PARTNERS IN HEALTH FAMILY MEDICINE
PATIENT INFORMATION

PATIENT INFORMATION

Name:____Date of Birth:____/____/______ Age:_____

Sex: ___M or ___F SSN:_____-_____-________ Marital Status:___Single ___Married ___Widowed ___Divorced ___Partner

Race:_____________________ Ethnic Group:___African American ___Hispanic/Latino ___Not Hispanic/Latino ___Other

Language (if not English):_________________ Other Communication Issues: ___Yes ___No - Detail:_________________

Mailing Address:____
Street/PO Box Apt. #. City State Zip

Physical Address (if different from mailing address):____
Street Apt# City State Zip

Home Phone: (_____)______-________Cell Phone:(_____)______-________Work Phone:(_____)______-________

Would you like to sign up for the
patient portal? ___Yes ___No If yes, please provide email address:______________________________

Preferred Reminder Method: ___Work Phone ___Home Phone ___Cell Phone. May we leave voicemail? ___Yes ___No

SPOUSE/PARTNER INFORMATION

Spouse/Partner Name:_________________________________DOB:____/_____/_____ Phone:(_____)_____-_______

Address (if different from patient):____
Street Apt # City State Zip

EMERGENCY CONTACT INFORMATION

Emergency Contact Name:____Phone:(_____)_____-________

Address:____Relationship:_________________
Street Apt # City State Zip

GUARANTOR/PARENT INFORMATION

Responsible Party:______________________________________Date of Birth:____/____/______ Sex ___M ___F

SSN:_____/_____/________ Home Phone:(_____)_____-_______Cell:(____)____-_______Work:(____)____-_______

Employer:_________________________Occupation:_____________________Relationship to Patient:______________

Address:____
Street Apt # City State Zip

INSURANCE INFORMATION (Please provide insurance card and photo ID to receptionist)

Primary Insurance:________________________________Ins. ID #:__________________ Group No:_______________

General Phone:(_____)_____-_______ Claims Phone:(_____)_____-_______ Office Fax:(_____)_____-________

Insurance Address:____
Street Suite # City State Zip

Policy Holder's Name:_________________________________Date of Birth:____/____/______SSN:____-____-______

Secondary Insurance:________________________________**Ins. ID #:**_________________ **Group No:**_______________

General Phone:(_____)_____-_______ Claims Phone:(_____)_____-_______ Office Fax:(_____)_____-________

Insurance Address:____
Street Suite # City State Zip

Policy Holder's Name:_________________________________Date of Birth:____/____/______SSN:____-____-______

I hereby authorize my insurance benefits to be paid directly to Partners in Health Family Medicine, PLLC, and I realize I am responsible for paying non-covered services. I understand that I am responsible for all charges incurred on my behalf, including any added costs incurred due to any effort to collect for services rendered. I hereby authorize the release of pertinent medical information to insurance carriers.

Patient/Guardian Signature:____Date:_________________

PARTNERS IN HEALTH FAMILY MEDICINE
PERSONAL AND FAMILY MEDICAL HISTORY

NAME:____ DATE OF BIRTH:____________________

Personal Medical History
Check all that apply:

___NONE
___ADD/ADHD
___AIDS/HIV
___Allergies/Hay Fever
___Alzheimer's/Other Dementia
___Anemia
___Anxiety
___Arthritis - Type:_______________
___Asthma
___Bladder Problems
___Blood Disorders
___Cancer - Type:________________
___Congestive Heart Failure
___Constipation
___COPD
___Depression
___Diabetes - Type I____or Type II___
___Diverticulosis/Diverticulitis
___Fibromyalgia
___Gout
___Heartburn/GERD
___Headaches: ___check if migraines
___Hearing loss
___Heart Disease/Coronary Artery Disease
___Hepatitis
___High Cholesterol
___High Blood Pressure/Hypertension
___Joint or Bone Problems - Type:______________
___Kidney Disease
___Kidney Stones
___Liver Disease
___Lung Disease - Type:________________
___MRSA/Staph Infection
___Obesity
___Osteoporosis
___Prostate Problems
___Seizures
___Stroke
___Urinary Tract Infections
___Other: Please List:

____

____

____

____

Family Medical History
Grandparents (GP), Parent (P) Siblings (S)
Check all that apply:

	GP	P	S
___Unknown			
___AIDS	___	___	___
___Alcoholism	___	___	___
___Alzheimer's	___	___	___
___Asthma	___	___	___
___Blood Disorders	___	___	___
___BPH (enlarged prostate)	___	___	___
___Breast Cancer	___	___	___
___Stroke	___	___	___
___Colon Cancer	___	___	___
___COPD	___	___	___
___Depression	___	___	___
___Diabetes	___	___	___
___Gout	___	___	___
___Heart Problems	___	___	___
___High Blood Pressure	___	___	___
___High Cholesterol	___	___	___
___HIV	___	___	___
___Hypothyroid	___	___	___
___Hypothyroid	___	___	___
___Kidney Stones	___	___	___
___MI (Heart Attack)	___	___	___
___Osteoarthritis	___	___	___
___Osteoporosis	___	___	___
___Prostate Cancer	___	___	___
___Rheumatoid Arthritis	___	___	___

___Other:________________________________

___Other:________________________________

___Other:________________________________

SURGICAL HISTORY: List all surgeries you have had, including date:

____

____

____

____

____

PARTNERS IN HEALTH FAMILY MEDICINE
MEDICATION/HEALTH MAINTENANCE INFORMATION

Name:____ **Date of Birth:**____________________

Preferred Pharmacy:_____________________________________ **Location:**______________________

Allergies: Allergic to any medications? ___Yes or ___No
If yes, please list below:

ALLERGY TO THIS MEDICATION:	REACTION TO MEDICATION:

MEDICATION LIST: Please include dosage and frequency

MEDICATION	DOSAGE	FREQUENCY

Specialists you see:

Doctor:	Specialty:

Tobacco Use: ___Yes ___No ___Former

	How Many?	How Long?
___Cigarettes:		
___Cigars:		
___Vape:		
___Smokeless:		

Alcohol Use: ___Yes or ___No

	How Much?	How Often?
___Beer:		
___Wine:		
___Liquor:		

Illicit Drug Use: ___Yes or ___No

HEALTH MAINTENANCE:
Last Colonoscopy Date: ______________

Last Mammogram Date: ______________

Last Pap Smear Date: ________________

Last Tetanus Shot: ___________________

Last Flu Shot: _______________________

Last Pneumonia Shot: _______________

Last Shingles Shot: __________________

Exercise Level: ___None ___Some ___Moderate ___Heavy

Do you have any of the following?

___Living Will ___Power of Attorney

___Health Care Proxy

Occupation:________________________
Place of Employment:

____

PARTNERS IN HEALTH FAMILY MEDICINE
PERMISSION TO DISCUSS PROTECTED HEALTH INFORMATION

NAME:_______________________________________ DATE OF BIRTH:___________________

I have received a copy of the Privacy Act of Partners in Health Family Medicine, PLLC, and I understand that the providers and staff at Partners in Health Family Medicine will not discuss my health information with my family, friends, or other non-authorized persons unless I expressly authorize them to do so as indicated below.

____ ________________________
Signature *Date*

PERMISSION TO VERBALLY DISCUSS PROTECTED HEALTH INFORMATION
I give permission to Partners in Health Family Medicine to VERBALLY discuss the following medical and billing information about me (check all that apply):

___Appointment Information

___Medical Information including my symptoms, diagnosis, medications, and treatment plan

___Behavioral Health Information including my symptoms, diagnosis, medications, and treatment plan

___Chemical Dependency Information including my symptoms, diagnosis, medications, and treatment plan

___Lab Test Results

___Billing and Payment Information

___Other:____

Partners in Health Family Medicine has my permission to discuss the above information with the following person(s):

1. Name:____Relationship:_________________________

Address:____
Street Apt. # City State Zip

Home Phone:(_______)_______-__________ Cell Phone:(_______)_______-________Work Phone:(______)______-_________

2. Name:____Relationship:_________________________

Address:____
Street Apt. # City State Zip

Home Phone:(_______)_______-__________ Cell Phone:(_______)_______-________Work Phone:(______)______-_________

I understand that I have the right to revoke my permission at any time except where PIH has already made disclosures in reliance upon this request. I understand that I must notify PIH in writing if I revoke my permission.

____ __________________________
Signature of Patient/Authorized Representative Date

If authorized representative, please attach copies of supporting legal documentation.

*Reason patient is unable to sign:*____

*Signature of Patient Representative:*____ *Date:*_____________________

PARTNERS IN HEALTH FAMILY MEDICINE
FINANCIAL POLICY

7216 Copperfield Dr.
Montgomery, AL 36117
(334) 244-1359

Our goal is to provide you excellent medical care in a comfortable, personal, and cost-effective manner. Our financial policies have been developed to help keep the cost of "doing medicine" down, which means lower fees for you. You can help by paying for your care in a timely manner.

Patient Name:____Date of Birth:______/______/___________

ASSUMPTION OF RESPONSIBILITY:

Payment to *Partners in Health Family Medicine* may be made by cash, check, VISA, or MasterCard. Patients are expected to pay all copies, deductibles, and/or coinsurance at the time of service. We do our best to include all charges at the time of service, but occasionally charges may be added or modified after the visit. (For example: an additional blood or urine test may be ordered, or the level of service may be modified per AMA guidelines.)

Partners in Health Family Medicine reserves the right to charge a fee for delinquent accounts. If ongoing medical care is needed, you are expected to pay on your old balance as well as payment in full for new charges at the time of service. Accounts with balances over ninety (90) days may be turned over to a collection agency unless you are making monthly payments on an approved payment plan.

Please check each:

___By signature below, I/we, whether signing as guarantor or as patient, understand and hereby agree that in consideration of services to be rendered to the patient named above, assume the obligation, the financial responsibility and agree to pay upon demand to *Partners in Health Family Medicine* all fees for such services and incidentals incurred by named patient. Should the account be referred to an attorney for collection or to a collection agency, the undersigned shall pay reasonable attorney fees, collection fees, and other expenses as a court my determine proper.

___By signature below, I/we understand that in connection with collection procedures, Partners in Health Family Medicine has the right to request, receive, and review all credit information as provided by a licensed and duly operated credit bureau.

___By signature below, the undersigned understands that all bills are payable upon presentation, and that the guarantor and NOT the insurance is responsible for the payment of all services. If the undersigned disagrees with any charges, they will contact this office in writing within thirty (30) days of the billing date.

ASSIGNMENT OF INSURANCE BENEFITS:

Please check each:

___I/we understand that insurance billing is a courtesy to our patients. Once my annual deductible has been met, PIH will bill my insurance company.

___I/we understand that I am expected to pay for any co-payment and non-covered services at the time of my visit.

___I/we understand it is my responsibility to pay any balance older than sixty (60) days (even if my insurance has not paid) and to follow up with my insurance company for reimbursement. A refund will be issued if PIH receives a payment fro your insurance company after your balance is paid. If we have made an error, we will gladly submit a corrected claim.

___By signature below, I/we hereby guarantee payment of all charges as outlined above and incurred for the account of the above named patient from the date of the first treatment until final date of discharge or termination of treatment.

___By signature below, I/we hereby assign direct payment of any hospital insurance benefits, medical insurance benefits, medical insurance benefits (including major medical benefits, insurance sick benefits, or injury benefits) payable of the liability of a third party or organization, and so forth, payable to or for the above named patient be paid in full.

NO SHOW AND CANCELLED APPOINTMENTS:

Partners in Health Family Medicine reserves the right to charge a fee for "no show" appointments with less than a 24-hour notice. Our policy requires: (1) receiving a 24-hour notice if the patient is unable to keep the appointment; (2) applying a fee for missed appointments; and (3) discharging a patient when three appointments are missed without prior notice.

No Show Appointments: 1st = Warning, 2nd = $45 to $75 charge, 3rd = Discharge from practice.

AUTHORIZATION TO RELEASE INFORMATION:

The undersigned hereby authorizes Partners in Health Family Medicine to release sociological and medical information officially acquired in the course of examination and treatment for the purpose of filing for insurance benefits and other financial coverage. This authorization to release information shall remain in place until all claims have been paid.

NOTICE: DO NOT SIGN THIS AGREEMENT BEFORE YOU READ, UNDERSTAND, AND AGREE TO THE CONDITIONS AS SET OUT ABOVE. YOU SHOULD KEEP A COPY OF THIS AGREEMENT IN YOUR RECORDS.

BY SIGNATURE BELOW, I ACKNOWLEDGE THAT I HAVE READ, I UNDERSTAND, AND I APPROVE ALL THE ABOVE.

Signature:____**Date:**_______________________________

Signature of Patient/Guarantor