Kramer Davis
HEALTH

Kramer Davis Clinic – Nashville
3901 Central Pike, Suite 500
Hermitage, TN 37076
(615) 933-7300 | kd.health

Dear Patients, Families, Guardians, and Care Givers,

Here at Kramer Davis, we strive to provide compassionate, interdisciplinary healthcare to patients with intellectual and developmental disabilities and we look forward to servicing your healthcare needs. In order to provide you with comprehensive care, it is necessary for us to maintain current and updated health information. Please complete the attached patient packet to initiate care and continued care here at the Clinic. This information needs to be completed annually.

In order for us to provide comprehensive care, we are requesting the following items:

1) **Legal guardian or conservator to complete New Packet Information for the Clinic (unless the patient has capacity to make his/her own decisions or there is a surrogate decision maker as allowed by law)**
2) **Copy of guardianship or conservator papers from court**
3) **Copy of current insurance cards**
4) **Copy of immunization record**
5) **List and dosage of all current medications taken, with dosage and administration Instructions (including all over-the-counter and PRN medication) Page 5**
6) **Financial statement packet completed and signed in all places by guardian. (Pages 1a-3a)**

Please ensure that each page of the patient packet is completed and signed by the patient/surrogate decision-maker/legal guardian/conservator as required. All medical information needs to be checked and the forms signed. After receiving the completed packet back at the clinic, the Kramer Davis clinicians will review and sign the documents and you will receive a call to schedule an appointment, therefore, it is important that we receive the packet back timely into the office signed and completed with all documents requested.

If you should have any questions, please do not hesitate to contact our office. We look forward to seeing you soon.

Sincerely,

Meera Gandhi, MHS, PA-C
Clinic Director

3901 Central Pike, Ste 500; Hermitage, TN 37076

Kramer Davis HEALTH

Patient Name: _____ Date of Birth: _____

☐ **No Changes**

PATIENT INFORMATION FACE SHEET

Patient First Name:	Middle Name:	Last Name:
Social Security Number:	Date of Birth:	Gender:
Street Address:	City:	County:
State:	Zip Code:	Race:

Guardian/conservator/surrogate Information:

Name:

Address:

Relationship to Patient:

Phone Number:

E-mail:

Next of Kin Information:

Name:

Address:

Relationship to Patient:

Email:

Phone:

Case Manager/Insurance Navigator Information:

Name:

Company Name:

Address:

Office Phone:

Cell Phone:

Does the patient have a valid Tennessee Power of Attorney?

☐ Yes (Please attach) ☐ No

Currently a Special Olympics Athlete?

☐ Yes ☐ No

Day Program Information:

Name:

Phone:

Is the Patient on a Waiver?

☐ HCBS ☐ Self-Determination
☐ Beckett ☐ Other: _____

Who do you authorize the clinic to contact to confirm appointments?

Name:

Relationship:

Phone:

E-mail:

Indepent Support Coordinator:

Name:

Phone:

DIDD Group:

In what setting does the patient live?

☐ With Family ☐ FHP
☐ Staffed Residence ☐ ICF/IID
☐ Independently ☐ Other:

Name of Provider: _____

Phone Number: _____

Employment status of patient:

☐ Student ☐ Unemployed
☐ Full-Time ☐ Retired
☐ Part-Time ☐ Other

How did you find out about the Kramer Davis?

Pharmacy Information:

Name:

Phone:

Address:

Does the patient have a Living Will or a Do Not Resuscitate order?

☐ Yes (Please attach) ☐ No

Do you require the services of a translator?

☐ No ☐ Sign Language ☐ Spanish

Other:_____

Please check all the services you are interested in at this time. *Note: Services may vary for each Kramer Davis location.*

X Medicine
☐ Dentistry
☐ Psychiatry
☐ Neurology
☐ Vision
☐ Psychology
☐ Behavioral
☐ Genetics
☐ Nutrition
☐ Hearing
☐ Crisis Intervention
☐ Physical Therapy
☐ Occupational Therapy
☐ Speech Therapy
☐ Other: _____

☐ No Changes

Patient Initials _____ Date of Birth: _____

MEDICAL INFORMATION

	Provider Name	Address	Phone
PCP			
Psychiatrist			
Dentist			
Neurologist			
Cardiologist			
Other:			

PAST MEDICAL HISTORY (Attach Additional Information if Necessary)

Please list all known current and prior illnesses (aside from minor injuries or infections).

Does the patient have intellectual disability? ☐ No ☐ Yes: ☐ Mild ☐ Moderate ☐ Severe ☐ Profound

Does the patient have any of the following conditions?

☐ Autism ☐ Cerebral Palsy ☐ Downs Syndrome ☐ Fetal Alcohol Syndrome ☐ Fragile X Syndrome ☐ Other: _____

Has the patient had genetic testing? ☐ No ☐ Yes, please state approximately how long ago? Findings?

HOSPITALIZATIONS, ER VISITS, PSYCHIATRIC ADMISSIONS (please include date, location, and reason for stay).

	Date:	Location:	Reason for stay:
☐ Hospitalization ☐ ER Visit ☐ Psych			
☐ Hospitalization ☐ ER Visit ☐ Psych			
☐ Hospitalization ☐ ER Visit ☐ Psych			
☐ Hospitalization ☐ ER Visit ☐ Psych			
☐ Hospitalization ☐ ER Visit ☐ Psych			

Surgeries (Please include date, location, and reason for surgery and what was done).

Date:	Location:	Reason for Surgery:	What was Done:

Please list any falls, major injuries, accidents, or traumatic events you have experienced in your life and list date:

Family History

Please tell us about any illnesses that run in the patient's family, include the relationship to the patient and age they were diagnosed.

Relationship	Illness	Age at which relative was diagnosed

Please tell us about any family members with birth defects, genetic disorders and intellectual of developmental disabilities

Social History: Please tell us about the following.

Does/Is the patient:

☐ Smoke?
☐ Chew tobacco?
☐ Chew nicotine?
☐ Use E-cigarettes?
☐ Drink alcohol?
☐ Drink caffeinated beverages?
☐ Use any street drugs?
☐ Addicted to any substances, including prescriptions?
☐ Sexually active? Please describe:

Allergies

Is the patient allergic to any of the following:

Medications: ☐ No ☐ Yes
Adhesive: ☐ No ☐ Yes
Insect bites/stings: ☐ No ☐ Yes
Latex: ☐ No ☐ Yes
Food: ☐ No ☐ Yes

Please list what the patient is allergic to and what happens if he or she is exposed to it:

Patient Initials _____ Date of Birth: _____

Please check if the patient has any of the following:

GENERAL

- ☐ Weight loss
- ☐ Weight gain
- ☐ Fatigue
- ☐ Insomnia
- ☐ Sleep disturbances
- ☐ Pain
- ☐ Fever
- ☐ Chills
- ☐ Difficult wound healing
- ☐ Problems with daily functions
- ☐ Other:

_____

_____

- ☐ **NO CHANGES**
- ☐ **NONE CURRENTLY**

VISION, HEARING, AND SPEECH

- ☐ Double vision
- ☐ Vision impairment
- ☐ Eye disorders
- ☐ Eye pain
- ☐ Red eyes/discharge
- ☐ Change in hearing
- ☐ Hearing impairment
- ☐ Ear pain/ drainage
- ☐ Nonverbal
- ☐ Glasses / Contacts
- ☐ Hearing Aid
- ☐ Has Communicative Device
- ☐ Other:

_____

- ☐ **NO CHANGES**
- ☐ **NONE CURRENTLY**

NOSE, MOUTH, THROAT, and NECK

- ☐ Nasal discharge
- ☐ Post nasal drip
- ☐ Mouth sores
- ☐ Non-healing mouth ulcers
- ☐ Difficult swallowing
- ☐ Choking
- ☐ Snoring
- ☐ Hoarseness of changing in the voice
- ☐ Neck pain
- ☐ Difficulty moving neck
- ☐ Other:

_____

_____

- ☐ **NO CHANGES**
- ☐ **NONE CURRENTLY**

DENTAL

- ☐ No teeth
- ☐ Metal fillings
- ☐ White composite filling
- ☐ Dental cleanings in the past
- ☐ Dental implants
- ☐ Dental crowns / caps
- ☐ Dentures
- ☐ Partial dentures
- ☐ Other:

_____

- ☐ **NO CHANGES**
- ☐ **NONE CURRENTLY**

DENTAL

- ☐ Tooth Extraction
- ☐ Root canal
- ☐ Braces
- ☐ Grind teeth
- ☐ Use of a bite guard
- ☐ Any painful teeth
- ☐ Tooth sensitivity to hot or cold
- ☐ Tooth sensitivity to sweets
- ☐ Other:

_____

- ☐ **NO CHANGES**
- ☐ **NONE CURRENTLY**

GASTROINTESTINAL

- ☐ Cannot eat by mouth
- ☐ Needs assistance eating
- ☐ Acid reflux, heartburn, or GERD
- ☐ Hiatal hernia
- ☐ Ulcers
- ☐ Colitis
- ☐ Nausea / vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in vomit / stool
- ☐ Decreased appetite
- ☐ Gastroparesis
- ☐ Abdominal pain
- ☐ Jaundice
- ☐ Hepatitis
- ☐ G-tube
- ☐ J-tube
- ☐ Colostomy
- ☐ Other liver disease
- ☐ Pancreatitis
- ☐ Gallbladder disease
- ☐ Any type of intestinal disease
- ☐ Enlarged Spleen
- ☐ Appendicitis
- ☐ Other:

_____

- ☐ **NO CHANGES**
- ☐ **NONE CURRENTLY**

CARDIOVASCULAR

- ☐ Palpitations
- ☐ Lightheadedness/dizziness
- ☐ Shortness of breath while lying down
- ☐ Heart murmur
- ☐ Pacemaker
- ☐ Heart attack
- ☐ Congenital heart defect
- ☐ Chest pain or pressure
- ☐ Coronary artery disease
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Loss of consciousness
- ☐ Heart infection
- ☐ Other: _____

- ☐ **NO CHANGES**
- ☐ **NONE CURRENTLY**

GENITOURINARY and REPRODUCTIVE

- ☐ Current Pregnancy
- ☐ Prior Pregnancy
- ☐ Polycystic Ovarian Syndrome
- ☐ Low testosterone
- ☐ Kidney stones
- ☐ Cancer of kidney or bladder
- ☐ Cancer of any reproductive organs
- ☐ Any infection of the reproductive organs
- ☐ Loss of bladder control
- ☐ Indwelling catheter
- ☐ Urostomy
- ☐ Sexually transmitted disease
- ☐ Other:

_____

- ☐ **NO CHANGES**
- ☐ **NONE CURRENTLY**

Please describe any items checked above (you may attach additional documents to this form):

Patient Initials _____ Date of Birth: _____

Please check if the patient has any of the following:

RESPIRATORY

- ☐ Shortness of breath
- ☐ Persistent cough
- ☐ Asthma / Wheezing
- ☐ Sleep Apnea
- ☐ Aspiration
- ☐ Uses inhaler
- ☐ History of pneumonia
- ☐ COPD or emphysema
- ☐ Tuberculosis
- ☐ Frequent respiratory infections
- ☐ Other:

_____

- ☐ NO CHANGES
- ☐ NONE CURRENTLY

SKIN, HAIR, NAILS, AND BREAST

- ☐ Rash
- ☐ Skin Cancer
- ☐ Skin sores
- ☐ Itching or pain in skin
- ☐ Psoriasis
- ☐ Eczema
- ☐ Hair loss or brittle hair
- ☐ Ectodermal dysplasia
- ☐ Problems with nails of hand or feet
- ☐ Breast pain
- ☐ Breast lumps
- ☐ Breast discharge
- ☐ Other: _____

- ☐ NO CHANGES
- ☐ NONE CURRENTLY

ENDOCRINE and METABOLIC

- ☐ Diabetes
- ☐ Thyroid disorder
- ☐ Adrenal gland disorder
- ☐ Growth hormone deficiency
- ☐ Pituitary disorder
- ☐ Other endocrine tumors
- ☐ Vitamin deficiency
- ☐ Hormone therapy
- ☐ Other:

_____

- ☐ NO CHANGES
- ☐ NONE CURRENTLY

MUSCULOSKELETAL

- ☐ Artificial Joint(s)
- ☐ Arthritis
- ☐ Scoliosis
- ☐ Gout
- ☐ Osteoporosis
- ☐ Fractures
- ☐ Muscular Dystrophy
- ☐ Myasthenia Gravis
- ☐ Fibromyalgia
- ☐ Spinal Rod
- ☐ Spina Bifida
- ☐ Other muscle / bone disorder
- ☐ Other:

_____

- ☐ NO CHANGES
- ☐ NONE CURRENTLY
- ☐ Uses Lift
- ☐ Walker
- ☐ Crutches
- ☐ Cane
- ☐ Wheelchair
- ☐ Gait Belt
- ☐ Removable Prosthetic

PSYCHIATRIC / BEHAVIORAL

- ☐ Impulsivity
- ☐ Depression
- ☐ Obsessive compulsive disorder (OCD)
- ☐ Attention Deficit / Hyperactivity (AD/HD)
- ☐ Anxiety / Panic attacks
- ☐ Schizophrenia
- ☐ Hallucinations
- ☐ Self-Injurious Behavior (SIB)
- ☐ Aggressive behavior (physical or verbal)
- ☐ Property destruction
- ☐ Other: _____

- ☐ NO CHANGES
- ☐ NONE CURRENTLY

BEHAVIORAL TRIGGERS

Behavior triggered by:

- ☐ Light
- ☐ Sound
- ☐ Smell
- ☐ Other: _____

HEMATOLOGICAL and VASCULAR

- ☐ Easy bleeding
- ☐ Sickle cell anemia or trait
- ☐ Any type of anemia
- ☐ Any type of blood disorder
- ☐ History of blood clots
- ☐ Swelling in the legs
- ☐ Lower leg pain with walking
- ☐ Other:

_____

- ☐ NO CHANGES
- ☐ NONE CURRENTLY

USE OF:

- ☐ Weighted blanket
- ☐ Use of wrist wrap
- ☐ Use of lap belt
- ☐ Use of papoose
- ☐ Oral sedation
- ☐ In-office I.V. sedation
- ☐ General anesthesia in operating room
- ☐ Other: _____

- ☐ NO CHANGES
- ☐ NONE CURRENTLY

NEUROLOGICAL

- ☐ Headache
- ☐ Seizures
- ☐ Impaired coordination or balance
- ☐ Weakness or paralysis
- ☐ Spastic muscles
- ☐ Stroke
- ☐ Difficulty with movement
- ☐ Hydrocephalus
- ☐ Vagus nerve stimulator (VNS)
- ☐ Shunt
- ☐ Concussion
- ☐ Other: _____

- ☐ NO CHANGES
- ☐ NONE CURRENTLY

SENSORY

- ☐ NO CHANGES
- ☐ NONE CURRENTLY

- ☐ Seeks out sensations or stimulus (specify mouthing objects, seeking weights or pressure, seeking music, or other stimulus)
- ☐ Bothered or distracted by sensations that do not bother others (specify and give examples e.g., smells, sounds, lights, sensations, etc.)
- ☐ Tolerates or seeks out stimuli that are noxious, dangerous, or perceived as harmful by others (Specify)
- ☐ Unusual responses to stimuli (specify and give examples e.g., gags easily, fearful of stairs)
- ☐ Other: _____

IMMUNOLOGICAL

- ☐ Seasonal allergies
- ☐ Rheumatic fever
- ☐ Any autoimmune disease
- ☐ HIV / AIDS
- ☐ Any chronic infection
- ☐ Cancer, tumors, or growths
- ☐ Chemotherapy
- ☐ Radiation Therapy
- ☐ Other:

_____

- ☐ NO CHANGES
- ☐ NONE CURRENTLY

Please describe any items checked above:

Patient Initials _____ Date of Birth: _____

MEDICAL INFORMATION (Continued)

Additional Medical History:

_____ **Name of Patient/Guardian/Conservator**	_____ **Relationship to Patient**	**FOR OFFICE USE ONLY**
_____ **Signature of Patient/Guardian/Conservator**	_____ **Date**	_____ Medical Provider Signature and Date _____ Psychiatry Provider Signature and Date _____ Dental Provider Signature and Date

Kramer Davis HEALTH

Patient Initials _____ Date of Birth: _____

Date Completed: _____

MEDICATION LIST

(Please include all over-the-counter medications, including supplements) vitamin supplements)

☐ **NO MEDICATIONS (CHECK HERE)**

☐ **NO CHANGES**

Date (mm/yy)	Medication	Dosage	Instructions	Physician

Comments

A printed list of medications with patient's name and date of birth can be used in substitution of this page.

Patient Initials _____ Date of Birth: _____

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PATIENT HEALTH INFORMATION

I hereby acknowledge receipt of the *Notice of Privacy Practices*. In addition, I agree to release of protected health information as defined under HIPAA to the individuals set forth below. **(Please include appointment contact, FHP, Case Manager, if applicable).**

1. Name: _____ Relationship: _____ Address: _____ Type of information to be released: ☐ All information ☐ Other: _____	**2. Name:** _____ Relationship: _____ Address: _____ Type of information to be released: ☐ All information ☐ Other: _____
3. Name: _____ Relationship: _____ Address: _____ Type of information to be released: ☐ All information ☐ Other: _____	**4. Name:** _____ Relationship: _____ Address: _____ Type of information to be released: ☐ All information ☐ Other: _____
5. Name: _____ Relationship: _____ Address: _____ Type of information to be released: ☐ All information ☐ Other: _____	**6. Name:** _____ Relationship: _____ Address: _____ Type of information to be released: ☐ All information ☐ Other: _____

This Authorization will remain in effect (check one of the two boxes)::

☐ For all past, present, and future periods of time unless I revoke (cancel) the Authorization

☐ Until this date: _____ or this specific event: _____

I may revoke (cancel) this Authorization at any time by sending a written request to Kramer Davis at hello@kd.health. I understand that I can look at the document named Kramer Davis' Notice of Privacy Practices for additional information aboutrevoking (canceling) this Authorization. I understand that revoking (canceling) this Authorization will not affect any actions that were taken by Kramer Davis before Kramer Davis received my written request asking to revoke (cancel) this Authorization.

I understand:

☐ I may refuse to sign this Authorization.

☐ Kramer Davis will not condition treatment, payment, enrollment, or eligibility of provision of services on this Authorization.

☐ My protected health information that is disclosed (shared with other people) using this Authorization may be disclosed (shared) by the people listed above and may be no longer protected under the law including HIPAA.

By signing below, I as the Patient or my Surrogate Decision-Maker (the person making decisions for me) agree and certify that: (i) I have read this Authorization; (ii) I agree that my protected health information described in the Authorization can be disclose to (shared with) other people; and (iii) I have received a signed copy of this Authorization.

_____ _____

Name of Patient/Guardian/Conservator **Relationship to Patient**

_____ _____

Signature of Patient/Guardian/Conservator **Date**

Patient Initials _____ Date of Birth: _____

CONFIRMATIONS AND SIGNATURES

I agree and attest that the information provided in the above named patient's MEDICAL INFORMATION is true and complete to the best of my knowledge. I understand and agree that Kramer Davis Health will use and rely on the information I am providing. I agree and affirm that I have received the Notice of Privacy Practices document. I will keep a copy of all documents I receive from Kramer Davis. By signing below, I agree:

I consent (agree) for Kramer Davis Health and its staff to examine me, to evaluate me, and to provide treatment to me as a patient.

I consent (agree) for Kramer Davis Health to take photographs of me for clinical purposes to use in my evaluation and treatment and to include the photographs in my medical record.

I consent (agree) for Kramer Davis Health to obtain, use and share my personal health information.

I consent (agree) for Kramer Davis Health to obtain my personal health information (PHI) from my other doctors and other treating healthcare providers, and to share my personal health information with other doctors and other treating providers. I consent (agree) for Kramer Davis Health to submit insurance claims to and receive payment from my insurance company for all professional services I receive, and to obtain information about my medication history from my pharmacy.

I consent (agree) for Kramer Davis Health to communicate with me in the following ways:

☐ Mail: I want mail to be sent to my mailing address.

☐ Cell Phone: It is okay to leave a voicemail on my cell phone.

☐ Home Phone: It is okay to leave a voicemail on my home phone.

Cell Phone # (to call or text): _____

Home Phone #: _____

Email Address: _____

Fax: _____

_____ _____

Name of Patient/Guardian/Conservator **Relationship to Patient**

_____ _____

Signature of Patient/Guardian/Conservator **Date**

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining acknowledgment
- ☐ An emergency prevented us from obtaining acknowledgement
- ☐ Other (please specify): _____

REVIEWED BY:

_____ _____

Signature **Date**

Kramer Davis HEALTH

Patient Initials _____ Date of Birth: _____

TELEMEDICINE INFORMED CONSENT FORM

Site Where Patient is Seen for Telemedicine (provide city and state):_____

Provider Location:_____

A clinical encounter using telemedicine technology may be through videoconferencing and/or telephone. You will be able to see and/or hear the provider and they will be able to see and/or hear you, just as if you were in the same room. The information may be used for diagnosis, treatment, therapy, follow-up and/or education as with any information if you were seen in person. Telemedicine often allows improved or more convenient access to care.

The Process:

You will be introduced to the provider and anyone else who is in the room with the provider. You may ask questions of the provider, anyone with the provider, or any staff in the room with you. If you are not comfortable seeing or hearing a provider using videoconference or telephone technology, you may decline the use of the technology and schedule a traditional face-to-face encounter at any time. Security measures are used so that the videoconference is secure. Any recording will be stopped if you request such.

Possible Risks:

Potential risks associated with the use of telemedicine which include, but may not be limited to:

- A provider may determine that the telemedicine encounter is not yielding sufficient information to make an appropriate clinical decision, and this may require an in-person visit.
- Technology problems may delay medical, psychological, psychiatric, behavioral, dental or therapeutic evaluation and treatment for the encounter.
- In very rare instances, security or communications protocols could fail, causing a breach of privacy of personal medical information.
- I may not be in a private place and others may overhear me

By Signing this Form, I understand the following:

1. I understand that I have the right to 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.
2. I understand that if the provider believes I would be better served by a traditional face-to-face encounter, the provider may at any time stop the telemedicine visit and schedule a face-to-face visit. I also understand that technology problems may necessitate an in-person visit with the provider.
3. 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.
4. I understand that the laws that protect privacy and confidentiality of medical information also apply to telemedicine.
5. I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit.
6. I understand that it is my responsibility to be in a private place so that others do not overhear me, and I bear the risks of being in a location where others may be able to hear me.
7. My telehealth files will be stored with all of my other medical records.

Patient Consent to the Use of Telemedicine:

I have read and understand the information provided above regarding telemedicine, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my care. I also consent to photographs of the video encounter being taken and stored in my patient file.

I hereby authorize Kramer Davis Health and its staff to use telemedicine in the course of my diagnosis and treatment.

_____ _____

Name of Patient/Guardian/Conservator **Relationship to Patient**

_____ _____

Signature of Patient/Guardian/Conservator **Date/Time**

_____ _____

Witness **Date/Time**

Kramer Davis HEALTH

Patient Initials _____ Date of Birth: _____

OUTPATIENT OR RESPONSIBLE PARTY FINANCIAL AGREEMENT AND ASSIGNMENT

OUTPATIENT INSURANCE BENEFITS

List any insurance which covers the patient, such as hospital, health, dental, accident, disability, annuity, including group, and individual policies.

Insurance (Name, Address)	Subscriber's Name	Policy No.	Group No.	Effective Date:
☐ NONE 1.				
2.				
Medicare ☐ A ☐ B	Other (Specify):	Social Security No. of Policy Holder(s)		
Number:		_____ - _____ - _____ _____ - _____ - _____		

I hereby certify that the financial information submitted and recorded as of this date, _____ 20_____, on this PATIENT OR RESPONSIBLE PARTY FINANCIAL RECORD is complete and true to the best of my knowledge.

It is further understood that Kramer Davis Health may void the accompanying FINANCIAL AGREEMENT if any financial information is found to be inaccurate or misleading, and I may be subject to penalties imposed by the state of Tennessee. I agree to be responsible for any amounts not covered by insurance.

_____ _____

Name of Patient/Guardian/Conservator **Relationship to Patient**

_____ _____

Signature of Patient/Guardian/Conservator **Date**

Kramer Davis HEALTH

Patient Initials _____ Date of Birth: _____

OUTPATIENT OR RESPONSIBLE PARTY FINANCIAL AGREEMENT AND ASSIGNMENT

I. The outpatient clinic services fee charge schedule has been provided to me and those fees are subject to change without prior notice.

II. I hereby assign any insurance benefits and other available coverage to the above-named health facility, and authorize the release of necessary information for the health facility to file benefit claims(s).

III. I acknowledge financial responsibility for services rendered or to be rendered to self or the above person, a patient at Kramer Davis Health

IV. A. I agree to be responsible for the payment of charges for services rendered during any visit to the specialty clinic based upon my ability to pay in accordance with a “means test” .It is further understood that any changes in income (increase or decrease) may alter my ability to pay.

B. Payment of ability to pay will be after available MEDICARE, MEDICAID, insurance, and other benefits have been applied to my charges.

V. Failure to provide the necessary information to determine the ability to pay may result in the patient being charged FULL PAY for all services rendered by the facility.

VI.. I, or we, the undersigned understand the terms of this Agreement and acknowledge receipt of a copy.

_____ _____

Name of Patient/Guardian/Conservator **Relationship to Patient**

_____ _____

Signature of Patient/Guardian/Conservator **Date**

Kramer Davis HEALTH

Patient Initials _____ Date of Birth: _____

CONSENT FOR EXAMINATION EVALUATION AND TREATMENT

Consent. On behalf of the above-named patient, I hereby give my permission for Kramer Davis Health clinicians, or any clinician designated by Kramer Davis Health to perform medical, dental, psychiatric, behavioral, neurological, therapeutic and/or any other health related procedures offered by Kramer Davis Health including, but not limited to: examination, diagnostic procedures, including photographic and video based procedures, x-rays, laboratory testing, HIV/AIDS testing, treatment and/or therapies. This includes minor surgery, biopsies, suturing and other procedures.

I understand that examination or treatment of any patient embodies some level of risk for injury, up to and including death. I also understand that examination and treatment of a patient with intellectual and/or developmental disability (IDD) involves additional risks unique to this patient population. I also understand that there are risks associated with not examining and/or not treating problems identified by Kramer Davis Health clinicians.

I understand that no outcome can be absolutely predicted or guaranteed as a result of treatment received, and I affirm that Kramer Davis Health has made no such prediction or guarantee.

Use of Anesthesia / Prescription Medication. I understand that some procedures done in the clinic requiring the use of anesthesia will involve local anesthesia. I understand that, should a referral to a hospital program, or should the utilization of IV sedation or general anesthesia be required to safely examine and treat, I will be informed and involved in the decision-making process.

I understand that the use of local anesthesia, or any medication that the clinician may prescribe, carries with it some inherent risks including, but not limited to previously undiagnosed drug allergy. I also understand that there are risks associated with not utilizing local anesthesia or other prescription medications.

I understand that, during the course of my treatment, certain controlled substances (medications) may be prescribed, and that the risks associated with the use of these types of medications may include but not be limited to: nausea, vomiting, drug allergy, drug tolerance, and drug dependence.

I understand that while I am on controlled substances my prescriber may ask for routine counts of prescriptions.

Guardian Notification. I understand that, from time to time, Kramer Davis Health clinicians may want to contact me to obtain permission to either discontinue a current psychotropic medication, pain medication or other controlled medication, or to prescribe a new psychotropic medication, pain medication or other controlled medication. If the Kramer Davis Health clinician or staff person is unable to contact me, I give my permission for the clinician to either discontinue or prescribe the psychotropic medication, pain medication or other controlled medication as they deem appropriate until such time as I can be reached.

Emergency Treatment. In case of emergency situations including but not limited to fractures of teeth / bones, acute infections, respiratory distress, or situations in which the clinician deems that severe pain or patient harm is either present or imminent, I give my permission for the clinician to provide the limited emergency treatment he / she deems appropriate to resolve the emergency situation.

Authorization to Photograph

I hereby give permission for Kramer Davis Health to photograph the above-named patient. I understand that these images will be used for purposes of planning and providing clinical care, maintaining clinical records, in consultation with other clinicians involved in the patient's care, or for education. I understand that these images will not be used for marketing purposes without my consent.

The Kramer Davis Health is a Teaching Clinic

I understand that Kramer Davis Health serves as a training site for medical students, medical residents, dental students, dental residents, dental hygiene students and other allied health care clinicians-in-training from various local educational facilities. And I understand and consent that, from time to time, such persons will render care to the above-named patient, and that such care will be supervised by the appropriate attending physician, dentist, hygienist, or therapist in that respective discipline as determined appropriate by the clinicians

_____	_____
Name of Patient/Guardian/Conservator	**Relationship to Patient**
_____	_____
Signature of Patient/Guardian/Conservator	**Date**

Kramer Davis HEALTH

Patient Initials _____ Date of Birth: _____

CONSENT TO USE MEDICAL IMMOBILIZATION

General Consent. I hereby give my permission for any Kramer Davis Health clinician, or any staff member he / she may designate, to utilize temporary medical immobilization during the delivery of services to the above-named patient, should the clinician deem it necessary for the safe delivery of care.

Associated Risks. I understand that the use of temporary medical immobilization embodies some level of risk for possible injury to the above-named patient. However, I also understand that there are risks associated with not using medical immobilization (e.g., risk of self-injury, etc.).

Medical Immobilization Policy. Our primary responsibility to our patients is to provide quality healthcare services in a safe environment. This includes protecting our patients with intellectual disabilities from self-injury during the delivery of care.

Patients who either lack the ability to control their body movements or lack sufficient cognitive functioning to understand that their body movements may interfere with the performance of a procedure or treatment and in so doing may cause injury to themselves should have their movements managed in such a way as to prevent that self-injury.

The level of medical immobilization employed should be the least restrictive, effective method necessary to safely deliver care. Though, it is important to note that what constitutes the least restrictive, effective method may change based on the clinical judgment of the clinician. The Clinic Hierarchy of Medical Immobilization Intervention describes, from most passive to most aggressive, what those levels of intervention involve.

Clinic Hierarchy of Medical of Medical Immobilization Intervention:

1) Gentle hand holding / redirecting of hand movements
2) Wrists wrap to limit upper limb movement
3) Papoose wrap to limit body movement
4) Oral sedation
5) IV sedation
6) Referral to the operating room for general anesthesia and endotracheal intubation

The following section, The Patient's Right to Freedom of Movement addresses the clinician's legal considerations; and The Patient's Right to Safety

discusses the medical considerations the clinician faces when deciding whether or not to employ medical immobilization.

The Patient's Right to Freedom of Movement. All patients served by Kramer Davis Health have a fundamental right to human dignity and privacy. Freedom of movement is an important part of both dignity and privacy. Many of the patients seen at Kramer Davis Health have had a person other than themselves designated by a Court as being their legal representative.

When obtaining consent to utilize medical immobilization, Kramer Davis Health provides the patient's representative with an opportunity to ask questions about medical immobilization and to have his or her questions answered in language he or she understands.

The Patient's Right to Safety. Many patients can be safety examined and treated in the Clinic with no medical immobilization intervention being required. As has been stated, utilization of medical immobilization is sometimes indicated in an effort to promote the safe delivery of care.

However, in cases where the patient is severely resistant to examination and treatment, the clinician may determine that further attempts to examine, treat, or to utilize medical immobilization is unsafe; and that the process itself represents a risk of injury to the patient. These cases will be referred for treatment in the operating room under general anesthesia and endotracheal intubation.

The use of medical immobilization is one of many issues constantly being evaluated when delivering care to patients. Decisions regarding patient positioning, positioning of the chair, are in many ways, related to improving patient safety and comfort. It is critical that these decisions remain very patient-centered, and that they remain subject to revision, as clinical realities evolve and change.

I agree that medical immobilization has been explained to me, and I agree to its use on the patient, with knowledge of risks.

_____ _____

Name of Patient/Guardian/Conservator **Relationship to Patient**

_____ _____

Signature of Patient/Guardian/Conservator **Date**

Kramer Davis HEALTH

Patient Initials _____ Date of Birth: _____

NOTICE OF PRIVACY PRACTICES

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to now affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 9/1/2023 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to other providers including a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us, or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you. an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends, or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

1) Prevent or control disease, injury or disability;
2) Report abuse or neglect;
3) Report reactions to medications or problems with products or devices;
4) Notify a person of a recall, repair, or replacement of products or devices;
5) Notify a person who may have been exposed to a disease or condition; or
6) Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with the Health Insurance Portability and Accountability Act (HIPAA).

Worker's Compensation. We may disclose your Personal Health Information (PHI) to the extent authorized by and to the extent necessary to comply with laws, relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized or permitted by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the

NOTICE OF PRIVACY PRACTICES (CONTINUED)

request or to obtain an order protecting the information requested. **Research.** We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Education. We may disclose your health information to others, with redactions as to all personal identifying information, for the purposes of training, education, quality assurance/improvement, and other such related activities.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to cany out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. 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. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested, we may contact you using the information we have.

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. if we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information Orin response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you. may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with 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. Our Privacy Official: Kramer Davis Compliance Director, 3901 Central Pike, Ste 500, Hermitage, TN 37076

Kramer Davis HEALTH

Patient Initials _____ Date of Birth: _____

CONSENT TO OPIOID TREATMENT

Please read the below information carefully and ask your Kramer Davis Health provider if you have any questions relating to the medication prescribed to you.

Using Opioids to Treat Pain

1. Opioids are used to treat moderate-to-severe pain of any type, and to treat anxiety and stress associated with moderate-to-severe pain.
2. These medications can be potentially effective tools that can help reduce pain, improve function, and improve quality of life.
3. Using these medications requires that both the physician and patient work together in a responsible way to ensure the best outcome, lowest side effects, and least complications.
4. Usually there are other options other than opioids to treat moderate to moderately severe pain, including therapy that does not involve medication. There are times when these other options may provide more pain relief with less risk.

How Do Opioids Work?

Opioid medications work at the injury site, the spinal cord, and the brain. They dampen pain, but do not treat the underlying injury. They may help to prevent acute pain from becoming persistent chronic pain. These medications may work differently on different people because of a number of factors. Side effects and complications will vary by individual.

Some common side effects and complications may include Constipation; Dry Mouth; Sweating; Nausea; Drowsiness; Euphoria; Forgetfulness; Difficulty urinating; and Itching.

Some uncommon side effects and complications may include: Confusion; Hallucinations; Shortness of Breath; Depression; and Lack of Motivation.

You should not expect that opioid treatment will cure the underlying injury, nor that it will totally eliminate pain, anxiety and stress.

Physical Dependency

Opioid medications will cause a physical dependency marked by abstinence syndrome when they are stopped abruptly. If these medications are stopped or rapidly decreased, the patient will experience chills, goose bumps, profuse sweating, increased pain, irritability, anxiety, agitation, and/or diarrhea. The medicines will not cause these symptoms if taken as prescribed and any decision to stop these medications should be done under the supervision of your physician in a slow downward taper.

Misuse of Medications

1. **Addiction:** This is a psychological condition of use of a substance. Between six and ten percent (6-10%) of the United States population have problems with Substance Use Disorder and addiction. Controlled medications, including opioids, are likely to activate addictive behavior in this group of people.
2. **Diversion:** It is illegal to share your controlled medications with other people. It is illegal to provide false information to a prescriber in an attempt to obtain controlled medication. It is illegal to doctor shop (visit multiple doctors in attempt to obtain controlled medications). Federal and Tennessee state laws exist to address diversion problems. It is critical that you safeguard your controlled medications and use them only as prescribed by your doctor.
3. **Driving:** Studies of patients with chronic pain demonstrate improved driving skills when taking certain controlled medications, but you individually may have problems driving and need to realistically assess your own skills, as well as listen to others who may be in a vehicle with you to determine if you should be driving while under the influence of opioids.

Additional Rules for Using Controlled Medications

1. Follow your physician's recommendations.
2. Do not take more or less pills than prescribed without discussing this first with your physician and receiving express permission to do so.
3. Do not share medications with family or friends, or anyone else at all.
4. Do not take medications from family or friends, or anyone else at all, aside from your prescriber.
5. Do not stop your prescribed medications abruptly. Any reduction in dosage must be discussed and cleared by your physician.

Patient Initials _____ Date of Birth: _____

CONSENT TO OPIOID TREATMENT

6. Do not take medications in any manner other than prescribed.
7. Keep all medications out of reach of children.
8. Do not leave your prescriptions or controlled medications lying around unprotected for others to steal and abuse them.
9. Do not operate a motor vehicle if you feel mentally impaired using controlled medications.
10. Alcohol use should be curtailed when using controlled medications.
11. Continued use of prescribed opioids is based on your physician's judgment and a determination of whether the benefits to you of using controlled medications outweigh the risks of using them.
12. Your physician may discontinue treating you at his or her discretion.

For Women between the Ages of 15 and 44, who are able to Have Children

I understand that I should take care to not become pregnant while taking opioids. If I do not want or plan to become pregnant, I will work with my provider to find the best contraceptive or birth control method for me. It is my responsibility to tell my provider immediately if I think I am pregnant or if I am thinking about getting pregnant. the risk to a developing baby if exposed to opioids during pregnancy includes low birth weight, the baby's dependency on opioids, and long withdrawal after birth (neonatal abstinence syndrome). I understand that a baby's exposure to opioids during pregnancy can cause the baby pain, suffering, and a longer time in the hospital.

We at Kramer Davis Health believe in treating your pain and we recognize the value of opioid treatment in this process. When used properly, opioids can help restore comfort, function, and quality of life. However, as stated above, opioids may also have serious side effects and are highly controlled because of their potential for misuse and abuse. It is important to work with your physician and communicate openly and honestly with him or her about your pain control needs. By doing so, medications can be used safely and successfully.

By your signature below, you are acknowledging that you:

1. Have been provided with the above information, and have read and reviewed these matters with your physician;
2. Have been given to opportunity to ask any questions to your physician, and any such questions regarding the above information have been adequately and appropriately answered; and
3. Have sufficient information to make an informed decision to use the opioids prescribed.

You should **NOT** sign this form if you do not believe you have enough information to make an informed decision about your use of opioids and how they fit in to your pain management treatment plan.

_____ _____

Name of Patient/Guardian/Conservator **Relationship to Patient**

_____ _____

Signature of Patient/Guardian/Conservator **Date**