HUNTSVILLE PEDIATRIC AND ADULT MEDICINE ASSOCIATES
PATIENT INFORMATION

Patient's Name ______________________________________ Sex __ Male __ Female **Date of Birth** __________
Address __________________________________City/State_______________________ Zip Code____________
Home Phone _________________ Cell Phone ________________ E-mail address __________________________
Driver License # ____________ **SS#**__________________ Marital Status __ Single __ Married __ Widowed
Occupation ____________________ Employer's Name _______________________ Work Phone _________
Spouse's Name _________________ Employer's Name _______________________ Work Phone _________
In case of emergency, notify____________________ Relation to Patient__________ Phone _________
Your Pharmacy ____________________ Phone ___________ Referred by ________________________

Complete the Following if the Patient is a Minor or a College Student
Responsible Party's Name _______________________________ Relationship to Patient _________________
Father's Name __________________________ Home Phone_______________ Cell Phone_________________
Social Security # ______________ **Date of Birth** ______________**Driver License #** _____________
Employer __________________________ Work Phone _______________ OK to call ____ Yes ____ No
Mother's Name __________________________ Home Phone_______________ Cell Phone_________________
Social Security # ______________ **Date of Birth** ______________**Driver License #** _____________
Employer __________________________ Work Phone _______________ OK to call ____ Yes ____ No
Hospital where child was born ____
Other Children (Names and Ages) ____
Is there anyone other than a parent authorized to seek treatment for your child? If so, please list below:
Name ____________________________________ Relationship to patient _____________________________
Name ____________________________________ Relationship to patient _____________________________

INSURANCE INFORMATION: (Please provide copy of current insurance card)
Insurance Name ___________________________ Policyholder's Name ___________________ **D.O.B**. _________
Policy Number ____________________ Group #_____________ Group Name ____________________________
Medicare # _______________________ Medicaid # __________________________

RELEASE OF INFORMATION:
I authorize Huntsville Pediatric and Adult Medicine Associates to release any medical or other information necessary to process claims for services provided to me.
ASSIGNMENT OF BENEFITS:
I authorize payment of government or other medical benefits to Huntsville Pediatric and Adult Medicine Associates for any services provided to me.
FINANCIAL POLICY:
I acknowledge that I have read and/or been offered a copy of this office's Financial Policy.
PRIVACY POLICY ACKNOWLEDGEMENT:
I acknowledge that I have read and/or been offered a copy of this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

I have read and agree to the Release of Information, Assignment of Benefits, Financial Policy, and Privacy Policy Acknowledgement paragraphs as stated above.

____ DATE ________________
Patient or Responsible Party Signature

____
Relationship to Patient If Not Parent or Legal Guardian

HUNTSVILLE PEDIATRIC AND ADULT MEDICINE ASSOCIATES
FINANCIAL POLICY

We are dedicated to providing you with the best possible care and service, and regard your understanding of our financial policies as an essential element of your care and treatment. If you have any questions, please feel free to discuss them with our staff.

FULL PAYMENT OR YOUR INSURANCE CO-PAY, CO-INSURANCE AND/OR DEDUCTIBLES, IF APPLICABLE, IS DUE AT THE TIME OF SERVICE. YOU MAY PAY BY CASH, CHECK, OR FOR YOUR CONVENIENCE, CREDIT CARD. WE ACCEPT VISA, MASTERCARD, AND DISCOVER.

IF YOU ARE UNABLE TO PAY AT THE TIME OF SERVICE, PAYMENT ARRANGEMENTS MUST BE MADE PRIOR TO BEING SEEN.

PATIENTS WITH INSURANCE THAT WE ACCEPT
It is your responsibility to know your insurance benefits. Coverage for services like well care, immunizations, lab, x-ray, etc. vary from one insurance plan to another and you are responsible for payment of services rendered whether or not they are covered by your insurance. The labs that we utilize are Clinical Pathology Laboratory (CPL) and Huntsville Memorial Hospital. If your insurance requires that your lab work be performed elsewhere, you must let us know. You are responsible for deductibles, co-pays, non-covered services, coinsurance, and items considered "not medically necessary" by your insurance company. **Payment of co-pays, co-insurance and/or deductibles is required at the time of service.** The remaining balance should be taken care of within one (1) month of notice from your insurance company. If your insurance delays payment over 60 days, we ask that you please begin payment on your outstanding balance which is your responsibility. Any overpayment by you or your insurance carrier will be refunded.

PATIENTS WITH INSURANCE THAT WE DO NOT ACCEPT
Please make payment for your care at each visit. We will provide you with a complete receipt that includes all items necessary for you to submit a claim to your insurance.

PATIENTS WITHOUT INSURANCE (PRIVATE PAY)
Please make payment for your care at each visit.

MEDICARE PATIENTS
Our office will submit your Medicare claim and your secondary insurance. You are responsible for deductibles, co-pays, and any non-covered services.

WORKERS COMPENSATION PATIENTS
We will file your Worker's Compensation claim if it can be verified by your employer and you provide us with the complete billing information. You are ultimately responsible for the balance.

PERSONAL INJURY PATIENTS (MVA OR ACCIDENT)
If you are a personal injury patient, you will be asked to pay for your services at the time of your visit. We will provide you with a complete receipt that includes all the necessary information for you to file your claim with the responsible party, however, the balance is ultimately your responsibility.

MINOR PATIENTS
For all services rendered to minor patients, the adult accompanying the patient is responsible for payment.

OUTSTANDING BALANCES
Any balances older than 30 days of services rendered may be subject to additional collection fees and/or finance charges of 18% annually (1 ½ % per month) unless previous financial arrangements have been made. We realize that temporary financial problems may, at times, affect timely payment of your account. If such problems do arise, we encourage you to contact our Billing Dept. promptly to make payment arrangements.

PLEASE NOTIFY OUR OFFICE OF ANY CHANGES IN YOUR INSURANCE STATUS

HUNTSVILLE PEDIATIC AND ADULT MEDICINE ASSOCIATES

ADULT PAST MEDICAL HISTORY

Patient Name: ________________________________ D.O.B.___________ Date: _______________

SURGERY (TYPE AND DATE) HOSPITAL SURGEON

1. ____
2. ____
3. ____
4. ____

HOSPITALIZATIONS (TYPE AND DATE) HOSPITAL PHYSICIAN

1. ____
2. ____
3. ____
4. ____

GYNECOLOGIC HISTORY: Last Pap Smear ________________ Last Mammogram __________
First day of last menstrual period _________________________

MEDICAL ILLNESSES:

1. _______________________________________ 4. ___________________________________
2. _______________________________________ 5. ___________________________________
3. _______________________________________ 6. ___________________________________

History of Blood Transfusions: __________________________________ When: _________________

IMMUNIZATIONS:

Last Tetanus Shot _________________ **Hepatitis B _______________**
Pneumovax ________________________ **Flu Vaccine ______________**
Misc. _____________________________

MEDICATIONS CURRENTLY TAKING (Prescription and Over The Counter)

Birth Control: ____
All Other: ____

Patient Name: ________________________ D.O.B. _______________

ALLERGIES: ____

____

<u>OTHER PHYSICIANS YOU USE FOR WHAT PROBLEM(S)?</u>

1. ____

2. ____

3. ____

FAMILY HISTORY:

FAMILY MEMBER	**ACTIVE/DECEASED**	**ILLNESS/CAUSE OF DEATH**
MOTHER		
FATHER		
BROTHER(S)		
SISTER(S)		

HAVE ANY FAMILY MEMBERS HAD: (Circle all that apply and explain in space below)

HEART ATTACK	**OTHER HEART PROBLEMS**	**HYPERTENSION**
HIGH CHOLESTEROL	**STROKE**	**DIABETES**
CANCER	**TUBERCULOSIS**	**LUNG PROBLEMS**
BLOOD DISEASE (i.e. Sickle Cell or Leukemia)		**DEPRESSION**
SUICIDE	**SEIZURES**	**ALCOHOLISM**

Any other illnesses that run in the family?
EXPLANATION: ____

____

____

Patient Name: ________________________ D.O.B. ______________

BIRTH DATE: _________ PLACE OF BIRTH: ________________ MARITAL STATUS: _______

OTHER COUNTRIES OR STATES LIVED IN: ____

WHO LIVES AT HOME WITH YOU: ____

EDUCATION: _________ Years HIGH SCHOOL: _______ Years COLLEGE: _______Years

OCCUPATION: __________________________ SPOUSE'S OCCUPATION: ________________

CHEMICAL EXPOSURES: ____

DO YOU SMOKE? ________ HOW MUCH DAILY? ________ FOR HOW LONG? ________

HOW MUCH ALCOHOL DO YOU DRINK? ____

DO YOU USE ANY OTHER TYPES OF DRUGS? ____

DO YOU EXERCISE REGULARLY? ______ IF YES, WHAT DO YOU DO? _________________

DO YOU FOLLOW ANY PARTICULAR DIET? ____

DO YOU DRINK CAFFEINATED PRODUCTS? ________ HOW MANY PER DAY? _________

HOBBIES: ____

ANY CONCERNS: ____

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