Dear Patient,

Welcome to our practice and thank you for choosing the Highland Medical, P.C., providers for your health care needs.

In order to expedite the registration process, please complete the new patient forms and bring with you to your first appointment. This will ensure that you are seen quickly and help us finalize the registration process efficiently and thoroughly. Also, please remember to bring the following items with you to your appointment:

- Your insurance card(s)
- Photo ID such as driver’s license or passport
- Co-payment or deductible that your insurance requires (cash, check, or credit cards are accepted)
- List of all current medications, including dosage and frequency, and allergies
- Referrals that might be required prior to services rendered

We look forward to meeting and providing you with the quality healthcare services you deserve.

Sincerely,

The Staff at Highland Medical, P.C.
PATIENT INFORMATION:

last name    first name     middle initial

marital status          gender

street address          city/state/zip

home phone      cell     work

e-mail address

date of birth   race   ethnicity   preferred language

occupation      employer

INSURANCE INFORMATION:

primary insurance     policy/ID number

cardholder’s name     relationship   cardholder’s date of birth

street address          city/state/zip

secondary insurance     policy/ID number

cardholder’s name     relationship   cardholder’s date of birth

street address          city/state/zip

Is this a work-related injury or illness? (please circle)   YES   NO

REFERRING PHYSICIAN INFORMATION (if any):

referring physician

telephone      fax

referring physician street address        city/state/zip
ASSIGNMENT OF BENEFITS:
I hereby authorize direct payment of medical benefits to Highland Medical, P.C., for services rendered. I understand that I am financially responsible for any charges not covered by my insurance carrier(s). This may include deductibles, co-payments, co-insurance, and denied (non-covered) services.
I certify that the information given by me in applying for payment is correct. I request that payment of authorized benefits be made on my behalf. A photocopy of these assignments shall be valid as an original.

signature                        date

name                            date of birth

signature of parent/guardian (if minor)    date

RELEASE OF INFORMATION:
I authorize Highland Medical, P.C., to release any necessary medical information to process my insurance claims.

signature                        date

signature of parent/guardian (if minor)    date

GUARANTEE OF PAYMENT:
In consideration of services rendered by Highland Medical, P.C., I, the undersigned, agree to pay Highland Medical, P.C., any co-payment, co-insurance or deductible mandated by my health insurance plan. In addition, I agree to pay for all services that are not covered by my health insurance plan provided that I am informed of same prior to rendering of said services.

signature                        date

signature of parent/guardian (if minor)    date

PATIENT COMMUNICATIONS:
In accordance with state and federal regulations, Highland Medical, P.C., wants to assure you that your personal medical information will be held in confidence and with the utmost respect. Please assist us in maintaining that confidence by completing this form. Please provide below the phone number(s) which we should use to contact you.

home phone          cell          work
LEAVING A CONFIDENTIAL MESSAGE:
Please indicate at which number, if any, you authorize us to leave a confidential voice message if we are unable to speak to you:

Phone Number for Confidential Message: ________________________________
Initial Here: ___________

USE OF EMAIL:
Please indicate whether we can send information to you by email:   YES   NO

__________________________________________________________________________________________________
email address

EMERGENCY CONTACT:
Is there any person that you want us to contact in the event of an emergency or if we are unable to reach you?

__________________________________________________________________________________________________
name relationship phone number

street address city/state/zip
☐ I give Highland Medical, P.C., permission to discuss my personal health information with the individual listed above if I cannot be reached.

__________________________________________________________________________________________________
name relationship phone number

street address city/state/zip
☐ I give Highland Medical, P.C., permission to discuss my personal health information with the individual listed above if I cannot be reached.

I understand that Highland Medical, P.C., will adhere to the regulations outlined by HIPAA and will follow the guidelines I have outlined above.

__________________________________________________________________________________________________
signature date

__________________________________________________________________________________________________
signature of parent/guardian (if minor) date
Over the past few years, the number of different health insurance programs has increased at a significant rate. Even within one insurance company, there may be several programs with varying benefits and requirements. There is no way we can possibly know, or keep up to date with each insurance company’s policies, programs, and provisions.

Some programs require a specific facility be used for your radiology and laboratory tests.
Some programs require pre-authorizations and notification of hospital and ER visits.
It is your responsibility to know:
1. Whether this office is participating with your insurance company and if they will cover physicals, immunizations, surgeries, etc.
2. To advise this office of your insurance requirements in advance, each and every time we provide a service. We will do our very best to comply with any responsible requirements your insurance company may have.

Please understand that if we have not been advised in advance of your insurance requirements or conditions and we provide a service or use a laboratory that is outside your insurance, you will be responsible for the appropriate fees. In addition, there may be times where we may not be able to obtain a consultant or laboratory that participates with your insurance. It is up to you to work this out with your insurance company.

Unless you carefully follow your insurance company’s regulations, they may decline all or part of your claim. Your insurance carrier should have provided you with a phone number to use if you have any questions about your coverage.

I acknowledge receipt of this information.

______________________________________  ________________
patient signature                           date
ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE:

I have received a copy of the Highland Medical, P.C., Notice of Privacy Practices written in plain language. The notice provides in detail the use and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights and the practice’s legal duties with respect to my health information.

I understand that Highland Medical, P.C., reserves the right to change terms of its Notice of Privacy Practices and make changes regarding all protected health information resident at, or controlled by, this practice. If changes occur, this practice will provide me with a revised Notice of Privacy Practices upon request. Furthermore, I understand that without my signed consent, medical information will not be released to any unauthorized individuals.

<table>
<thead>
<tr>
<th>patient name</th>
<th>date of birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>patient signature</td>
<td>date</td>
</tr>
<tr>
<td>signature of parent/guardian (if minor)</td>
<td>date</td>
</tr>
</tbody>
</table>
MEDICAL HISTORY

Name:______________________________________ Date: _________________ Date of Birth:__________________

Referring Physician:________________________ Reason For Visit:____________________________________

Sex:   Male   or    Female         Marital Status:   M    S    D    W

Occupation:_____________________________________________________________________________________

<table>
<thead>
<tr>
<th>Medical Illnesses</th>
<th>Year of Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Operations</th>
<th>Year</th>
<th>Hospital</th>
<th>Surgeon</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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Do you have, or have you ever had, any of the following? (Check all that apply.)

<p>| | | | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>Asthma</td>
<td>Rectal Pain</td>
<td>Late Night Urination</td>
</tr>
<tr>
<td>Arthritis</td>
<td>Tuberculosis</td>
<td>Change in Bowel Habits</td>
<td>Urinary Frequency</td>
</tr>
<tr>
<td>Phlebitis/Blood Clots</td>
<td>Emphysema (COPD)</td>
<td>Blood/Mucus in Stool</td>
<td>Kidney Stones</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>Chronic Cough</td>
<td>Black Tarry Stools</td>
<td>Abnormal Vaginal Bleeding</td>
</tr>
<tr>
<td>Heart Attack</td>
<td>Nausea/Vomiting</td>
<td>Weight Loss</td>
<td>Normal PAP in Last 2 Years</td>
</tr>
<tr>
<td>Chest Pain (Angina)</td>
<td>Diarrhea</td>
<td>Loss of Appetite</td>
<td>High Cholesterol</td>
</tr>
<tr>
<td>Shortness of Breath</td>
<td>Constipation</td>
<td>Jaundice</td>
<td>Depression</td>
</tr>
<tr>
<td>Stroke</td>
<td>Rectal Bleeding</td>
<td>Heartburn</td>
<td>Thyroid Problems</td>
</tr>
<tr>
<td>Irregular Periods</td>
<td>Osteoporosis</td>
<td>Vitamin Deficiency</td>
<td>Excess Hair Growth</td>
</tr>
<tr>
<td>Menopause</td>
<td>Infertility</td>
<td>Erectile Dysfunction</td>
<td>Excess Hair Loss</td>
</tr>
<tr>
<td>Bariatric Surgery</td>
<td>Tummy Tuck</td>
<td>Liposuction</td>
<td>High or Low Calcium</td>
</tr>
</tbody>
</table>

Family history of cancer, heart disease, diabetes, thyroid problems, high blood pressure, obesity.

<table>
<thead>
<tr>
<th>Who</th>
<th>What Type</th>
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### Drug Allergies

<table>
<thead>
<tr>
<th>Drug Allergies</th>
<th>Reaction</th>
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### Smoking

<table>
<thead>
<tr>
<th>Smoking</th>
<th>Alcohol Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current, Former, Never:</td>
<td>Yes \ No</td>
</tr>
<tr>
<td>Duration:</td>
<td>Duration:</td>
</tr>
<tr>
<td>Amount Per Day:</td>
<td>Amount Per Day:</td>
</tr>
</tbody>
</table>

### FOR FEMALE PATIENTS:

- Last normal period: ____________________  Any post menopausal bleeding? ____________________
- Do you examine your breasts? __________  Last mammogram and where? ____________________
- Last PAP test: _______  Do you take birth control pills? _______  Could you be pregnant? _______

### FOR OFFICE USE ONLY:

- Height: ____________________
- Weight: ____________________
- Blood Pressure: _________
Please include all prescriptions, as well as all over the counter (OTC) medications, and vitamins/supplements taken on a regular basis.

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dose</th>
<th>Frequency</th>
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</table>

I do not take any medications consistently. (check here) ______________

Consent to check medication history?  Yes____  No ____
Dear Patient,

According to HIPAA Federal Regulations, each patient must be assured that his/her medical records are held in the strictest confidence. In order for Highland Medical, P.C., to comply with regulations, we ask that you take a moment to complete the following questionnaire.

Your signature is required where requested.

With what individuals may we discuss medical history, test, or lab results?

__________________________________________________________________________________________________
name          relationship to patient
__________________________________________________________________________________________________
name          relationship to patient
__________________________________________________________________________________________________
name          relationship to patient

Where may we contact you?: (please circle)

Home Phone:   YES   NO   Phone Number: ___________________________________________________________

Cell Phone:   YES   NO   Phone Number: ___________________________________________________________

Work Phone:   YES   NO   Phone Number: ___________________________________________________________

Email:       YES   NO   Email Address: _____________________________________________________________
I understand the Highland Medical, P.C., will adhere to the regulations as outlined by HIPAA and will follow the guidelines I have outlined above.

I have received Highland Medical, P.C., notice of Privacy Practices written in plain language. This notice provides in detail the use and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights and the practice's legal duties with respect to my health information.

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__________________________________________________________________________________________________
patient name         date of birth
__________________________________________________________________________________________________
patient signature         date
__________________________________________________________________________________________________
signature of parent/guardian (if minor)      date
TO:  

I hereby authorize and request that my medical records be released to Highland Medical, P.C., at the following practices:

<table>
<thead>
<tr>
<th>Practice Name</th>
<th>Address</th>
<th>City/State/Zip</th>
<th>Phone Number</th>
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<tbody>
<tr>
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</table>

Please send the medical records in your possession for the time period ______________ concerning my treatment and/or illness.

*This authorization may include disclosures of information relating to alcohol and drug abuse, mental health treatment, and confidential HIV-related information ONLY if I initial below:

[ ] Alcohol/Drug Treatment  [ ] Mental Health information  [ ] HIV-related information

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Address</th>
<th>City/State/Zip</th>
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</table>

Patient Signature: __________________________ Date: ______________

Witness: __________________________ Date: ______________