Patient Registration

Please complete all sections. The patient, if an adult is regarded as being responsible for all charges generated.

Date: _____ **Social Security #:** _____

Patient Name: ☐ Ms. ☐ Mrs. ☐ Miss ☐ Mr. _____ (First) _____ (Last)

Current gender identity: _____ **Sex assigned at birth:** _____ **Preferred pronoun(s):** _____

Date of Birth: _____ **Age:** _____

Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Address: _____

City: _____ **State:** _____ **ZIP:** _____

Home Phone: _____ **Cell:** _____ **Work Phone:** _____

Email: _____ **Pharmacy:** _____

Emergency contact: _____ (First Name) _____ (Last Name)

Relationship to Patient: _____ **Phone:** _____

INSURANCE INFORMATION - PRIMARY INSURANCE

Person responsible for account: _____ (First Name) _____ (Last Name)

Relationship to Patient: _____ **Date of Birth:** _____ **Social Security #:** _____

Address (if different from above): _____

City: _____ **State:** _____ **ZIP:** _____

Insurance Company: _____ **Contact #:** _____

Subscriber #: _____ **Group #:** _____

Name of Insured on Card: _____

Responsible party agrees to fill out new form when any of the above information changes.
Wrong information may result in incorrect filing and subsequent charges.

Continued on next page ▶

INSURANCE INFORMATION - SECONDARY INSURANCE

Insurance Company: _____ Contact #: _____

Subscriber #: _____ Group #: _____

ASSIGNMENT AND RELEASE

I, the undersigned, hereby authorize and direct my insurance carrier to pay directly to Inspire Medical Group of California, PC all insurance benefits, if any, due to me under by insurance plan. I further agree to pay the balance of the charges not paid by my insurance. I hereby authorize the release of any information necessary to secure payment of benefits. I also authorize the use of this signature on all insurance submissions. If the patient is a minor, I as a legal guardian give consent for treatment for this and future services rendered. I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Signature: _____ Date: _____

Medical History

Date: _____

☐ Ms. ☐ Mrs. ☐ Miss ☐ Mr. **Patient Name:** _____ _____
First Last

Current gender identity: _____ **Sex assigned at birth:** _____ **Preferred pronoun(s):** _____

Date of Birth: _____ **Age:** _____

Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Race: _____ **Ethnicity:** _____ **Language:** _____

Height: _____ **Weight:** _____

Address: _____

Home Phone: _____ **Occupation:** _____ **Work Phone:** _____

Allergies to Medications, X-Ray Dyes, or Other Substances?: ☐ No ☐ Yes

If Yes, please list name of medicine and type of reaction:

Name:	**Reaction:**

Medications (Prescriptions, Over-the-Counter, Vitamins, Herbs etc.):

Drug Name/Dose/Frequency	Drug Name/Dose/Frequency	Drug Name/Dose/Frequency

Continued on next page ▶

Past Medical History and Review of Systems
Please check if you have had any problems with or are presently experiencing any of the following:

- ☐ High Blood Pressure
- ☐ Bronchitis
- ☐ Change in Bowel Habits
- ☐ Arthritis Diabetes
- ☐ Pneumonia
- ☐ Unexplained weight gain/loss
- ☐ Low back problems
- ☐ Cancer
- ☐ Persistent cough
- ☐ Hemorrhoids
- ☐ Difficulty Urinating
- ☐ Heart disease
- ☐ Tuberculosis
- ☐ Gall bladder disease
- ☐ Skin diseases
- ☐ Chest pain/tightness
- ☐ Hay Fever
- ☐ Colitis
- ☐ Blood disorders
- ☐ Shortness of breath
- ☐ Headache
- ☐ Hepatitis or Jaundice
- ☐ Venereal diseases
- ☐ Swollen ankles
- ☐ Thyroid Disease
- ☐ Anxiety
- ☐ Depression
- ☐ Palpitations
- ☐ Indigestion
- ☐ Head or neck radiation
- ☐ Anemia
- ☐ Lightheadedness
- ☐ Nausea
- ☐ Abdominal discomfort
- ☐ Alcohol abuse
- ☐ Frequent urination
- ☐ Vomiting
- ☐ Kidney disease
- ☐ Drug abuse
- ☐ Rheumatic fever
- ☐ Constipation
- ☐ Kidney stones
- ☐ Gout
- ☐ Asthma
- ☐ Diarrhea
- ☐ Impotence or Erectile Dysfunction
- ☐ Other

If "Other", please explain:

GYNECOLOGIC AND OBSTETRIC HISTORY

Age at onset of periods: _____ **Frequency:** _____ **Length of Period:** _____

Pregnancies: _____ **Births:** _____ **Miscarriages:** _____

Currently pregnant? ☐ No ☐ Yes **Breastfeeding?** ☐ No ☐ Yes

Prolonged or abnormal bleeding: ☐ No ☐ Yes **(If yes, please describe):** _____

Leakage of urine: ☐ No ☐ Yes **(If yes, please describe):** _____

Pelvic pain: ☐ No ☐ Yes **(If yes, please describe):** _____

Abnormal discharge: ☐ No ☐ Yes **(If yes, please describe):** _____

History of abnormal pap smear: ☐ No ☐ Yes **(If yes, please describe):** _____

Are you currently using a method of birth control? ☐ Yes ☐ No
If yes, what method _____

Continued on next page ▶

Medical History

When was your last:

Pap Smear: _____ Breast Exam: _____ Colon Cancer Test: _____

Mammogram: _____ Cholesterol Check: _____ Prostate Exam: _____

Immunization History - Have you had:

Hepatitis B ☐ Yes ☐ No Flu ☐ Yes ☐ No Other ☐ Yes ☐ No

Pneumovax ☐ Yes ☐ No Tetanus ☐ Yes ☐ No COVID-19 Vaccination ☐ Yes ☐ No

Please list and supply the dates of:

Operations:

Hospitalization other than for surgery:

Family History - Please write down blood relatives with relevant medical information

Relation	Age	State of Health	Age at Death *(If Applicable)*	Cause of Death *(If Applicable)*

Check if your blood relatives had any of the following:

☐ Arthritis, Gout ☐ Asthma, Hay Fever ☐ Cancer ☐ Chemical Dependency

☐ Diabetes ☐ Heart Disease, Stroke ☐ High Blood Pressure ☐ Tuberculosis

☐ Other (Please explain): _____

Continued on next page ▶

PREVENTION

Do you exercise regularly? ☐ Yes ☐ No If yes, duration and number of times per week _____

Do you smoke? ☐ Yes ☐ No If yes, how many packs per day _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how much per week _____

If there is a gun in your home, do you keep it unloaded and out of children's reach? ☐ Yes ☐ No ☐ N/A

Do you use drugs (marijuana, cocaine, etc)? ☐ Yes ☐ No

If yes, explain _____

Have you ever engaged in any activity that has put you at risk of getting AIDS? ☐ Yes ☐ No

Do you wish to be tested for AIDS? ☐ Yes ☐ No

Have you ever worked with chemicals, paints, asbestos or other hazardous material? ☐ Yes ☐ No

Are you in a relationship in which you have been physically hurt (e.g. slapped, kicked, punched, bruised) by your partner? ☐ Yes ☐ No

Do you ever feel afraid of your partner? ☐ Yes ☐ No ☐ N/A

Do you have advanced directive? ☐ Yes ☐ No

Informed Consent for Telemedicine Services

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files.

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption

Expected Benefits

- Improved access to medical care by enabling a patient to remain in a remote site while the physician obtains test results and consults from a distant/other site.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

Possible Risks

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.

By reading this text, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.
4. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
5. I understand that it is my duty to inform my doctor of electronic interactions regarding my care that I may have with other healthcare providers.
6. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
7. I understand that my insurance deductibles and/or co-pays apply to telemedicine services.

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Patient Consent To The Use of Telemedicine Services

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize an Inspire Medical Group of California, PC provider to use telemedicine services in the course of my evaluation, diagnosis and treatment.

Printed Name	Relationship to patient
Signature of Patient (or legal representative)	Date

Authorization for Disclosure of Health Information

inspire MEDICAL GROUP OF CALIFORNIA

Patient Name: _____

Date of Birth: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make the disclosure:

   Inspire Medical Group of California, PC
   333 W El Camino Real, Ste 230
   Sunnyvale, CA 94087

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).

   ☐ Complete health records
   ☐ Lab results/X-ray reports
   ☐ Physical exam
   ☐ Consultation reports
   ☐ Immunization record
   ☐ Other (please specify): _____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
5. This information may be disclosed to the following individual(s):

   Name: _____

   Address: _____

   City: _____ State: _____ Zip: _____

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

   _____

_____ _____

Signature of patient or legal representative Date

Financial Responsibility Agreement

inspire MEDICAL GROUP OF CALIFORNIA

Patient Name: _____ _____
First Last

Date of Birth: _____

1. I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits. This includes any medical service or visit, preventive exam or physical, lab testing, x-ray, EKG, and any other screening service or diagnostic testing ordered by the physician or the physician's staff.
2. I understand and agree it is my responsibility and not the responsibility of the Physician or Office to know if my insurance will pay for my medical service or visit, preventive exam or physical, lab testing, x-ray, EKG, and any other screening service or diagnostic testing ordered by the physician or the physician's staff.
3. I understand and agree it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network amounts, usual and customary limit, or any other type of benefit limitation for the services I receive, and I agree to make full payment whenever required.
4. I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provider is not recognized by insurance company or plan, it may result in claims being denied or higher out of pocket expense to me. I understand this and agree to be financially responsible and make full payment.
5. I understand and agree it is my responsibility to know if my PCP (primary care physician) choice had been processed by my insurance company or plan. If I have requested a PCP change that is not processed by my insurance company, it may result in claims being denied. I understand this and agree to be financially responsible and make full payment.
6. I understand that the physician may charge a $35.00 fee if I do not show up for my appointment or cancel without a 24 hour notice.
7. I understand that if I need a copy of my medical records, a $15.00 printing fee will be charged.
8. I understand that any forms to be filled out by the physicians will have a fee assessed.
9. I understand that I will be required to provide a valid form of payment, either check or credit card which will be run electronically. Any returned check will be charged $30 penalty fee.
10. I understand that any account balance that is 90 days past due will be sent to collections and that it is my responsibility to ensure that my insurance and contact information is always current and updated.

Responsible Party Name: _____
Please print name of Responsible Party if different from Patient

_____ _____
Signature of patient or responsible party Date

HIPAA Compliance Patient Consent

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	☐ YES	☐ NO
May we phone, email, or send a text to you to send results?	☐ YES	☐ NO
May we leave a message on your answering machine at home or on your cell phone?	☐ YES	☐ NO
May we discuss your medical condition with any member of your family?	☐ YES	☐ NO

If YES, please name the members allowed:

_____

This consent was signed by: _____

Please print name

_____ _____

Signature of patient or legal representative | Date

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect December 01, 2021 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made these changes. In the event we make a material change in our privacy practices, we will change this Notice and provide it to you. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations.

Treatment: We may use or disclose your health information to another healthcare provider for:

a. The provision, coordination, or management of health care and related service by healthcare providers;

b. Consultation between health care providers relating to a patient;

c. The referral of a patient for health care from one health care provider to another, or

d. Recall information

Payment: We may use and disclose your health information to obtain payment for services we provide to you. This may include:

a. Billing and collection activities and related data processing;

b. Actions by a health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims;

c. Medical necessity and appropriateness of care reviews, utilization review activities; and

d. Disclosure to consumer reporting agencies of information relating to collection of premiums or reimbursement.

Healthcare Operations: We may use and disclose your health information in connection with our health care operations such as quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, and certification, licensing or credentialing activities.

Your Authorization: You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Marketing Health Products or Services: We will not use your health information for marketing communications without your prior written authorization. We may provide you with information regarding products or services that we offer related to your health care needs. We will never sell your health information without prior authorization.

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To You, Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so or if it is necessary in our professional judgment.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you an opportunity to object to such uses of professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Required by Law: We may use or disclose your health information when we are required to do so by law, including judicial and administrative proceedings.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials, health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment Reminders and Treatment Alternatives: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters) or information about treatment alternatives or other health related benefits and services that may be of interest to you.

PATIENT RIGHTS

Access: You have the right to review or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information at the end of this Notice. We will charge you a reasonable cost based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request an alternative format, we will charge a cost based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to request a list of instances in which we or our business associates disclosed your information for purposes, other than treatment, payment, healthcare operations, where you have provided an authorization and certain other activities. If you request this accounting we may charge you a reasonable fee for responding to these requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request in writing that we communicate with you about your health information by alternative means or to alternate locations. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Website or by electronic mail (e-mail) you are entitled to receive this Notice in written form.

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QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have any questions or concerns, please contact us.
If you are concerned that we may have violated your privacy rights, or you disagree with a decision we have made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of the Notice. You may also submit a written complaint to the U.S Department of Health and Human Services upon request. We support your right to the privacy of your health information.
We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Inspire Care, PC
1500 W Elk Ave Ste 205
Elizabethton, TN 37643-2655