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 # _____ 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 <u>Minor or a College Student</u>
Responsible Party's Name _____ Relationship to Patient _____
Father's Name _____ Home Phone_____ Cell Phone_____
Date of Birth _____ **Driver License #** _____
Employer _____ Work Phone _____ OK to call ____ Yes ____ No
Mother's Name _____ Home Phone_____ Cell Phone_____
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 <u>current</u> insurance card)
Insurance Name _____ Policyholder's Name _____ **D.O.B**. _____
Policy Number _____ Group #_____ Group Name _____
Medicare # _____ Medicaid # _____

<u>RELEASE OF INFORMATION</u>:
I authorize Huntsville Pediatric and Adult Medicine Associates to release any medical or other information necessary to process claims for services provided to me.

<u>ASSIGNMENT OF BENEFITS</u>:
I authorize payment of government or other medical benefits to Huntsville Pediatric and Adult Medicine Associates for any services provided to me.

<u>FINANCIAL POLICY</u>:
I acknowledge that I have read and/or been offered a copy of this office's Financial Policy.

<u>PRIVACY POLICY ACKNOWLEDGEMENT</u>:
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 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: _____

_____

OTHER PHYSICIANS YOU USE **FOR WHAT PROBLEM(S)?**

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. _____

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: _____

_____

_____

_____

_____

_____

Huntsville Pediatrics and Adult Medicine Associates

New Patient Review of Systems

Please check all that apply.

PATIENT NAME: _____ D.O.B. _____ Age: _____ Date: _____

Health Survey for 65yrs. and older

As your physician, I care about your well-being. During today's visit, you can use this handout as a guide to discuss your health concerns and needs. Please take a moment to answer these questions:

- Have you fallen or had trouble with balance or walking in the past 12 months?
  ☐ Yes ☐ No
- Do you have bladder controls problems?
  ☐ Yes ☐ No
- Does your physical health interfere with your daily activities?
  ☐ Yes ☐ No
- Would you best describe your emotional health as stable?
  ☐ Yes ☐ No

Provider Initials: _____

General:
__ Weight loss/gain
__ Fatigue or weakness
__ Fever or chills
__ Trouble sleeping

Skin:
__ Rashes
__ Lumps

Head:
__ Headache
__ Head injury
__ Neck pain

Ears:
__ Decreased hearing
__ Ringing
__ Earache or drainage

Eyes:
__ Vision loss/changes
__ Pain
__ Redness
__ Flashing lights
__ Glaucoma
__ Cataracts
__ Last eye exam: _____

Nose:
__ Stuffiness
__ Discharge
__ Itching
__ Nosebleeds
__ Sinus pain

Throat:
__ Hoarseness
__ Sore
__ Thrush
__ History of sleep apnea

Neck:
__ Lumps
__ "Swollen glands"
__ Pain
__ Stiffness

Breast:
__ Lumps
__ Pain
__ Discharge
__ Breastfeeding
__ Last mammogram: _____

Respiratory:
__ Cough
__ Sputum production
__ Coughing up blood
__ Wheezing
__ History of Asthma/COPD
__ Painful breathing

Cardiovascular:
__ Chest pain or discomfort
__ Tightness
__ Palpitations
__ Shortness of breath (SOB) with activity
__ Difficulty breathing lying down
__ Difficulty with usual activities due to lack of energy
__ Leg swelling
__ Sudden awaking from sleep with SOB

Gastrointestinal:
__ Swallowing difficulties
__ Heartburn
__ Change in appetite
__ Nausea or vomiting
__ Rectal bleeding
__ Constipation or diarrhea
__ Yellow eyes or skin
__ Last colonoscopy: _____

Urinary:
__ Frequency
__ Urgency
__ Burning or pain
__ Blood in urine
__ Bladder leakage
__ Urinary incontinence
__ Change in urinary strength

Vascular:
__ Calf pain with walking
__ Leg cramp

Musculoskeletal:
__ Muscle or joint pain
__ Stiffness
__ Back pain
__ Joint redness
__ Joint swelling

Neurologic:
__ Dizziness
__ Fainting
__ Seizures
__ Headaches
__ Numbness
__ Weakness
__ Tingling
__ Tremor

Hematologic:
__ Easy bruising
__ Easy bleeding

Endocrine:
__ Heat or cold intolerance
__ Sweating excessively
__ Urinating at night > once
__ Change in appetite
__ Abnormal menstrual cycles
__ Menopause symptoms
__ Hysterectomy
__ Last pap smear: _____

Psychiatric:
__ Nervousness
__ Stress
__ Depression
__ Memory problems
__ History of physical or sexual abuse

IMPORTANT

Please list all medications, supplements, and over the counter medicines you take.

(For explanation on why this information is important to update, see reverse side.)

Please give this to the Medical Assistant who calls you to the exam room.

Date: _____

NAME: _____ **DOB:** _____

PHARMACY: _____PHARMACY PHONE #: _____

Allergies: _____

MEDICATION	DOSE	HOW OFTEN DO YOU TAKE IT?	Reviewed By

Huntsville Pediatric & Adult Medicine
ASSOCIATES

Acknowledgement of Financial Policy

I understand and agree to the following:

- Huntsville Pediatric and Adult Medicine Associates (HPAM) will copy my insurance card and driver's license. I understand it is my responsibility to notify HPAM in the event of insurance coverage change.
- HPAM will obtain demographic information including mailing address, contact phone numbers, and email address. In addition, I understand HPAM may use and disclose demographic and medical information in order to provide a written, telephone, text message, or email reminder of an upcoming appointment. I further understand it is my responsibility to notify HPAM if any demographic information changes.
- HPAM does not accept Worker's Compensation. Patients must contact their HR Department for a provider.
- Payment for co-payments, deductibles, and percentages not covered by insurance are due from me at the time services are rendered. In addition, I understand the amount collected is only an estimate and the amount due may increase due to accounting error, insurance company payments and/or correspondence and additional services provided during and/or after visits including additional lab.
- If I do not have insurance coverage I will be responsible for services rendered at the time of service and any additional services provided after my visit including additional lab services.
- If I am a Medicare recipient, I understand I will be responsible for annual deductibles, 20% co-insurance, non-covered services, and any charges Medicare states I am responsible for.
- A $30.00 service charge will be applied to all returned checks.
- A $25.00 fee will be charged for missed appointments and appointments cancelled less than 4 business hours prior to my appointment time.
- I will receive a separate statement from the Radiologist that interprets all x-rays done at HPAM.
- That a fee is charged for copies of medical records and is due prior to the release of records.
- It is my responsibility to provide all of my insurance card(s) at each visit.
- HPAM may file my health insurance as a courtesy. However, if the insurance company does not make payment to HPAM, it is my responsibility to:
    - 1) contact HPAM to make sure the correct insurance was filed; and
    - 2) contact my health insurance company for reasons for non-payment or underpayment.

  If I do not resolve payment in a timely manner, within 90 days, I will be responsible for the full balance.
- Most health insurance companies have a filing deadline of 90 days. This means HPAM may not be able to file claims after 90 days after the date of service.
- If I do not resolve financial matters within 90 days, HPAM will start collections process that may include discharge from the clinic.
- It is my responsibility to know if my health insurance is in-network with HPAM providers. If it turns out my insurance is out-of-network, then I will be responsible for any outstanding balance.
- Minors must have authorization for medical treatment signed by their parent/legal guardian and are responsible for providing current insurance information for self. Co-payments/deductibles are due at time of service.
- HPAM does not get involved in disputes between divorced parents regarding financial responsibility for the child's medical expenses. By signing as Responsible Party below, you agree to be financially responsible for the care we provide to your child, regardless of whether a divorce decree or other arrangements places that obligation on a different party.

For Insurance Billing:

I hereby authorize Huntsville Pediatric and Adult Medicine Associates (HPAM) to furnish my insurance company with all the information which the insurance company may request concerning me and/or my present illness or injury. I hereby assign to Huntsville Pediatric and Adult Medicine Associates all money to which I am entitled for medical expenses related to the service reported. I understand I am financially responsible to Huntsville Pediatric and Adult Medicine Associates for charges not covered by this assignment.

Patient Name **Patient Date of Birth**

Responsible Party (Printed Name) **Responsible Party (Signature)** **Date**

Huntsville Pediatric & Adult Medicine
ASSOCIATES

Patient Authorization to Release Protected Health Information

I, _____, give my authorization to release my protected information including results of my laboratory tests, x-ray, and/ or other test results to the following designated representative(s).

_____ (Initial) Spouse Name _____

_____ (Initial)Child(ren) Name(s) _____

_____ (Initial) Other Name(s) _____

_____ (Initial)Parent Name(s) _____

_____ (Initial) Authorize Huntsville Pediatric and Adult Medicine to call the following numbers and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items, and any calls pertaining to my clinical care such as test results.

_____(Initial) Home Number (as on file)

_____(Initial) Cell Number (as on file)

_____(Initial) Work Number (as on file)

_____(Initial) Other Number(s): _____

_____ (Initial) Authorize Huntsville Pediatric and Adult Medicine to mail to the following address any items that assist the practice in carrying out treatment, payment. And healthcare operations, such as appointment reminder cards, unable to reach patient by phone letters, and statements as they are marked Personal and Confidential.

_____(Initial) My home address (as on file).

_____(Initial) Other address: _____

_____

I understand that this release of information is considered valid until a new release of information is submitted or my child turns 18. The office will not disclose any information to any items above that do not have an initial beside it.

Patient or Legal Guardian Signature: _____

Patient Name: _____ Patient DOB: _____ Age:_____

Date:_____

Office Use Only:

_____This patient is a child and will be 18 as of ____/_____/_____ and will need a new release of information form.

Huntsville Pediatric & Adult Medicine
ASSOCIATES

Patient Name_____ DOB: _____

Billing Address_____City_____

Zip Code_____Primary Contact Number_____

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COORDINATION OF BENEFITS

My primary insurance coverage: _____

Subscriber Name: _____

ID #: _____ Group #: _____

Do you have other health coverage? Please check one:

__No, the above insurance is the only active insurance, go to signature section.

__No Insurance/Private Pay

__Yes, please give name of Other Insurance Carrier below, sign, and date.

OTHER INSURANCE CARRIER:

Name of the Other Insurance Carrier: _____

Name of the Subscriber for the Other Insurance policy:_____

Name of the Employer: _____

Insurance Carrier Claim address: _____

Insurance Carrier phone number: _____

Policy Number: _____Group Number: _____

Beginning date of Coverage: _____End date of Coverage (if applicable): _____

Other insurance covers? ____Self ____Spouse ____Child ____Other _____

_____

Signature (Parent/Guardian, if minor)/Relationship to Patient

_____

_____