Columbiana Clinic

PATIENT'S INFORMATION

☐ MR. ☐ MS. ☐ MRS. ☐ DR. LAST NAME FIRST MIDDLE

☐ MALE ☐ FEMALE | ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

SOCIAL SECURITY #: DATE OF BIRTH: SPOUSE NAME:

HOME ADDRESS: APT#: CITY: STATE:ZIP:

HOME#: CELL#: WORK#: EMAIL:

EMPLOYER: CITY:STATE: ZIP:

EMERGENCY CONTACT PERSON(S): CONTACT#:

PREFERRED COMMUNICATION: ☐ HOME # ☐ CELL# ☐ WORK# ☐ EMAIL ☐ MAIL ☐ DECLINE ☐ OTHER

GUARANTOR INFORMATION (Person Responsible for Payment of Bill)

NAME: RELATIONSHIP: DOB: SS#:

HOME ADDRESS: APT#: CITY: STATE: ZIP:

EMPLOYER: CITY: STATE:ZIP:

OCCUPATION: CELL#: WORK#:EMAIL:

INSURANCE INFORMATION

	PRIMARY INSURANCE	SECONDARY INSURANCE
INSURED NAME:		
INSURANCE CO.:		
POLICY #:		
GROUP NAME#:		

***IF THE PERSON INSURED IS DIFFERENT FROM THE GUARANTOR, PLEASEPROVIDE THE INFORMATION BELOW SO WE CAN ASSIST YOU IN FILING YOUR MEDICAL CLAIM.**

NAME: RELATIONSHIP: DOB: SS#:

HOME ADDRESS: APT#: CITY: STATE: ZIP:

EMPLOYER: CITY: STATE: ZIP:

OCCUPATION: CELL#: WORK#:EMAIL:

☐ I HEREBY AUTHORIZE YOU TO RELEASE ANY INFORMATION ACQUIRED IN MY EXAMINATION OR TREATMENT NECESSARY TO PROCESS MY INSURANCE CLAIMS. I RELEASE YOU FROM ALL LEGAL RESPONSIBILITY THAT MAY ARISE FROM THE ACT I HAVE AUTHORIZED.

☐ I DO NOT AUTHORIZEYOU TO RELEASE ANY INFORMATION ACQUIRED IN MY EXAMINATION OR TREATMENT NECESSARY TO PROCESS MY INSURANCE CLAIMS. IN DOING SO I AM RESPONSIBLE FOR MY MEDICAL BILLS.

_____ _____

Signature of Patient/Legally Authorized Representative Date

Columbiana Clinic

PATIENT HEALTH HISTORY

PATIENT NAME: _____ DATE OF BIRTH:_____ AGE:_____ ☐ MALE ☐ FEMALE

HOME PHONE: _____ WORK PHONE: _____

RETAIL PHARMACY:_____ PHONE:_____

MAIL ORDER PHARMACY: _____ PHONE:_____

REASONS FOR THIS VISIT:_____

PLEASE LIST THE NAMES OF ALL PHYSICIANS YOU CURRENTLY SEE:

_____ _____

_____ _____

MEDICATIONS: (LIST ALL MEDICATIONS, INCLUDING DOSE AND HOW OFTEN YOU TAKE IT)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

PLEASE LIST ALL OVER THE COUNTER MEDICATIONS (EXAMPLES: Tylenol, Advil), HERBAL SUPPLEMENTS AND VITAMINS YOU CURRENTLY TAKE.

_____ _____

_____ _____

ALLERGIES: _____

PREVIOUS MEDICAL HISTORY:

Do you suffer from any of the following medical conditions?

HIGH BLOOD PRESSURE	☐ Yes	☐ No
HEART DISEASE	☐ Yes	☐ No
STROKE	☐ Yes	☐ No
DIABETES	☐ Yes	☐ No
ASTHMA	☐ Yes	☐ No
MALIGNANCY/CANCER	☐ Yes	☐ No
SEIZURES	☐ Yes	☐ No

CHECK IF ANY OF YOUR BLOOD RELATIVES HAD ANY OF THE FOLLOWING:

			Relationship to you
HIGH BLOOD PRESSURE	☐ Yes	☐ No	_____
HEART DISEASE	☐ Yes	☐ No	_____
STROKE	☐ Yes	☐ No	_____
DIABETES	☐ Yes	☐ No	_____
ASTHMA	☐ Yes	☐ No	_____
MALIGNANCY/CANCER	☐ Yes	☐ No	_____
SEIZURES	☐ Yes	☐ No	_____

DO YOU SMOKE/HOW OFTEN? _____

DO YOU USE ALCOHOL/HOW OFTEN? _____

FOR FEMALE PATIENT ONLY: DATE OF YOUR LAST MENSTRUAL CYCLE? _____

LIST ANY SURGERIES: _____

LIST OTHER ILLNESSES: _____

_____

OFFICE POLICIES

Here are a few of our policies that we would like for you to be aware of:

Check In Process

1- Insurance card and a valid ID are required during check in for every visit.
2- A patient/parent/guardian must notify the office of changes in address, telephone number or insurance.
3-All past due balances and copays are due at time of service. Insurance company contracts require that we collect copay on the date of service.
4-We accept cash/check/debit cards/and most major credit cards.
5-Private pay patients will be asked to pay a deposit of $150. If the office visit is less $150 you will receive a refund of the difference. Some private pay fees may be eligible for a discount if paid in full on the date of service.
6-If you have a high deductible plan you may also be asked for a $150 deposit. After you receive an explanation of benefits you may call our office for a refund of difference in case of overpayment or we will credit your account in case of overpayment.
7-There is a $25 fee for returned checks.

Appointments

1-Patients who are 15 minutes late for their appointments may have to reschedule. We will try to work you in if time allows.
2-If you are scheduled for an annual physical or wellness exam and have an active problem or illness you will have a copay due to separate insurance filing.
3-Your appointment spot has been reserved for you. Please be considerate of other patients and give 24 hour notice of cancelled appointments.
4-No Shows may be charged a $25 fee.

Medication Refills

1-Medication refills for chronic stable conditions can be requested by phone during business hours if you have been seen in the previous 3 months. Please request all necessary refills during and office visit. Please note that if you are out of refills you may be due for a follow up appointment.
2-Antibiotics will not be prescribed over the phone. If you feel you or your child may need an antibiotic, he/she will need to be seen.

Controlled Substances

1-Certain controlled substances and all Opioid pain medications require an appointment for refill.
2-The Alabama Pain Management Act of 2013 requires any patient on a Schedule II Narcotic be seen at least every three months.
3-All new patients are subject to query in the Alabama Controlled Substance Data Base. If the database reveals that you have been dismissed from a pain management clinic or have been visiting multiple physicians for narcotic medications we may decline to take over or withdraw from your care. This is subject to each physicians discretion.

continued

Others:
1-There may be document fees for any form which requires a physician signature.
2-Medical records can be faxed to other physicians free of charge. Paper copies of records for any other reason are subject to a printing/copy fee according to law (CMS.org)
3-An excused absence for school or work will only be issued if the patient was actually seen in the office.

I have read and understand these policies:

_____ Date_____

___I certify that I have never filed a malpractice claim against a physician or hospital.

___I have filled a malpractice claim against a physician or hospital.

Explanation_____

_____

Signature_____ Date_____

Columbiana Clinic

INSURANCE & FINANCIAL RESPONSIBILITY AGREEMENT

Welcome to Columbiana Clinic. Webelieve that you deserve the best care. That's why we always provide you with the best medical care possible to treat your personal situation. Each year we provide outstanding medical care to hundreds of patients. Some have medical benefits but some don't. If you have medical benefits, congratulations! You are very fortunate. Here are some important things you should know:

INITIAL:

_____ ▪ Your medical benefits are based upon a contract made between you or your employer and an insurance company. If you have any questions regarding your medical benefits please contact your employer or insurance company directly. Most medical benefit plans will never pay 100% of your medical care. It is only meant to assist you.

_____ ▪We will bill your insurance as a courtesy. If insurance does not pay within 45 days, we reserve the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between **YOU and your insurance company.** Our office is not, and cannot be, a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office. Any delinquency on your account will result in a $25 monthly late fee added to the account. In the event that we incur any expense in the collection of your account, expenses for collections agencies or court costs will be applied to your account.

_____ ▪ We currently accept all private pay, and most of the major commercial health insurance plans. This means that we work with literally hundreds of insurance companies. It is your responsibility to know if Dr. King is a contracted in-network provider recognized by your insurance plan. Although we can maintain a computerized history of payments by a given company, they do change; therefore it is impossible to give you a guaranteed quoteat the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE.**If you would like to know your insurance benefit, we will be happy to file a "pre-authorization" with your insurance company prior to treatment. Keep in mind that this is still not a guarantee of coverage. This does delay treatment but will give you the best estimate of what your out-of- pocket figures will be.

_____ ▪ It is**your responsibility** to know if your insurance has any deductibles, co-payments, agelimits, exclusions, waiting periods, clauses or any other type of benefit limitation for the services received. Many times these exclusions are provided to employees only & are not made available to our staff when confirming benefits. They are your responsibility to know and we can only estimate based on what your insurance discloses to us.

_____ ▪ We do require payment in full for your estimated portion at the time of service. We accept all major credit cards, cash and checks. If your check payment has a non-sufficient fund and is returned to us there will be a $25 fee. Any discount you may had at the time of service will be revolted, and your future payment must be in cash, credit or debit card.

_____ ▪ A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we do require **at least 24 hours'** notice to avoid a $25 cancellation feefor office visit and a $35 cancellation feefor Physical/Wellness visit. (Emergencies are an exception).

_____ _____

Signature of Patient/Legally Authorized Representative Date

Columbiana Clinic

Authorization to Release Medical Records

PATIENT INFORMATION:

Name (print) DOB SSN

_____ _____ _____

INFORMATION TO BE RELEASED FROM:

Name of facility or provider

_____

Address

_____

INFORMATION TO BE SENT TO:

Name of designated recipient

_____

Address City State Zip

_____ _____ _____ _____

INFORMATION TO BE RELEASED: (check one)

_____ The most recent 2 years of pertinent information (chart notes, labs, x-rays and special tests)
_____ All medical records
_____ Specific information (please specify) :

PURPOSE FOR WHICH THE DISCLOSURE IS BEING MADE: (please check one)

_____ Attorney _____ Insurance _____ Doctor _____ Personal

PATIENT AUTHORIZATION:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

* EXCLUDE the following information from the records released (please initial)

_____ Drug / Alcohol abuse/treatment & diagnosis _____ Sexually transmitted disease
_____ HIV/AIDS diagnosis/treatment/testing _____ Mental illness or psychiatric diagnosis/treatment

MY RIGHTS:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

Signature: _____ Date: _____

(Patient, guardian*, or Authorized representative*)

CONSENT FOR MEDICAL CARE AND PRIVACY NOTICE

I understand that my health conditions may require diagnosis and treatment. I hereby voluntarily consent to such treatment services, and procedures as ordered by my doctor, his consultants, associates and assistants. I also understand that occasionally student doctors and others in professional training programs may be among those who care for me.

I authorize Columbiana Clinic to discuss my medical history, diagnosis, treatment and prognosis as authorized by the HIPPA privacy act as it is enforced by the Department of Health and Human Services (HHS.gov). I have the right to add anyone or any organization that I do not wish to have my medical information by requesting in writing at any time.

I understand there are times when Columbiana Clinic has to release information without my consent as outlined in the notice of privacy practices. For example, to other doctors and health professionals as necessary, to government agencies as authorized by law, to insurance companies, and to any court of law which issues a subpoena or court order.

I also understand that Alabama law provides if any health care worker is exposed to my blood or other bodily fluid, Columbiana Clinic may perform tests, with or without my consent, on my blood or other bodily fluid to determine the presence of any communicable disease, including but not limited to Hepatitis, HIV/AIDS and Syphilis. I understand that such testing is necessary to protect those caring for me as a patient and that the results of tests taken under these circumstances are confidential and do not become a part of my medical record.

In the State of Alabama patients age 14 and above, emancipated minors, and pregnant patients may consent for their own medical treatment.

I hereby give consent to Columbiana Clinic to discuss my medical condition and any test results and/or billing information to the following individuals:

A._____ Relationship _____

B._____ Relationship _____

C._____ Relationship _____

My signature certifies that I have read and understand this privacy notice.

X_____Date_____