FRONTIER
MEDICAL ASSOCIATES

101 WESTOVER CIRCLE STE C, MADISON, ALABAMA 35758
TELEPHONE NUMBER: (256) 461 0209 | FAX: (256) 325 3147

PATIENTS INFORMATION

Facility: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ City: _____

State: _____ Zip code: _____ Country: _____

Mobile Phone: _____ Home Phone: _____ Work phone: _____

DOB: ___/___/_____ SSN: _____ Sex: ☐ F ☐ M Drivers License: _____

Race/Ethnicity: _____ Marital Status: _____

Patient's Employer: _____ Occupation: _____

Email address: _____

EMERGENCY CONTACT DETAILS

Contact Person: _____ Relationship: _____ Phone #: _____

Contact Person: _____ Relationship: _____ Phone #: _____

Contact Person: _____ Relationship: _____ Phone #: _____

PRIMARY INSURANCE

Plan Name: _____ Group Number: _____

Contract/Member ID: _____

Name of Prescriber: _____ DOB: __/__/____ SSN: _____

Employer: _____ Relationship to Patient: _____

SECONDARY INSURANCE

Plan Name: _____ Group Number: _____

Contract/Member ID: _____

Name of Prescriber: _____ DOB: __/__/____ SSN: _____

Employer: _____ Relationship to Patient: _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Signature: _____ **Date:** _____

I hereby authorized FRONTIER MEDICAL ASSOCIATES LLC to apply benefits on my behalf for the covered services rendered by the office or the office order. I request that payment from my Insurance Company be made directly to FRONTIER MEDICAL ASSOCIATES LLC or to the party who accepts the assignment. I certify that the information I have reported with regard to my insurance coverage is correct.

Signature: _____ **Date:** _____

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Patients Name: _____ DOB: ____/____/_____

Reasons for visit: _____

Allergies: _____

REVIEW OF SYSTEMS (CHECK ALL THAT APPLY)

Current Symptoms

☐ Fatigue
☐ Fever
☐ Weight Loss
☐ Weight Gain
☐ Rash
☐ Joint Pain
☐ Muscle Aches
☐ Headache
☐ Cough
☐ Nasal Drainage
☐ Eye Pain
☐ Ear Pain
☐ Nose Bleeds
☐ Chest Pain
☐ Shortness of Breath
☐ Decreased Appetite
☐ Nausea
☐ Stomach Pain
☐ Blood in Urine
☐ Blood in Stool
☐ Painful Urination
☐ **Others:**

_____
_____
_____
_____

Last Menstrual Period

_____

Number of Pregnancy

_____

Number of Children

_____

Past Medical History

☐ Anemia
☐ Allergic Rhinitis
☐ Asthma
☐ Cancer
Type: _____
☐ Diabetes
Type: _____
☐ Eczema
☐ Heart Disease
☐ Hepatitis
☐ A ☐ B ☐ C
☐ High Cholesterol
☐ High Blood Pressure
☐ HIV
☐ Migraine
☐ Peptic Ulcer
☐ Psychiatric Disorder
☐ Seizure
☐ Stroke
☐ Substance Abuse
☐ Thyroid Disorder
☐ Hypothyroidism
☐ Hyperthyroidism
☐ **Others**: _____
_____
_____
_____
_____
_____

Have you had any of the following screening tests? (check all that apply)

☐ Dexa Scan ☐ PAP smear
☐ Mammogram
☐ Colonoscopy

Family History

☐ Anemia
☐ Allergic Rhinitis
☐ Asthma
☐ Cancer
☐ Diabetes
☐ Eczema
☐ Heart Disease
☐ Hepatitis
☐ High Cholesterol
☐ High Blood Pressure
☐ HIV
☐ Migraine
☐ Peptic Ulcer
☐ Psychiatric Disorder
☐ Seizure
☐ Stroke
☐ Substance Abuse
☐ Thyroid Disorder
☐ Hypothyroidism
☐ Hyperthyroidism

Social History

(Check all that apply)

☐ Tobacco Use
☐ Alcohol Use
☐ Drug Use
☐ Seatbelt Use
☐ Exercise: _____
☐ Hobbies: _____

Past Surgeries: _____
_____
_____
_____

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ADVANCED BENEFICIARY NOTICE (ABN)

We expect that the responsible party will pay for all services ie., Lab services, Clinic or Physician Services, however, your insurance company may not pay for all of your healthcare costs as your contract only pays for covered items and services when the insurance company's specific rules are met. The fact that your insurance company may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your MD has recommended it.

The purpose of this form is to help you make an informed decision about whether or not to receive these items or services knowing that you may have to pay for these items or services. Before you make any decisions about the options you should:

- Read the entire notice carefully.
- Ask for an explanation if you do not understand why your insurance may or may not pay.
- The estimated cost of items or services varies according to the item or services.

Yes, I want to receive these items or services and I understand that my insurance carrier will not decide whether or not to pay unless I receive these items or services. Please submit my claim to my insurance carrier. I understand that you may bill me for items or services and that I may be responsible for the bill my insurance carrier does not pay. I agree to be personally and fully responsible for payment and will pay out of pocket.

_____ _____

Signature over printed name Date

NOTICE OF PRIVACY ACKNOWLEDGMENT

Full Name: _____ DOB: _____/_____/_____

I have received a copy of the FRONTIER MEDICAL ASSOCIATES LLC Notice of Privacy Practices (Effective Date: 12/15/2008)

_____ _____

Signature over printed name Date

IF SIGNED BY A REPRESENTATIVE

Full name: _____ Relationship to Patient: _____

Witness: _____ Date: _____/_____/_____

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

To request Release of Medical Information, please sign this form and return it to:

FRONTIER MEDICAL ASSOCIATES

101 Westover Circle, Suite B

Madison, Alabama, 35758

Phone: 256-461-0209 Fax: 256-325-3147

PATIENTS INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ City: _____

State: _____ Zip code: _____ Country: _____

Mobile Phone: _____ Home Phone: _____ Work phone: _____

DOB: ___/___/_____ SSN: _____ Sex: ☐ F ☐ M Drivers License: _____

FRONTIER MEDICAL ASSOCIATES LLC has my permission to release medical information and may obtain medical information from the entity listed below:

Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____ Email: _____

INFORMATION REQUESTED

☐ H&P ☐ Discharge Summary ☐ Progress Note ☐ Labs ☐ Imaging ☐ Pathology ☐ Referrals

PURPOSE OF RELEASE: MEDICAL MANAGEMENT

I understand that My Health Record may include information about Drug or Alcohol Abuse, Psychiatric Illness, Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), or other protected information unless otherwise specified. I am aware that FRONTIER MEDICAL ASSOCIATES LLC can not control how the recipient uses or shares the information and that laws protecting it's confidentiality at FRONTIER MEDICAL ASSOCIATES LLC may or may not protect this information once it has been disclosed to the recipient. Information will not be released without a valid signature below. This authorization will expire within one (1) year of the signature dated below. I can cancel this authorization in writing at any time except to the extent that FRONTIER MEDICAL ASSOCIATES LLC has relied upon it.

I permit FRONTIER MEDICAL ASSOCIATES LLC to release or discuss my personal medical information with _____ relationship _____.

Signature of Patient/Representative: _____ **Date:** ____/_____/_____

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CONSENT FOR TREATMENT

Name: _____ DOB: ____/____/_____ Date: ____/____/_____

I, the undersigned hereby voluntarily consent to outpatient care at FRONTIER MEDICAL ASSOCIATES LLC encompassing routine diagnostic procedures, examinations, and medical treatment including but not limited to routine laboratory work, radiological studies, cardiac studies, and administration of medications prescribed by the Physician. I further consent to the performance of those diagnostic procedures, examinations, and rendering of medical treatment by the medical staff and their assistants.

DEDUCTIBLES/COPAYMENTS

Co-payments are due at the time of services without exceptions. The deductible amount will be billed after the payment is received from the Insurance Company. Payment is due within thirty (30) days of the invoice from the Billing Department. Questions concerning billing should be directed to the biller.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, hereby give my consent for FRONTIER MEDICAL ASSOCIATES LLC to use and disclose protected health information about me to carry out treatment, payment, and healthcare operations. The Notice of Privacy Practices provided by FRONTIER MEDICAL ASSOCIATES LLCdescribes such uses and disclosures completely. I have the right to review the Notice of Privacy Practices prior to signing this consent. FRONTIER MEDICAL ASSOCIATES LLC reserves the right to revise its notice of privacy at any time and may be obtained by written request. With this consent, FRONTIER MEDICAL ASSOCIATES LLCmay call my residence and speak to me in-person, leave a message and/or mail to my residence any items that assist the practice in carrying out health care operations such as appointment reminders, insurance, and Patient statements, and any items pertaining to my clinical care including but not limited to Laboratory results. By signing this form, I am consenting to FRONTIER MEDICAL ASSOCIATES LLC to use and disclose my protected health information to carry out Health Care Operations. I may revoke my consent in writing except to the extent that the Practice has already made disclosures in reliance on my prior consent. If I do not sign this consent or later revoke it, FRONTIER MEDICAL ASSOCIATES LLC may decline to provide treatment to me.

Patient/Patient's Representative Signature: _____ Date: ____/____/_____

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MEDICATION LIST

Full Name: _____ DOB: _____/_____/_____

NO	DATE STARTED	MEDICATION	DOSAGE	ROUTE	FREQUENCY
1					
2					
3					
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NOTICE OF PRIVACY PRACTICES

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA), this notice describes how your (as part of this practice) health information may be used and disclosed and how you can get access to your individually identifiable health information.

PLEASE REVIEW THIS NOTICE CAREFULLY

A. Our commitment to your privacy

FRONTIER MEDICAL ASSOCIATES LLC is dedicated to maintaining the privacy of your individually identifiable health information (also called protected health information or PHI). In conducting our business we will create records regarding you and the treatment and services we provide you. We also are required by law to provide you with this notice of our legal duties and privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information

- How we may use and disclose your PHI
- Your privacy rights in your PHI
- Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by the practice. FRONTIER MEDICAL ASSOCIATES LLC reserves the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all your records that the practice has created or maintained in the past, and for any of your records that the practices may create or maintain in the future. The practice will post a copy of the current Notice in our offices, in a visible location at all times, and you may request a copy of the most current Notice at any time.

B. Questions

If you have any questions about this Notice, please contact FRONTIER MEDICAL ASSOCIATES LLC at 256-325-3800 for further information.

C. Use of PHI

We may use and disclose your PHI in the following ways. The following categories describe the different ways in which we may use and disclose your PHI.

1. Treatment

The practice may use your PHI to treat you. For example, the practice may ask you to have laboratory testing (such as a blood or urine test) and the practice may use the results to help reach a diagnosis. The practice might use your PHI in order to write a prescription for you, or might disclose your PHI to a pharmacy when ordering a prescription for you. Many of the people who work for the practice including, but not limited to our doctors and nurses may use or disclose your PHI in order to treat you or assist others in your treatment. Additionally, the practice may disclose your PHI to other health care providers for purposes related to your treatment.

2. Payment

The FRONTIER MEDICAL ASSOCIATES LLC practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from the services rendered. For example, the practice may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits) and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. FRONTIER MEDICAL ASSOCIATES LLC may also use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, FRONTIER MEDICAL ASSOCIATES LLC may use your PHI to bill you directly for services rendered. FRONTIER MEDICAL ASSOCIATES LLC may disclose your PHI to other healthcare providers and entities to assist in their billing and collection efforts.

3. Deductibles/Percentage Pays/Co-Payments

Co-payments will be billed at the time of the physician visit. Deductibles will be billed at the time the payment from your insurance company is received. Payment is due within thirty (30) days of the date on the invoice. Patients are to keep payments current.

4. Health Care Operations

The FRONTIER MEDICAL ASSOCIATES LLC practice may use and disclose your PHI to operate day to day business. For example, the practice may use your PHI to evaluate the quality of care you received from FRONTIER MEDICAL ASSOCIATES LLC, or to conduct cost-management and business planning activities for the practice. Your PHI may be disclosed to other healthcare providers and entities to assist in their healthcare operations.

5. Appointment Reminders

FRONTIER MEDICAL ASSOCIATES LLC may use and disclose your PHI to contact you and remind you of an appointment.

6. Treatment Options

The practice may use and disclose your PHI to inform you of potential treatment options or alternatives

7. Health Related Benefits and Services

FRONTIER MEDICAL ASSOCIATES LLC may use and disclose your PHI to inform you of potential treatment options or alternatives.

8. Release of Information

FRONTIER MEDICAL ASSOCIATES LLC may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask the babysitter to take their child to the Pediatricians office for treatment of a cold. In this example, the babysitter may have access to the child's medical information.

9. Disclosures Required by Law

FRONTIER MEDICAL ASSOCIATES LLC will use and disclose your PHI when required to do so by federal, state or local law.

D. Use and Disclosure of PHI in Special Circumstances

The following categories describe unique scenarios in which we may use or disclose your identifiable health information.

1. Public Health Risk

FRONTIER MEDICAL ASSOCIATES LLC may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records such as births and deaths.
- Reporting abuse or neglect.
- Preventing or controlling disease, injury or disability.
- Notifying a person regarding potential exposure to communicable disease.
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition.
- Reporting reactions to drugs or problems with products or devices.
- Notifying individuals if a product or device they may be using has been recalled.
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of a patient (including domestic violence); however, FRONTIER MEDICAL ASSOCIATES LLCwill only disclose the information if the patient agrees or FRONTIER MEDICAL ASSOCIATES LLC are required by law to disclose this information.
- Notifying your employer under limited circumstances related to primary workplace injury or illness or medical surveillance.

2. Health Oversight Activities

FRONTIER MEDICAL ASSOCIATES LLC may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activity can include investigations, inspections, audits, surveys, licensure, and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor programs, compliance with civil rights and the health care system in general.

3. Lawsuit and Similar Proceedings

FRONTIER MEDICAL ASSOCIATES LLC may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. FRONTIER MEDICAL ASSOCIATES LLCmay also disclose your PHI un response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if FRONTIER MEDICAL ASSOCIATES LLC has made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement

FRONTIER MEDICAL ASSOCIATES LLC may release PHI if asked to do so by law enforcement officials.

- Regarding a crime victim in certain situations. If FRONTIER MEDICAL ASSOCIATES LLC is unable to obtain the person's agreement.
- Concerning the death FRONTIER MEDICAL ASSOCIATES LLC believes has resulted from criminal conduct.
- Regarding criminal conduct at the FRONTIER MEDICAL ASSOCIATES LLC office.
- In response to a warrant, summons, court order, subpoena or similar legal process.
- To identify/locate a suspect, material witness, fugitive or missing person.
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator.

5. Deceased Patient

FRONTIER MEDICAL ASSOCIATES LLC may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, FRONTIER MEDICAL ASSOCIATES LLC also may release information in order for funeral directors to perform their duties.

6. Organ and Tissue Donation

FRONTIER MEDICAL ASSOCIATES LLC may release your PHI to organizations that handle organ, eye or tissue procurement of transplantation, including organ donation bank, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research

FRONTIER MEDICAL ASSOCIATES LLC may use and disclose your PHI for research purposes in certain limited circumstances. FRONTIER MEDICAL ASSOCIATES LLC will obtain your written authorization to use your PHI for research purposes except when an Internal Review Board or Privacy Board has determined the waiver of authorization satisfies all of the following conditions:

A. The use or disclosure involves no more than minimal risk to your privacy based on the following:
    a. An adequate plan to protect the identifies from improper use and disclosures.
    b. An adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is health or research justification for retaining the identifiers or such retention is otherwise required by law)
    c. Adequate written assurances that the PHI will not be reused or disclosed to any other person or entity (except as written assurances that the PHI will not reused or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study or the research for which the use or disclosure would otherwise be permitted.
B. The research could not practicably be conducted without the waiver
C. The research could not practicably be conducted without access to and use of the PHI

8. Serious Threat to Health and Safety

FRONTIER MEDICAL ASSOCIATES LLC may use and disclose your PHI when necessary to reduce or prevent serious threats to your health and safety or the health and safety of another individual or the public. Under these circumstances, CUREME CLINIC LLC will only make disclosures to a person or organization able to help prevent the threat.

9. Military

FRONTIER MEDICAL ASSOCIATES LLC may disclose your PHI if you are a member of the U.S. or foreign military forces (including veterans) and if required by appropriate authorities.

10. National Security

FRONTIER MEDICAL ASSOCIATES LLC may disclose your PHI to federal officials for intelligence and national activities authorized by law, FRONTIER MEDICAL ASSOCIATES LLC may also disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of states or conduct investigations.

11. Inmates

Our practices may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. DIsclosures for these purposes would be necessary:

I. For the institution to provide health care services to you
II. For the safety and security of the institutions, and/or to protect your health and safety or the health and safety of other individuals.

12. Workers Compensation

Our practices may release your PHI that we maintain about you.

E. Your rights regarding your PHI that we maintain about you:

1. Confidential communications. You have the right to request that our practice communicate with you about your health related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home rather than work. In order to request a type of confidential communication. In order to request a type of confidential

communication, you must make a written request to FRONTIER MEDICAL ASSOCIATES LLC (Fax # 256-325 3147) specifying the requested method of contact or the location where you wish to be contacted. Our practices will accommodate reasonable requests. You do not need to give a reason for your request.

2. Requesting restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or healthcare operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members or friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law. In emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to FRONTIER MEDICAL ASSOCIATES LLC (Telephone number: 256-461-0209). Your request must describe in a clear and concise fashion:
    - The information you wish is restricted.
    - Whether you are requesting to limit our practice's use, disclosure or both.
    - To whom you want the limits to apply.
3. Inspection and copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to FRONTIER MEDICAL ASSOCIATES LLC (Telephone number 256-461-0209) in order to inspect and/or obtain a copy of your PHI. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however; you may request a review of our denial. Another licensed healthcare professional chosen by us will conduct reviews.
4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to FRONTIER MEDICAL ASSOCIATES LLC (Telephone number 256-461-0209). You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion:
    - Accurate and complete
    - Not part of the PHI kept by or for the practice
    - Not part of the PHI which you would be permitted to inspect and copy.
    - Not created by our practice, unless the individual or entity that created the information is not available to amend the information.
5. Accounting of disclosures. All of our patients have the right to request an "accounting of disclosures". An "accounting of disclosures" is a list of certain non routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations. Use of your PHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse or the billing department using your information to file your insurance claim, in order to obtain an accounting of disclosures, you must submit your request in writing to FRONTIER MEDICAL ASSOCIATES LLC (Telephone number 256-461-0209). All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you requested within a twelve (12) month period is free of charge, but our practice may

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charge you for additional lists within the same twelve (12) month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a paper of this notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact FRONTIER MEDICAL ASSOCIATES LLC(Telephone number 256-461-0209).
7. RIght to file a complaint. If you believe your privacy acts have been violated, you may file a complaint with our practice. Contact FRONTIER MEDICAL ASSOCIATES LLC (Telephone number 256-461-0209). All complaints must be submitted in writing. You will not be penalized for filing a complaint.
8. RIght to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for other uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization, Please note: we are required to retrain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact FRONTIER MEDICAL ASSOCIATES LLC (Telephone number 256-461).

ACKNOWLEDGEMENT

I acknowledge that I have been provided a copy of the FRONTIER MEDICAL ASSOCIATES LLC

“Notices of Privacy Practices”

Which provides a description of the manner in which FRONTIER MEDICAL ASSOCIATES LLC may use.

And disclose a Patient’s protected health information.

_____ _____/_____/_____

Signature of Patient/Sponsor/Representative Date

_____

Patients full name (Please print)