Elberta Clinic Family Practice: Patient Registration

Patient Information:

Patient Name:_____ Date of Birth:_____-_____-_____

Address:_____ SS# _____

_____ Marital Status: S M D W Sex: M F Age:____

Phone Numbers: Home:_____ Cell:_____ Work:_____

Employer Name:_____ Hours/Days at Work:_____

Employer Address:_____ email: _____

Race: (circle) Asian Black Hispanic/Latino White Other Language: English Spanish Other:_____

Ethnicity: Non Hispanic Hispanic Other Personal email:_____

Responsible Party: if same as above skip this section

Name:_____ Date of Birth: _____-_____-_____

Address:_____ SS# _____

Phone Number: _____ Work # _____ Marital Status: S M D W

Cell Number: _____ Relationship to Patient: _____

Email: _____

Insurance Information: (if you have additional insurance, please put that information on the back of this sheet)

Primary Ins. Company: _____ Policy Number: _____

Subscriber: _____ Group Number: _____

Insurance address: _____ Phone Number: _____

_____ email: _____

Emergency/Personal contacts:

Name: _____ Relationship to Patient: _____

Phone Number: H C W _____

Name: _____ Relationship to Patient: _____

Phone Number: H C W _____

SELF OR PRIVATE PAY: Please read and sign if we are NOT filing insurance for you or the patient listed above.

I understand that I am financially responsible for all charges rendered to me or to the patient listed and agree to pay for such charges, present and future, at the time services are provided.

Signature of Patient or Responsible Party_____

****

HEALTH INSURANCE ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with_____
(Name of Insurance Company)
and assign directly to the physician providing services to me at Elberta Clinic, P.C. all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian_____Date_____

****

(MEDICARE ONLY)
MEDICARE AND MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and Medigap benefits, if applicable, be made either to me or on my behalf to the physician providing services to me at Elberta Clinic, P.C. for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on the other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. I understand that the deductible, coinsurance, and noncovered services will be my full responsibility.

Signature of Beneficiary_____Date_____

****

(ALL PATIENTS)
CONSENT FOR TREATMENT

I hereby grant authorization and consent for medical treatment and procedures for myself or the patient listed above, and understand that no guarantee or assurance has been made as to the results which may be obtained.

Signature of Patient or Guardian_____Date_____

EFFECTIVE DATE APRIL 1, 2003

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the practice may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the practice or the hospital. For example, we may disclose medical information about you to people outside the practice who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.

For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts.

WHO WILL FOLLOW THIS NOTICE. This notice describes our practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the practice, whether made by practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities, inmates; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; protective services for the President and others; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.

CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the practice's waiting room.

COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, contact **Laura Kichler, OM at 251-986-5057.** All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.

I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights.

_____ _____

Patient or Patient's Personal Representative **Date**

Terry A. Kurtis, M.D.
Joseph P. Walsh, M.D.
Carolyn Holman, CRNP

24980 State Street
P.O. Drawer 519
Elberta, AL 36530

251-986-7301
Fax: 251-986-5927
elclinic@gulftel.com

INSURANCE AGREEMENT

Due to many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible.

Therefore, we urge you, as the patient, to please check with your insurance company prior to any testing or surgery being performed. **It is your responsibility to know your individual coverage.** Failing to comply with this suggestion could result in you, the patient, being responsible for all costs incurred.

Please remember you insurance policy is between you and your insurance company and not with the insurance company and your doctor.

RELEASE, ASSIGNMENT & GUARANTEE OF PAYMENT

I authorize the release of my medical information to any pertinent party, in addition to any insurance companies for the processing of my claims.

I authorize and request payment of medical benefits directly to my physicians.

I agree this authorization will cover all medical services rendered until such authorization is revoked by me.

I authorize the use of fax in order to submit medical information to pertinent parties.

I agree that a photocopy of this form may be used in lieu of the original.

I understand that I am financially responsible for any balance that is not covered by my insurance carrier after 30 days.

Signature_____ Date _____

Witness _____

THE ELBERTA FAMILY CLINIC, P.C.

POLICY 7

CONSENT FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PAYMENT, TREATMENT AND HEALTH CARE OPERATIONS

By signing below, you hereby consent for this Practice to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purposes of treatment, payment and health care operations. You may refuse to sign this consent form.

You should read the Notice of Privacy Practices for PHI attached to this form before signing the Consent. The terms of the Notice may change from time to time, and you may always get a revised copy of it by asking the Privacy Officer for this Practice.

You have the right to request that the Practice restrict how PHI is used or disclosed to carry out treatment, payment, or health care operations. The Practice is not required to agree to requested restrictions, however; if the Practice agrees to your requested restrictions, the restriction is binding on it.

Information about you is protected under federal law, and you have the right to revoke this Consent, unless we have taken action in reliance on your authorization (as determined by our Privacy Officer). By signing below, you recognize that the protected health information used or disclosed pursuant to this Consent may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

You may communicate with the following individuals regarding my condition or course of treatment:_____

You may communicate confidential information to me, including invoices for services, to the following address and/or phone numbers:_____

_____ _____

Individual Signature Date

As a personal representative, I have authority
to act for the individual because I am the individual's

_____

MEDICATION AND HISTORY SHEET:

Name:_____ Birth Date:_____ Date:_____

PLEASE LIST YOUR MEDICAL CONDITIONS:

_____

_____

_____

_____

_____

_____

_____

_____

_____

(example: diabetes since 1998)

PRIOR SURGERIES AND DATES:

_____

_____

_____

_____

_____

_____

_____

Comments:_____

_____

PLEASE LIST YOUR MEDICATIONS AND SUPPLEMENTS: include dose and frequency

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

(example: baby aspirin 81 mg once a day)

ALLERGIES AND REACTIONS:

_____

_____

_____

(Example: penicillin caused rash)

Tobacco use: yes/no

cigs/snuff how long?_____ years

packs per day?_____

PATIENT MEDICAL HISTORY

Date: _____

Name: _____ Date of Birth: _____ ☐ single ☐ married ☐ divorced ☐ widow (er)

Occupation: _____ Spouse's occupation: _____

Education: Circle the last grade you completed: grade 5 6 7 8 | high school 1 2 3 4 | college 1 2 3 4 | post-grad _____ yrs degrees

Have you traveled outside the U.S. in the last year?

Do you have any pets?

Who referred you to this clinic?

FAMILY HISTORY

	Age	if living Health	Age at death	If deceased, cause
Father				
Mother				
Brother or sister				
Husband or wife				
Son or Daughter				

Has any blood Relative ever had?	Please circle answer No or yes	Who?
Cancer (type)	no yes	
Tuberculosis	no yes	
Diabetes	no yes	
Heart trouble	no yes	
High blood pressure	no yes	
Stroke	no yes	
Epilepsy	no yes	
Mental illness	no yes	
Suicide	no yes	
Birth defects	no yes	
Thyroid disease	no yes	
Alcoholism	no yes	
Other:		

Comments:

PERSONAL HISTORY:

Illnesses: Have you ever had?

Measles or German Measles	yes	no	Ulcers (stomach or intestinal)	yes	no
Chicken pox or mumps	yes	no	Hepatitis or yellow jaundice	yes	no
Whooping cough	yes	no	Gallbladder disease	yes	no
Scarlet fever or Scarletina	yes	no	Hiatus hernia	yes	no
Migraine headaches	yes	no	Diverticular disease	yes	no
Stroke or paralysis	yes	no	Kidney stones or kidney failure	yes	no
Blindness (even temporary)	yes	no	Bright's disease	yes	no
Seizures or epilepsy	yes	no	Kidney or urinary infections	yes	no
Meningitis or polio	yes	no	Venereal disease	yes	no
Pneumonia or pleurisy	yes	no	Gonorrhea or syphilis	yes	no
Tuberculosis	yes	no	Arthritis or rheumatism	yes	no
Asthma	yes	no	Bursitis, Sciatica, Lumbago	yes	no
Influenza or flu	yes	no	Neuritis or Neuralgia	yes	no
Hayfever or allergies	yes	no	Anemia or "low blood"	yes	no
Hives or eczema	yes	no	Unusual bleeding or bruising	yes	no
Heart attack	yes	no	Poisoning (food, chemicals, drugs)	yes	no
Angina	yes	no	Thyroid disease or Goiter	yes	no
Heart failure	yes	no	X-ray therapy or radiation	yes	no
Rheumatic fever	yes	no	Nervous breakdown	yes	no
Heart murmur	yes	no	Severe depression	yes	no
High blood pressure	yes	no	Frequent sore throats	yes	no
High cholesterol	yes	no	Frequent infections	yes	no
Diabetes or sugar	yes	no	Any other disease—list_____		

Have you ever been immunized for?

Diptheria	yes	no		Pneumonia	yes	no	when_____?
Tetanus	yes	no	when_____?	Influenza	yes	no	when_____?
Polio	yes	no		Measles	yes	no	

Have you ever had a Tuberculosis skin test? When_____? Results_____?

When was your last mammogram? _____

When was your last colon check? _____

When was your last prostate check or bloodwork? _____

When was your last female check or PAP smear? _____

When was your last chest X-ray? _____

Have you ever received a blood transfusion? Yes no If yes, when? _____

Allergies (Are you allergic to?)

Penicillin	yes	no	Iodine or seafood	yes	no	
Sulfa	yes	no	Antihistamines	yes	no	
Erythromycin	yes	no	Any food	yes	no	what food?_____
Aspirin	yes	no	Cosmetics	yes	no	
What happens? Stomach pain or swelling?			Serums or immunizations	yes	no	

Injuries: have you had any?

Broken bones	yes	no	Concussion or head injury	yes	no
Sprains or dislocations	yes	no	Whiplash or neck injury	yes	no
Cuts or lacerations	yes	no			

Hospitalizations:

Tonsillectomy yes no
Appendectomy yes no
Any other surgeries and year performed

_____
_____
_____
_____
_____

Hospitalizations other than for surgery:

_____
_____
_____
_____
_____
_____

Outpatient procedures: _____
_____

Habits:

Do you smoke?	Yes	no	If yes, how much and how long? _____
Use alcoholic beverages?	Yes	no	If yes, how much? _____
Do you sleep well?	Yes	no	
Do you gamble excessively?	Yes	no	
Do you drive fast?	Yes	no	
Do you exercise regularly?	Yes	no	
Do you follow a diet?	Yes	no	If yes, what diet? _____

Women only:

Age at onset of menstruation _____
Date of last period _____
Is it possible you are pregnant? Yes no

Pregnancies: How many? _____
Children born alive _____
Stillbirths _____
Cesarean sections _____
Miscarriages _____
Complications _____
Breast-fed babies _____

Please list your medications:

_____
_____
_____
_____
_____
_____
_____
_____

Patient's signature _____ Date: _____

Elberta Family Practice Clinic
24980 State Street
Elberta, AL 36530
251-986-7301 Fax: 251-986-5927

Terry Kurtts, MD
Joseph Walsh, MD
Robert Roe, MD

Date _____

Patient Name _____

PRESCRIPTION / CONTROLLED SUBSTANCE AGREEMENT

The purpose of this agreement is to prevent misunderstanding about the medications you have been or will be prescribed. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals.

I understand that this Agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this Agreement.

I understand that if I break this agreement, my doctor will stop prescribing these medications.

In this case, my doctor will taper off the medicines over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

I will not use any illegal controlled substances, street drugs, marijuana, cocaine, etc.

I will not share, sell or trade my medications with anyone.

I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or antianxiety medicines from any other doctor.

I will safeguard my medications from loss, theft or damage. Lost or stolen medications will not be replaced even with a police report. Any attempts to alter a prescription is grounds for dismissal from the practice.

I will not be given refills early for any reason or circumstance. Vacations, going out of town or any other reason will not justify early refills.

I agree that refills of my prescriptions for controlled medicine will be made only at the time of an office visit. No refills will be available during weekends, evenings or without an office visit.

I agree to use _____ pharmacy, located at

_____, telephone number _____, for all of my medications.

I authorize the doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my controlled medications. I authorize my doctor to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

I agree that I will provide a blood or urine specimen when requested by my doctor to determine my compliance with my medication regimen.

I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.

I will bring all unused medications to every office visit.

I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

This agreement is entered into on this _____day of_____, 20____.

Patient's signature _____

Physician's signature _____

Witnessed by _____

APPOINTMENT REMINDER CONSENT
TEXT MESSAGE AND/OR EMAIL NOTIFICATION

Patient Name: _____ Date of Birth: _____ MRN _____

Complete this form and sign below to give your permission for Elberta Clinic, PC to provide automatic appointment reminder service by email or by cell phone text message.

My CELL PHONE number is: _(_____)_____-_____

I recognize that normal text messaging rates may apply.

My Cell Phone Carrier is: (circle only one)

AT&T	Verizon	T-Mobile	Sprint PCS	Virgin Mobile	US Cellular
Nextel	Boost Mobile	Alltel	Straight Talk	Assurance Wireless	Consumer Wireless
Metro PCS	Cricket Wireless		Southern Link	H2O Wireless	

My email address is: _____

I understand that I will NOT be able to respond to text messages or emails. I understand that I will need to call the Clinic's main number 251.986.7301 to change/cancel my appointment 24 hours prior. I understand that I will need to update my information should I change it in the future to continue receiving text/email notifications. I further understand that the provider email system is not encrypted and that such email may be intercepted, hacked, or read by others; for this reason only the applicable names, times and dates of appointments, no other personal information about the patient will be included in the email.

Patient, Parent or Legal Guardian

Signature: _____ Date: _____

Printed Name: _____