Alabama Clinics

PATIENT DATA

Last Name	First Name	Middle Initial
Social Security #	Date of Birth	Age
Address Apt #	City State Zip	
Home Phone # ( )	Sex (Circle One) Male Female	Martial Status (Circle One) Single – Married – Divorced
Employment Status	Employer	Business #
Nearest Friend or Relative (other than Spouse): Name:	Phone #	
Are you a Veteran? (Circle one) Yes No	Are you a Hospice Patient? (Circle one) Yes No	
Primary Insurance Plan	Insurance Policy Number	Insurance Group Number
Insured's Name	Insured's Date of Birth	Insured's SSN
Secondary Insurance Plan	Insurance Policy Number	Insurance Group Number
Insured's Name	Insured's Date of Birth	Insured's SSN

Reason for visit: _____

Referred by _____

Our office accepts certain insurances. Please check with your insurance company to see if we are providers and can file your insurance claims. Please give your insurance card to the receptionist so that she may make a copy of your card. We must have a copy of your card and a photo I.D., or we will be unable to file your insurance.

Authorization for treatment and release of medical records:
I hereby authorize the treating physician to release any information acquired in the course of my treatment to obtain payment for services rendered.

Authorization for sending results:
I hereby authorize the treating physician to release any information acquired in the course of my treatment to obtain payment for services rendered. I hereby consent and state my preference to have Professional Resource Management/ Alabama Clinics/ Prime Med of Ozark communicate with me by, App, email or standard SMS messaging regarding various aspects of my medical care, which may include, but shall not be limited to, test results, prescriptions, appointments, and billing. I understand that email and standard SMS messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email and standard SMS messaging regarding my medical care might be intercepted and read by a third party.

Policy regarding non-covered services:
In the event that my insurance denies payment for all or part of the services provided, I will be held responsible for payment of the charges. I hereby agree to pay a reasonable interest and attorney's fee, should this account be turned over for collection.

Signature _____ Date _____

CONSENT TO DISCLOSE PHI TO FAMILY MEMBERS OR FRIENDS

I hereby give my consent for the staff of Alabama Clinics to disclose protected health information (PHI) about me to the persons I have listed below.

In the event that I wish to remove a name from the list below, I may do so by writing to the Privacy Office at the office of Alabama Clinics and making my wishes known.

	Name	**Relationship**
1		
2		
3		
4		
5		

_____ _____

Signature of Patient or Legal Guardian Date

_____

Print Patient Name

I HAVE RECEIVED AND UNDERSTAND THE HIPPA POLICIES FOR ALABAMA CLINICS

DATE:_____ SIGNATURE_____

OFFICE POLICY

It is our policy that payment in full is due at the time of service. We do file Medicare, Medicaid, BCBS, Value Options, Behavioral Health Systems and Tri-Care, however, you will be required to pay all co-pays and deductibles not covered by your insurance company. In the event that services are not covered under your policy, you will be responsible for all charges. We would also like for you to understand that your health insurance policy is an agreement between you and the insurance company and that ultimately you are responsible for all charges.

A 24 hour cancellation notice is required if you are unable to keep a scheduled appointment. Three No-Shows will result in the patient not being rescheduled in this office. Emergency services are available Monday – Friday between the hours of 8:00 a.m. and 5:00 p.m. by calling the office at 334-712-1170. If you have an emergency at any other time, services are available though the local emergency room of your choice.

I understand that if my account becomes delinquent it will be placed with Prim, Freeman & Mendheim LLC. Further, I agree to the following terms regarding any outstanding balance that I owe: (1) I will incur interest at the rate of 1 ½ percent per month (18% PER ANNUM); (2) I agree and hereby consent that I will be responsible for reasonable collection costs, reasonable attorney's fees in addition to the outstanding balance, and costs of court incurred by ALABAMA CLINICS, in the collection of same, whether such outstanding balance is satisfied prior to, after initiation of a lawsuit, or after a judgment has been issued in a lawsuit; and (3) I agree and hereby consent that any lawsuit and/or legal proceeding surrounding the outstanding balance and debt, and fees and costs thereon, shall be initiated and litigated in the court of appropriate jurisdiction of Houston County, Alabama, and I hereby waive any and all defenses and/or objections to said jurisdiction. By signing below, I consent to the terms contained herein and affirmatively acknowledge that I have read the same before signing. Furthermore, I agree that if a cell phone number has been provided I can be contacted regarding my balance on said cell phone. Additionally, if I reside in Florida I agree to waive my rights to any exemption that would prohibit a wage garnishment should same become necessary to secure payment of any outstanding balance.

When a child is brought in for services, the parents are responsible for the charges unless otherwise authorized. If the parents are separated, filing for divorce, or are divorced, the parent bringing the child in for services is responsible for the bill.

I have read and agree to the above Office Policy.

_____ _____

Signature (Parent or Guardian if patient is age 13 or under) Date

*Patient Name*_____ *Date of Birth:* _____ *Today's Date:* _____

Please check all symptoms that you are experiencing today			
General ☐ *Change in appetite* ☐ *Change in weight* ☐ *Chills, fever, sweats* ☐ *Last flu shot*	*Urinary System - Female* ☐ *Irregular periods* ☐ *Menopausal-no periods* ☐ *Hysterectomy* ☐ *Vaginal discharge* ☐ *Difficulty Urinating* ☐ *Blood in urine* ☐ *Date of last menstrual period*	*Head* ☐ *Frequent Headaches* ☐ *Recent Trauma*	*Muscles/Bones* ☐ *Pain* ☐ *Weakness* ☐ *Joint Swelling* ☐ *Backache* ☐ *Degenerative Disease* ☐ *Chronic fatigue*
Eyes ☐ *Reading glasses* ☐ *Change in vision* ☐ *Double vision* ☐ *Blurred vision*	*Nervous System* ☐ *Dizziness* ☐ *Loss of consciousness* ☐ *Seizures* ☐ *Blackouts* ☐ *Nervous Exhaustion* ☐ *Numbness/tingling* ☐ *Strokes* ☐ *Ministroke/TIA* ☐ *Tremors* ☐ *Blank stare* ☐ *RLS*	*Ears/Nose/Throat/Mouth* ☐ *Loss of hearing* ☐ *Ringing in ears* ☐ *Gum problems* ☐ *Bleeding* ☐ *Nose Bleeding* ☐ *Hoarseness* ☐ *Difficulty swallowing* ☐ *Morning cough* ☐ *Toothache* ☐ *Vertigo* ☐ *Dizziness*	*Skin* ☐ *Skin cancer* ☐ *Rash* ☐ *Non healing lesion* ☐ *Lumps* ☐ *Psoriasis* ☐ *Skin tags* ☐ *Moles*
Respiratory ☐ *Difficulty breathing* ☐ *Cough* ☐ *Shortness of breath* ☐ *Coughing up blood* ☐ *Wheezing/Asthma*	*Emotional Status* ☐ *Nervousness* ☐ *Mood changes* ☐ *Schizophrenia* ☐ *Depression* ☐ *Insomnia*	*Heart* ☐ *Chest pain* ☐ *Heart beating fast* ☐ *Difficult breathing on activity* ☐ *Elevated Cholesterol* ☐ *Palpitations* ☐ *Heart wall issues*	*Endocrine/Glands* ☐ *Thyroid* ☐ *Heat intolerance* ☐ *Cold intolerance* ☐ *Diabetes* ☐ *Excessive thirst* ☐ *Excessive hunger* ☐ *Frequent urination*
Digestive System ☐ *Abdominal pain* ☐ *Nausea* ☐ *Vomiting* ☐ *Bloating* ☐ *Diarrhea* ☐ *Constipation* ☐ *Blood in stool* ☐ *Frequent belching* ☐ *Acid reflux* ☐ *Heartburn*	*Blood/Lymph System* ☐ *Anemia* ☐ *Easy bruising* ☐ *Easy bleeding* ☐ *AIDS/HIV* ☐ *Swollen glands*	*Urinary System - Male* ☐ *Penile discharge* ☐ *Difficulty urinating* ☐ *Blood in urine* ☐ *Get up every night to urinate* ☐ *Prostate trouble* ☐ *Burning with urination*	*Allergies* ☐ *None/Normal* ☐ *Hay fever* ☐ *Environmental allergies*

Current Medications (Please list all vitamins, supplements and over the counter as well)					
Drug Name	*Dose*	*Frequency*	*Drug Name*	*Dose*	*Frequency*

Allergies (include any medication that caused allergic reactions)	
Drug Allergies	*Allergic Reaction*

Patient Medical History

Epilepsy/Seizures	*No*	*Yes*	*Spinal Cord Injury/Disease*	*No*	*Yes*	*Liver disease/Hepatitis*	*No*	*Yes*
Diabetes	*No*	*Yes*	*Peptic Ulcer Disease*	*No*	*Yes*	*Renal/ GU Disease*	*No*	*Yes*
Hypertension	*No*	*Yes*	*Bleeding Disorder*	*No*	*Yes*	*Arthritis/ Gout*	*No*	*Yes*
Cancer	*No*	*Yes*	*Anemia*	*No*	*Yes*	*HIV*	*No*	*Yes*
Stroke	*No*	*Yes*	*Depression*	*No*	*Yes*	*COPD*	*No*	*Yes*
Heart Attack	*No*	*Yes*	*Thyroid Disease*	*No*	*Yes*	*Asthma*	*No*	*Yes*
Head Injury	*No*	*Yes*	*Headache*	*No*	*Yes*	*Bronchitis*	*No*	*Yes*
High Cholesterol	*No*	*Yes*	*Crohn's Disease*	*No*	*Yes*	*Seasonal Allergies*	*No*	*Yes*
Ulcerative Colitis	*No*	*Yes*	*Irritable Bowel Syndrome*	*No*	*Yes*	*Fibromyalgia*	*No*	*Yes*
Lupus	*No*	*Yes*						

Social History
Occupation:
Tobacco History: ☐ *None* ☐ *Chews* ☐ *Currently Smoking* ☐ *Previously Smoked* ____*Packs per day* *Alcohol History:* ☐ *Never* ☐ *Previously* ☐ *Occasionally* ☐ *Moderate to heavy* *Marital Status* ☐ *Married* ☐ *Single* ☐ *Separated* ☐ *Divorced* ☐ *Widowed* _____*# children* *Pets*_____ *Religious Preference*_____

Surgical History			
Surgery	*Date*	*Surgery*	*Date*
1.		*8.*	
2.		*9.*	
3.		*10.*	
4.		*11.*	
5.		*12.*	
6.		*13.*	
7.		*14.*	