Gadsden
Physician Clinics

PATIENT INFORMATION - Part 1/7

Name:_____
(Last) (First) (Middle)

DOB:_____ SSN:_____

Mailing Address_____ City_____ State_____ Zip_____

Sex: Male / Female (Circle One)

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

Email Address:_____

Marital Status (Circle One): Single Married Divorced Separated Widowed Partner

Language (Circle One): English Spanish Other_____

Race (Circle One): White African American Hispanic Other_____ Declined

Membership (Circle One): Healthy Women Senior Circle Both Neither

Who referred you to our practice? _____

Would you like an appointment follow up call? YES or NO

If so, which is the best number to reach you? Home Phone Work Phone Cell Phone

What is your Primary Pharmacy?

EMERGENCY CONTACT NAME _____ RELATION_____ CONTACT PHONE_____

Was this an accident : YES or NO If so, indicate: Auto_____ Workers' Comp_____ Other_____

BILLING INFORMATION

Patient's Relationship to Guarantor (Circle One): Self Spouse Child Other_____

Guarantor Name:_____
(Last) (First) (Middle)

Guarantor DOB:_____

Mailing Address_____ City_____ State_____ Zip_____

Guarantor SSN: _____ Guarantor Phone:_____

Guarantor Email:_____ Guarantor Employer:_____

INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance Co. Name | Address, City, State, Zip Code, Telephone Number

Subscriber's ID Number | Group Number | Policyholder's Name | Social Security #

Patient's relationship to policyholder (please circle one): Self Spouse Child Other Date of Birth of Subscriber:_____

SECONDARY INSURANCE

Insurance Co. Name | Address, City, State, Zip Code, Telephone Number

Subscriber's ID Number | Group Number | Policyholder's Name | Social Security #

Patient's relationship to policyholder (please circle one): Self Spouse Child Other Date of Birth of Subscriber:_____

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FINANCIAL POLICY - 2/7

We strongly feel all patients deserve the very best medical care that we can provide. Everyone benefits when financial arrangements are agreed upon. We have prepared this material to acquaint you with our policy.

Our professional services are rendered to you, not the insurance company. Payment for treatment is your responsibility.

FINANCIAL AGREEMENTS

INITIAL

_____ I understand if I fail to pay amounts owed; the clinic has the right to secure an outside collection agency and/or attorney to collect the unpaid debt and to report the unpaid debt to a credit-reporting agency. I further understand that I will be responsible for any additional charges or fees necessitated by securing the collection agency or attorney, including reasonable attorney's fees.

SELF PAY AGREEMENT

INITIAL

_____ I have no insurance coverage I understand that I am responsible for payment of services rendered to myself or dependentsat the time of service.

INSURANCE AUTHORIZATION AND ASSIGNMENT

INITIAL

_____ I hereby authorize the release of any information necessary to process insurance claims and request payment of benefits to be made for services rendered to my dependents or myself.

_____ I understand I am responsible at the time of service for paying any required co-payment and deductible.

MEDICARE/MEDIGAP

For Medicare Patients Only _____
Medicare Number

_____ I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Finance Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

Medigap Authorization Statement _____
Policy Number

_____ I Authorize any holder of medical or other information about me to be released to process this Medigap claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to myself or to the party who accepts assignment.

There will be a $35.00 charge on all returned checks.

I HAVE READ AND UNDERSTAND THE PAYMENT POLICY OF THIS OFFICE AND AGREE TO ABIDE BY THE SAID POLICY.

_____ _____
Patient/Parent/Guardian **Date**

Please present both your insurance card and your driver's license so we may make a copy for our records.

I will be paying by:_____Check_____Cash_____MasterCard/Visa/Discover/American Express

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Patient Confidentiality Notice - Part 3/7

It is the office policy to NOT release confidential and/or unauthorized information by home telephone, work voicemail, or cell voicemail. Whenever returning calls and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Information will also NOT be left with an unauthorized person who may answer the telephone. Also, anyone who comes to the office on your behalf will not be able to pick up medication, prescriptions, or reports without your authorization.

I, _____, AUTHORIZE GADSDEN PHYSICIAN CLINICS AND/OR THEIR STAFF TO LEAVE MEDICAL INFORMATION PERTAINING TO MY CARE BY THE FOLLOWING METHODS AND WILL ASSUME RESPONSIBILTY TO NOTIFY THEM WHEN EVER THIS INFORMATION CHANGES, (THIS INCLUDES LEAVING A MESSAGE TO REMIND ME OF MY APPOINTMENT).

Mark all that apply:

HOME ANSWERING MACHINE _____Yes _____No **WORK VOICEMAIL** _____Yes_____No **CELL PHONE** _____Yes_____No

Please list names of authorized people to leave messages/medical information, medications, prescription, and reports with:

NAME: _____RELATIONSHIP_____ NAME: _____RELATIONSHIP_____

NAME: _____RELATIONSHIP_____ NAME: _____RELATIONSHIP_____

SIGNATURE_____**DATE**_____

MEDICAL CONSENT FORM

In consideration of the care given and to be given to me:

Patient Name: _____ Birth Date: _____

I hereby give consent to receive medical treatment, including medications and hospitalization.

I hereby give consent to use of such necessary examinations, injections, tests, or immunizing treatments as in the opinion of the attending physician.

I hereby authorize the release of any requested medical information from private physicians and/or institutions.

_____	_____	_____
Patient Signature / Legal Guardian if a Minor	**Relationship to Patient**	**Date**

PATIENT CONSENT FOR E-PRESCRIBING (ELECTRONIC PRESCRIBING)

I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

Parent, Patient's Signature or Authorized Representative	**Date**	**Time**
Relationship to Patient	**Interpreter, if utilized**	
Witness' Signature		

MEDICALHISTORY– Part 4/7

PrintName

SurgicalHistory

Please list all surgical procedures you have experienced and the approximate date:

OtherProviders

Please list other health care providers you see (dentist, surgeon, other specialist, etc):

MedicationList

Please list all of the medications you take, including prescribed and over-the-counter drugs. Also list any nutritional or herbal supplements that you take:

Allergies andAdverse Reactions

If you have had an allergic reaction or other adverse reaction to a medication, please list the medication and type of reaction:

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MEDICALHISTORY– Part 5/7

Problems — Please tell us if you have had any of the following problems:

- ☐Attention deficit disorder/hyperactivity
- ☐Aneurysm
- ☐Anxiety
- ☐Asthma
- ☐Bariatric surgery (for weight loss)
- ☐Breast disorders
- ☐Cancer
- ☐Cardiac rhythm problems
- ☐Carotid artery disease
- ☐Cerebrovascular disease (TIA,stroke)
- ☐Cervical dysplasia (abnormal Pap smear)
- ☐Chronic pain
- ☐Colon polyps
- ☐Congenital anomalies (birth defects,etc)
- ☐COPD (chronic bronchitis, emphysema)
- ☐Coronary heart disease
- ☐Degenerative disc disease (back or neck)
- ☐Dementia or cognitive impairment
- ☐Depression
- ☐Diabetes
- ☐Disabilities
- ☐Ear or hearing disorders
- ☐Endocrine disorders
- ☐Erectile dysfunction (impotence)
- ☐Eye or vision disorders
- ☐Fibromyalgia
- ☐Fractures
- ☐Gastrointestinal disorders
- ☐Genital or reproductive disorders
- ☐GERD (heartburn, reflux, etc)
- ☐Gastrointestinal bleeding/hemorrhage
- ☐Glaucoma
- ☐Glucocorticoid (steroid) use
- ☐Heart disease
- ☐Hematologic (blood) disorders
- ☐Hernias
- ☐HIV/AIDS
- ☐Hypertension (high blood pressure)
- ☐Hypogonadism (hormone deficiency)
- ☐Immune deficiency
- ☐Inflammatory bowel disease (UC, Crohn)
- ☐Kidney disease (CKD, nephropathy,etc)
- ☐Kidney stones
- ☐Lipid (cholesterol) disorders
- ☐Liver disease (cirrhosis, hepatitis, etc)
- ☐Malnutrition or nutritional deficiency
- ☐Mental or psychiatric disorders
- ☐Migraines or chronic headaches
- ☐Muscle or skeletal disorders
- ☐Neurologic (nervous system) disorders
- ☐Obesity
- ☐Osteoarthritis
- ☐Osteoporosis or osteopenia
- ☐Pacemaker or defibrillator implant
- ☐Parkinson disease
- ☐Peripheral artery disease
- ☐Pregnancy-related disorders
- ☐Prostate disorders (BPH,cancer,infection)
- ☐Respiratory (breathing) disorders
- ☐Rheumatologic disorder (arthritis, lupus)
- ☐Seizure disorder or epilepsy
- ☐Skin disorders
- ☐Sleep apnea
- ☐Sleep disorders (insomnia, etc)
- ☐Splenectomy (removal or loss ofspleen)
- ☐Thromboembolism (blood clots,phlebitis)
- ☐Thyroid disorders
- ☐Transplantprocedure
- ☐Tuberculosis
- ☐Urinary tractdisorders ☐Venous(vein) disorders
- ☐Venous(vein) disorders

MEDICALHISTORY– Part 6/7

FamilyHistory — Please tell us about your family history (parents, siblings, children):

Family Member	Medical Problems or Cause ofDeath	Living	Age atDeath
Father		☐Y☐N	
Mother		☐Y☐N	
Sibling or Child		☐Y☐N	
Sibling or Child		☐Y☐N	
Sibling or Child		☐Y☐N	
Sibling or Child		☐Y☐N	
Sibling or Child		☐Y☐N	

Family History of Premature Heart Disease - Has anyone in your family (parent, sibling, or child) developed heart disease or died ofa heart attackatan early age? — Early age means a woman less than 65 or a man less than 55. ☐Y☐N

WorkHistory - Whatis your occupation?

Education

- ☐ Less than 8th grade
- ☐ 8th to12th grade
- ☐ High school graduate
- ☐ 2-year college
- ☐ 4-year college
- ☐ Postgraduate degree

Alcohol and Drug Use

- ☐ I do not use alcohol or drugs
- ☐ In the last year, I have consumed alcohol or used drugs more than I meant to.
- ☐ I have wanted or needed to cut down on my alcohol or drug use during the past year.

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TobaccoUse History

- ☐ I have never used tobacco
- ☐ I quit using tobacco _____ (date).
- ☐ I have smoked in the past 12 months
- ☐ I started smoking at the age of_____.
- ☐ I now smoke cigarettes — _____ pack/day
- ☐ I now smoke cigars — _____ cigars/day
- ☐ I now chew tobacco
- ☐ I now use chewing tobacco or snuff

MaritalStatus

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Separated
- ☐ Widowed
- ☐ Domestic partnership

REVIEWOFSYSTEMSQUESTIONNAIRE – Part 7

Please tell us if you have any problems related to the following body systems.Check **No problems** atthe top ofeach category if you have no symptoms related tothatbody system. Circle any specific problems thatyou have.

Constitutional	☐**No problems**
fever	weight gain
chills	weight loss
night sweats	exercise intolerance
change in appetite	

Eyes	☐**No problems**
dry eyes	floaters
irritation	sensitivity tolight
pain	double vision
visual change	discharge

Eyes,Nose,Throat	☐**No problems**
difficulty hearing	neck pain/tender
ear pain	unusual taste
vertigo	bleeding gums
ringing in ears	snoring
difficulty smelling	change in voice
frequent nosebleeds	dry mouth
sinus problems	mouth ulcers
sore throat	teeth problems
difficulty swallowing	mouth breathing

Cardiovascular	☐**No problems**
chest pain	heart murmur
arm pain w/ exercise	lightheadedness
shortness ofbreath	calf pain w/ exercise
breathless laying flat	jaw pain w/ exercise
irregular heartbeat	ankle/leg swelling

Respiratory	☐**No problems**
wheezing	coughing up blood
shortness ofbreath	coughing up sputum
rapid breathing	frequent cough

Gastrointestinal	☐**No problems**
nausea	loss of appetite
vomiting	diarrhea
vomiting blood	constipation
abdominal pain	heartburn
blood in stools	reflux
black/tarry stools	jaundice

Genitourinary	☐**No problems**
pain with urination	frequent urination
loss ofbladder control	urge tourinate
difficulty urinating	flank pain
blood in urine	frequent infections
vaginal discharge	awaking tourinate

Musculoskeletal	☐**No problems**
muscle aches	muscle weakness
muscle cramps	back pain
joint pain	problems walking
joint swelling	footdrop

Skin	☐**No problems**
dry skin abnormal	excessive sweating
moles breast	itching
discharge breast	rash
lump or pain	change in skin color

Neurologic	☐**No problems**
loss consciousness	tingling
slurred speech	tremor
weakness	seizures
numbness	dizziness
headache	memory problems
restless legs	loss ofbalance

Psychiatric	☐**No problems**
irritability	sleep problems
depression	paranoid thoughts
anxiety	suicidal thoughts
panic attacks	hallucinations

Endocrine	☐**No problems**
fatigue	increased thirst
cold or heat intolerance	abnormal hair growth
body odor	hair loss
decreased sex drive	irregular periods
erection problems	abnormal menses

Blood&Lymphatic	☐**No problems**
swollen glands	easy bruising
blood clots	bleeding problems

Allergy & Immune	☐**No problems**
nasal allergies	hives
frequent infections	

Notice of Communication Accessibility Services

Our staff wants to communicate effectively with you and your family members. Please fill out this paper and return it to Registration Clerk or your Nurse.

All of the communication accessibility aids and/or services that you need are **free of charge to you.**

Do you think you need any of the following aids and/or services?*

	YES	NO
American Sign Language interpreter		
Oral interpreter		
TTY/TDD		
Hearing-aid compatible telephone receiver with volume control		
Television closed captioning		
Written/printed materials in other formats (i.e. large print, audio, accessible electronic or other formats as available)		
Written/printed materials in Braille (if available). Other alternatives will be made available to accommodate individuals who are blind or have limited vision.		

Additional aids and/or services may be available. Please list any other ways we may better communicate with you:

*Please note that some aids or services will only be necessary in certain situations.

Patient/Family Member/Companion Signature	Date/Time ☐AM ☐PM
Signature of person, *if any*, who filled out this form on behalf of the patient, family member, or companion:	Date/Time ☐AM ☐PM

This provider complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-256-494-4000 (TTY: 1-800-548-2546).

Este proveedor cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-256-494-4000 (TTY: 1-800-548-2546).

이 제공자는 관련 연방 공민권법을 준수하며 인종, 피부색, 출신 국가, 연령, 장애 또는 성별을 이유로 차별하지 않습니다.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-256-494-4000 (TTY: 1-800-548-2546)번으로 전화해 주십시오.

Signature	Date/Time ☐AM ☐PM
Witness	Date/Time ☐AM ☐PM

Patient Label

TODAY'S DATE _____

Acknowledgement of Receipt of Notice of Privacy Practices

The Health Insurance Portability and Accountability Act (HIPAA) requires us to give you a notice of our privacy practices and to acknowledge your receipt of the notice.

What is the *Notice of Privacy* Practices?

The Notice of Privacy Practices explains how your protected health information may be used or disclosed by us. In addition, it explains your rights with regard to your protected health information, as well as our legal responsibilities.

1. **I have been provided a copy of the Notice of Privacy Practices:**

   _____ _____
   Print Name **Date of Birth**

   _____ _____
   Signature of Patient or Patient Representative **Relationship**

2. **Can we share your medical information with others listed below to appropriately care for you?**

   YES NO Spouse: _____
   Name and Telephone Number

   YES NO Parents: _____
   Name and Telephone Number

   YES NO Children: _____
   Name and Telephone Number

   _____
   Name and Telephone Number

   _____
   Name and Telephone Number

   _____
   Name and Telephone Number

   YES NO Friend: _____
   Name and Telephone Number

*****After you read the *Privacy Notice*, contact us if you require confidential communication or restrictions of your protected health information and we will have you complete the necessary forms.*****

All portions of this form ***must*** be completed to constitute a valid authorization for release of health informatio under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations. If any field is left bl the authorization will be considered defective.

Patient's Name				Date of Birth	Medical Record Number
Address	City	State	Zip	Telephone Number	Email Address

I authorize the use and disclosure of health information about me as described below:

Facility Authorized to Release my Health Information				
Address	City	State	Zip	Telephone Number

Agency or Individual(s) Authorized to Receive my Health Information				
Address	City	State	Zip	Telephone Number

Health Information that may be used / disclosed is limited to the following:

☐ Progress Notes ☐ Emergency Room Record
☐ Discharge Summary ☐ History and Physical ☐ Consultation(s) ☐ Lab ☐ Pathology Report
☐ Operative Note(s) ☐ Imaging/X-Ray Films ☐ X-Ray Reports ☐ Entire Record ☐ Fetal Heart Monitor Strips
☐ Other *(specify)* _____

Sensitive Information: ☐ Alcohol Abuse ☐ Drug Abuse ☐ Communicable diseases, including HIV status
☐ Genetic Testing ☐ Psychiatric/Behavioral Diagnoses

Health Information that may be used / disclosed is limited to the following periods of healthcare:

From (date): _____ To (date): _____ Account Number: _____
From (date): _____ To (date): _____ Account Number: _____

Health information to be released to the above named agency / individual is to be used / disclosed for the following purpose(s):

☐ Treatment/Consultation ☐ At Request of Patient ☐ Research ☐ Marketing ☐ Billing or Claims Payment
☐ At Request of Employer ☐ Other _____

"Health Information" identifies you (the patient) by name, and includes other demographic information about you. "Health Information" may include, but is not limited to: medical records, X-Ray films, slides, tracings, strips, etc.

I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release of information authorized herein, including Sensitive Information as indicated above, which was compiled during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility.

Protected Health Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by this privacy rule. If research-related Health Information is used or disclosed for continued research purposes, an expiration date or event does not apply.

This authorization will automatically *expire 60 days* after the date of signature below (except as indicated below), unless an earlier date is specified, or at the conclusion of a specified event. I understand that I have a right to revoke this authorization at any time, in writing, as stated in the Notice of Privacy Practices, except where the facility has already made disclosures in reliance upon my prior authorization.

Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining an authorization if the HIPAA prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage.

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: This information is to be treated in accordance with (HIPAA) privacy regulations.

Patient's Signature or Legal Representative			Date/Time
Relationship to Patient / Authority to Act on Patient's Behalf		Interpreter, if Utilized	Date/Time
Witness Signature	Date/Time	Expiration Date or Event	

☐ **Signature validated against driver's license or signature in Medical Record. There may be a charge for copying Medical Records.*
☐ Electronic copy requested.

Patient Label

Patient Consent for E-Prescribing (Electronic Prescribing)

I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

Parent, Patient's Signature or Authorized Representative	Date	Time
Relationship to Patient	Interpreter, if utilized	
Witness' Signature		