TAYLORVILLE FAMILY MEDICINE

Jennifer L Burdette, MD Kimberly L Carver, CRNP Sarah Pate, CRNP Jodi Fields, CRNP
**7700 Highway 69 South, Ste C, Tuscaloosa, AL 35405 **Phone: (205)349-1040 **Fax: (205)349-4015

Demographic Information

■ Patient's Information

Patient's Full Name : _____
Please Print FIRST MIDDLE LAST

Date of Birth : _____/_____/_____ Age: _____ Sex: ☐ Male ☐ Female SSN #: _____
(MM / DD / YYYY)

Race: ☐ American Native ☐ Asian ☐ Black/African American ☐ Hispanic or Latino ☐ Native Hawaiian ☐ White

Home Address:
_____
_____
_____, _____, _____
(CITY) (STATE) (ZIP CODE)

Primary phone: ( )_____-_____
Secondary phone: ( )_____-_____
Work Phone: ( )_____-_____

E-Mail Address: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employment Status: ☐ Retired ☐ Student ☐ Unemployed ☐ Employed *(Employer:_____)*

Person to Notify In case of Emergency: _____ Relation:_____

*Phone: ( )_____-_____

■ Guarantor Information

**** If the patient is a child, has a legal guardian, or is not responsible for the bill, please choose who the guarantor will be:** *(Please check ☐ if applicable)*

☐ Parent of Child ☐ Legal Guardian ☐ Spouse ☐ Other party responsible for bill

Guarantor's Full Name : _____
Please Print FIRST MIDDLE LAST

Date of Birth : _____/_____/_____ Age: _____ Sex: ☐ Male ☐ Female SSN #: _____
(MM / DD / YYYY)

Race: ☐ American Native ☐ Hispanic or Latino ☐ Asian ☐ Black/ African American ☐ White

Home Address: _____
_____
_____, _____, _____
(CITY) (STATE) (ZIP CODE)

Primary phone: ( )_____-_____
Secondary phone: ( )_____-_____
Work Phone: ( )_____-_____

E-Mail Address: _____

■Patient's Insurance Information

Does the patient have Health Insurance?

☐Yes ☐No

If Yes, Please Provide Information Below and Give Insurance Card to Receptionist to Copy :

◆**Primary Insurance**:

Name of Insurance Company:_____

Contract/Policy #:_____

Group #:_____ Effective Date: _____

Name of Policy Holder:_____

Social Security # of Policy Holder: _____ D.O.B. of Policy Holder:_____/_____/_____

Patient relation to holder. *(Please check one of options below)*

☐ Self. *Policy Holder is the patient.*

☐ Insured Person. *(Please provide additional information)*

Name of Insured Person: _____

Insured Person's Relationship to Policy Holder: _____

Social Security # of Policy Holder: _____ D.O.B. of Policy Holder:_____/_____/_____

◆**Secondary Insurance:**

Name of Insurance Company:_____

Contract/Policy #:_____

Group #:_____ Effective Date: _____

Name of Policy Holder:_____

Social Security # of Policy Holder: _____ D.O.B. of Policy Holder:_____/_____/_____

Patient relation to holder. *(Please check one of options below)*

☐ Self. *Policy Holder is the patient.*

☐ Insured Person. *(Please provide additional information)*

Name of Insured Person: _____

Insured Person's Relationship to Policy Holder: _____

Social Security # of Policy Holder: _____ D.O.B. of Policy Holder:_____/_____/_____

■How do you know about us (optional)

☐ Facebook ☐ Family or Friend ☐ Google ☐Radio ☐ Instagram ☐ Other:_____

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HEALTH HISTORY AND REVIEW OF SYSTEMS

NAME : _____
(Please Print) First M Last

DATE OF BIRTH : _____/_____/_____
(MM / DD / YYYY)

◆Allergies:_____

◆Preferred Pharmacy-(name and location):_____

◆Current Medications (prescription and over the counter)

If you have not disclosed all medications you may possibly be dismissed as a patient.

_____
_____
_____
_____

◆Would you say your health is : ☐Excellent ☐Good ☐Fair ☐Poor
(Please check ☐if applicable)

◆**HEALTH HABITS**:

Special Diet?	☐Yes☐No	What kind: (Vegetarian, Atkins, Weight watchers, etc) _____
Exercise?	☐Yes☐No	What kind: (walking, gym, aerobic, etc) _____
Caffeine use?	☐Yes☐No	How much and how often? _____
Alcohol use?	☐Yes☐No	How much and how often? _____
Tobacco use?	☐Yes☐No	What kind, how often, and how long? _____
Drug use?	☐Yes☐No	What kind and how often, or history of abuse? _____

◆**OCCUPATIONAL CONCERNS**:

Hazardous material:	☐Yes☐No	Loud noise:	☐Yes☐No
Heavy lifting:	☐Yes☐No	Stress:	☐Yes☐No

Please list any surgeries, hospitalizations and injuries you have had in the past *(include the year)*:

_____

_____

Any metal, implant or stent? *(identify)* _____

◆**IMMUNIZATION RECORDS**:

Childhood shots up to date? ☐Yes☐No☐Not Sure (*provide shot record if applicable)*

◆HEALTH HISTORY

Please check conditions you have had in the past:

□AIDS/HIV	□Diabetes	□MS
□Alcoholism/Substance abuse	□Goiter	□Pacemaker/Defibrillator
□Anemia	□Epilepsy/Seizure disorder	□Polio
□Anorexia/Bulemia	□Heart Disease	□Psychiatric care
□Arthritis – Osteo/Rheumatoid	□Hernia	□Prostate problems
□Bleeding Disorder	□Hepatitis ____	□Stroke/TIA
□Asthma/COPD/Emphysema	□High Cholesterol	□STD _____
□Bronchitis/Pneumonia	□Kidney Disease	□ TB
□Breast Lump	□Liver disease	□Ulcers/GERD
□Cancer _____	□Migraines	□Vaginal infections
□Cataracts/Glaucoma	□Mononucleosis	□other _____

Please list any specialist you have seen for any of the above: _____
_____

◆ FAMILY HISTORY:

Please note the relationship to you any relatives with the following:

_____	□Asthma/COPD/Emphysema/chronic bronchitis		
_____	□Cancer*(what kind?* _____*)*	_____	□Gout
_____	□Diabetes	_____	□Stroke/TIA
_____	□Heart Disease	_____	□Kidney Disease
_____	□Hypertension	_____	□Other
_____	□Chemical Dependency *(identify substance* _____*)*		*(identify*_____*)*

◆ CURRENT HEALTH CONCERNS

Please check any symptom/illness you have/ have had in the past year:

General health problems:
□ Blood transfusion Date: _____
□Chills/sweats
□Fever
□Forgetfulness
□Loss of sleep
□Loss of weight (usual weight _____)
□Numbness/tingling

Head problems:
□Headache
□Depression
□Dizziness
□Fainting
□Head injury or concussion
□Nervousness/moodiness

Ear, nose and throat problems:
□bleeding gums
□loss of hearing
□ear drainage/ear ache/ringing in ears
□hay fever/sinus problems
□hoarseness/difficulty swallowing
□swollen glands/thyroid/goiter disease

Heart problems:
□leg/hand/ankle swelling/poor circulation
□chest pain/palpitations
□heart murmur/irregular heart beat
□high/low blood pressure
□stroke/TIA
□short of breath/sleep on multiple pillows
□varicose veins

Eye problems:
□Blurred vision
□Crossed eyes
□Double vision
□Eye pain
□Vision halos
Last eye exam :_____
Wears Contacts or glasses YES/NO

Skin problems:
□Bruise easily
□Change in moles
□Hives
□Itching
□Rashes
□Scars
□Sores that won't heal

Muscle/Joint problems:
□Arms/hands
□Back/hips
□Legs/feet
□Neck/shoulders

Genital/Urinary problems:
□Blood in urine
□Frequent urination
□Kidney stones/infection
□Leakage of urine
□Trouble starting stream
□History of STD's
□Breast lump/nipple discharge
□Erection difficulties
□Sores on penis/discharge
□Vaginal sores/infections/discharge
□Pain with intercourse

last EKG date: _____

Stomach problems:
□Change in appetite
□bloating/gas/change in bowel habits
□bloody/black, tarry stools
□excessive thirst
□stomach pain/ulcers/heartburn
□nausea/vomiting/diarrhea/constipation
□hepatitis/jaundice
□hemorrhoids

Men: Last Prostate Exam _____
Last PSA blood test _____
Urologist: _____

Women: Last Pap smear _____
Last Mammogram _____
where? _____
Do you self breast exam? YES/NO
□history of abnormal pap smear? YES/NO
treatment? _____
□abnormal periods/spotting
□menopausal symptoms/hot flashes
□birth control method _____
□age periods started _____
□periods: heavy/med/light
regular/irregular
number of pregnancies _____
number of live births _____
vaginal _____/c section _____
miscarriages _____
abortions _____
Are you pregnant? YES/NO/ (here to find out)
Gynecologist: _____

Other problems or detailed explanation of positive answers : _____
_____
_____

This form will be retained in your medical record.

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NOTICE OF PRIVACY PRACTICES

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.
- The patient understands the practice:

  a) may phone, email or send a text to you to confirm appointments.

  b) may leave a message on your answering machine at home or cell phone;

  c)discuss your medical condition with any member of patient's family

please name the members allowed:

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Name: _____ Relationship:_____

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date: _____

If this acknowledgment is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

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Authorization for Insurance Assignment and Consent to Pay the Physician

I hereby assign all insurance benefits to Taylorville Family Medicine, I understand that I am responsible to Taylorville Family Medicine for my charges and my family's individual charges incurred during the course of treatment, even though I may have insurance or third-party coverage. I recognize that the cost of the medical care may exceed the amount reimbursed by my insurance carrier. I promise to pay this amount when due. In event of default, I agree to pay reimburse Taylorville Family Medicine the fees of any collection agency, which may be based on a percentage at a maximum of 33.3% of the debt, and all cost and expenses, including reasonable attorneys' fees.

I understand that certain insurance carriers and health maintenance organizations require a referral from designated primary care physician prior to being seen by Taylorville Family Medicine. It is patient's responsibility to secure this authorization. It is understood that if the referral was not secured or approved, that patient is responsible for all charges. Any charges that rejected as "non-covered" are also the responsibility of patient. It is the patient's responsibility to determine if Taylorville Family Medicine is a preferred provider for your insurance carrier. Any charges rejected as "non-covered" are the responsibility of the patient.

I authorize the clinic and all clinical providers who have provided care or interpreted my test, along with any billing service and their collection agency or attorney who may work on their behalf, to contact me on my cell phone and/or home phone using pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication.

By my signature below, I acknowledge that I was offered a copy of **Taylorville Family Medicine's Authorization for Insurance Assignment and Consent to Pay the Physician** and agree the above Authorization and Consent.

_____ _____

Printed name of patient Date

_____

Signature of patient

_____ _____

Signature of witness Date

If this acknowledgment is signed by a personal representative on behalf of the client, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

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MEDICAL APPOINTMENT CANCELLATION POLICY

Dear Patient,

We strive to provide excellent medical care to you, your family and all of our patients. In order to do so effectively and efficiently, we have developed an appointment system that sets asides ample time for a patient.

"No-shows" and late cancellations inconvenience those individuals who need access to medical care in a timely manner. In an effort to reduce the number of such occurrences, we have implemented a Medical Appointment Cancellation Policy and it is effective immediately.

Our policy is as follows:

1. We require you to give our office a **24-hour notice** in the event you need to reschedule your appointment.

2. If you miss an appointment and do not contact us with at least a 24 hour prior notice, we will consider this a missed appointment and a **$50.00 no-show fee** will be assessed to you. This applies to late cancellations and "no-shows".

3. If you are more than **15 minutes late** for an appointment, it may be considered to be a "No-show". We will make an effort to work you into the schedule.

4. Our office makes reminder calls for appointments. If you are registered for the patient's portal, you will receive e-mail reminders as well. **It is ultimately the patient's responsibility to remember their scheduled appointments.**

The fee will be billed to you directly and is not covered by your insurance. This balance must be paid prior to your next appointment. If you don't have a scheduled appointment, the balance is expected in a timely fashion and if not, will be subject to collections.

ALL COPAYS AND PAST BALANCES ARE DUE AT THE TIME OF SERVICE.

We thank you for trusting Taylorville Family Medicine with your medical care.

I have read and understand the Medical Appointment Cancellation Policy and agree to the terms of this policy.

_____ _____

Signature Date

_____

Printed Name

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AUTHORIZATION FOR RELEASE OF INFORMATION FOR PURPOSES REQUESTED BY PHYSICIANS OFFICE FROM ANOTHER COVERED ENTITY

I hereby authorize _____ to disclose the following protected health information to Taylorville Family Medicine

Specific description of Information to be disclosed (including date(s)): ☐ Prior Treatments and relative documents

Other:_____

This protected health information is being used or disclosed to carry out treatment, payment and/or health care operations of Taylorville Family Medicine, in the following manner: ☐ Further Clinical Treatments

Other:_____

This authorization shall be in force and effect until ☐Treatment complete or _____ at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by notifying the Taylorville Family Medicine, at 7700 HWY 69 S, Ste B, Tuscaloosa, AL 35405. I understand that a revocation is not effective to the extent that Taylorville Family Medicine, PC has relief on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Taylorville Family Medicine will not condition my treatment, payment, enrollment (if applicable) in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to refuse to sign this authorization.

_____ _____

Signature of Patient or Patient Representative Date

_____ _____

Printed name of Patient &/or Patient Representative Date of Birth of Patient

Description of Representative Authority_____