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 Minor or a College Student
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 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 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. ________________

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 for any reason HPAM is not paid in full, within 90 days, I will immediately pay 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 ensure payment 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 pay any outstanding balance within 10 days.
- 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

____

____