- ☐ motion sickness
- ☐ osteoarthritis
- ☐ Parkinson's disease
- ☐ disorders of peripheral nerves
- ☐ neuromuscular junction/muscle
- ☐ prostate disorder
- ☐ restless leg syndrome
- ☐ rhythm disorder
- ☐ seizure disorder
- ☐ sleep apnea obstruction
- ☐ stroke
- ☐ thyroid disease

PLEASE TELL US ANYTHING ELSE YOU WANT US TO KNOW ABOUT THESE PROBLEMS:

Stress factors

- ☐ change in job
- ☐ currently in school having difficulty
- ☐ death of a family member
- ☐ family disruption
- ☐ marital problems
- ☐ recently divorced
- ☐ recent move
- ☐ sexually abused
- ☐ under stress

Allergies:

PAREKH MEDICAL CLINIC

300 Main Street Plaza

Senatobia, MS 38668

Telephone (662) 562-8278 Fax (662) 562-8279

NAME: _____ DATE: _____

DATE OF BIRTH: _____ PHONE # _____

TEMP TODAY: _____ FEVER in the last 48 hrs? YES or NO

Have you had direct exposure to Coronavirus/ COVID-19 personally or through your job? If so, explain:

Do you have any following symptoms?

Cough

Shortness of Breath

Muscle Aches or Pain

Headaches

Confusion

Sore Throat

Chest pain or pressure

Loss of Taste or Smell

Chills

Diarrhea

Nausea and/or vomiting

Rash

PMC Staff Initials: _____ Patient Initials: _____

COVID VACCINE?
YES OR NO