Elberta Clinic New Patient Instructions

Thank you for choosing Elberta Clinic. We are excited to welcome you as a new patient.

Important Notice:

Due to current regulations, our providers are unable to prescribe or refill controlled medications, including those for pain, anxiety, behavioral health, or sleep.

Required Documentation

Please provide the following items with your New Patient Paperwork:

- **Driver's License – Copy of the front and back (must be current and valid).**
- **Insurance Card(s) – Copy of the front and back.**
- **Prescription Card** – If separate from your medical insurance card, provide copies of the front and back.

If you are unable to provide copies in advance, please bring the originals with your completed packet, and our staff will gladly make copies for you.

First Visit Requirements

On the day of your first appointment, you must present the **original driver's license and insurance cards** so we can scan them into our system. We will also request updated copies each year, or whenever your insurance or driver's license information changes.

Please note: **Your new patient packet will only be reviewed once all required information has been provided.**

Annual Wellness Check-Up Agreement

Elberta Clinic strives to keep our patients healthy. Therefore, we have implemented a policy aimed at preventing chronic disease and promoting a healthy lifestyle.

All patients are required to complete an annual wellness check-up with our Nurse Practitioners. Most insurance companies mandate this, and research shows that detecting illnesses early greatly increases the chance of successful treatment.

During your visit, a nurse practitioner will review the preventative screenings recommended for your age group, explain the details, answer any questions, and may recommend outpatient testing or in-house vaccinations.

Outpatient tests will be scheduled on your behalf, and you will be notified of the appointment. If no notification is received within seven days, please call 251-986-7301 and select option 2.

All patients are required to bring their medications in the original bottles to every visit. This ensures accurate information for your care and helps prevent contraindications or adverse reactions.

By signing below, I acknowledge the above requirements of Elberta Clinic.

NAME _____ DATE _____

SIGNATURE: _____

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 requested. 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 and a 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 who 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 those of any health care professional authorized to enter information into your medical chart, any member of a volunteer group that we allow to help you, as well as all employees, staff, and other practice personnel.

Policy regarding the protection of personal information: We need to maintain the privacy of your medical information by law. We create a record of the care and services you receive at the practice. We need this record 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 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 workers' 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 have 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 the 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 with 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 Dawn Adams at 251-986-9057. 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 us will be made only with your written authorization. If you provide Elberta Clinic 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's or Personal Representative's Signature Date

Elberta Clinic HIPAA Authorization to Disclose Health Information

(Alabama & Federal HIPAA Compliant)

Patient Information:

Full Name: _____

Date of Birth: _____

Phone Number: _____

Patient Rights and Acknowledgment

- I understand that I may revoke this authorization in writing at any time.
- I understand that revocation will not apply to information already disclosed.
- I understand that information disclosed may be subject to re-disclosure.
- I understand that my treatment will not be conditioned on this authorization.

Persons Authorized to Receive My Health Information

I authorize the following individual(s) to have access to my protected health information:

Name	Relationship	Phone	Access Level
_____	_____	_____	☐ Full ☐ Limited
_____	_____	_____	☐ Full ☐ Limited
_____	_____	_____	☐ Full ☐ Limited

☐ Limited Access (describe what info can be shared):

_____

_____

Patient/Legal Representative Signature: _____

Date: _____

If Legal Representative, relationship to patient: _____

Patient Registration Form

Please fill out form completely

Patient's Full Name: _____ Date of Birth: _____ SS#: _____

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

Home Phone: _____ Cell: _____ Work: _____

Email: _____

Race:	Ethnicity:	Language
☐ Asian	☐ Non-Hispanic	☐ English
☐ Black/African American	☐ Hispanic	☐ Spanish
☐ American Indian/Alaska Native	☐ Other	☐ Other _____
☐ Caucasian		
☐ Native Hawaiian/Other Pacific Islander		

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

Employer: _____ Hours/Days at Work: _____

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

Phone: _____ Email: _____

Emergency Contacts:

Name: _____ Relationship: _____

Phone Numbers: Home: _____ Cell: _____

Name: _____ Relationship: _____

Phone Numbers: Home: _____ Cell: _____

Responsible Party: (If same as above, skip this section)

Name: _____ Date of Birth: _____ Email: _____

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

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

Appointment Reminder Consent: If you want to be notified of your appointments, please provide your cell number, email, and cell phone carrier below:

Cell: _____ Email: _____ Cell Phone Carrier: _____

Signature: _____ Date: _____

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 necessary information to secure 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 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 the 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 the release of the information to the insurer or agency shown. I understand that my deductible, coinsurance, and non-covered services will be my full responsibility.

Signature of Beneficiary _____ Date _____

CONSENT FOR TREATMENT

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

Signature of Patient or Guardian _____ Date _____

INSURANCE INFORMATION

Patient's Name: _____
Please Print Clearly

1. Please acknowledge your insurance by completing all requested areas.
2. Tricare members must include their subscribers' social security number (as your policy number) and date of birth.
3. If you have coverage with dual Medicare, be sure to also include the Medicare policy number in the space below.
4. Please ensure the name spelling matches your insurance card.

1st. Primary Insurance Coverage

Name _____ Ins. Company_____

Policy/Id Number _____ Group Number _____

Claim Address _____

Subscriber's Name: _____ Date of Birth: _____

Address if Different: _____

2nd. Secondary Insurance Coverage

Name _____ Ins. Company_____

Policy/Id Number _____ Group Number _____

Claim Address _____

Subscriber's Name _____ Date of Birth _____

Address Of Different: _____

3rd. Insurance to Primary Insurance

Name _____ Ins Company: _____

Policy/Id _____ Group _____

Claim Address _____

Subscriber's Name _____ Date of Birth _____

Address If Different: _____

Medicare # If Not Provided Above _____ Effective Date _____

In signing below, I acknowledge, to the best of my abilities, that the information is correct in information as well of priority.

Name: _____ Date: _____

PATIENT MEDICAL HISTORY

Please fill form out completely

Date:_____ Who were you referred by:_____

Patient Name: _____ Date of birth: _____ ☐ Single ☐ Married ☐ Divorced ☐ Widow(er)

Occupation:_____ Spouse's Occupation: _____ Do you have pets: ☐ Yes ☐ No

Highest level completed: ☐ High School ☐ 11th ☐ 12th ☐ College ☐ Postgraduate

PLEASE LIST YOUR MEDICAL CONDITIONS:

_____

_____

HOSPITALIZATIONS/SURGERIES

Surgery procedures and years performed	Hospitalizations other than surgeries

SOCIAL HISTORY

Do you smoke/dip? ☐ Yes ☐ No If yes, how many packs a day for how many years? _____ packs/day _____ years

Do you drink alcoholic beverages? ☐ Yes ☐ No If yes, type of alcohol, how much, how often? _____

Do you sleep well? ☐ Yes ☐ No Snore? ☐ Yes ☐ No Leg trouble at bedtime? ☐ Yes ☐ No

Drive fast? ☐ Yes ☐ No Wear a seat belt? ☐ Yes ☐ No Gamble excessively? ☐ Yes ☐ No

Do you have an exercise program? Describe:_____

Do you follow a special diet? Describe:_____

WOMEN ONLY:

Age at onset of menstruation? _____ Pregnancies: How many? _____

Date of last period? _____ Children born alive _____ Stillbirths:_____

Is it possible you are pregnant? ☐ Yes ☐ No C-sections: _____ Breastfed: _____

Do you see any specialists? Please list who and what conditions:_____

_____

IMMUNIZATIONS:

Do you get yearly flu shots? ☐ Yes ☐ No Have you had a shingles shot? ☐ Yes ☐ No When?_____

Have you had a pneumonia shot? ☐ Yes ☐ No When? _____ Have you had a whooping cough shot? ☐ Yes ☐ No

Do you remember the year of your last tetanus shot?_____

PATIENT MEDICAL HISTORY

HEALTH MAINTENANCE:

When was your last yearly blood work? _____

When was your last mammogram? _____ Where did you have your mammogram done? _____

When was your last colonoscopy? _____ What doctor and facility? _____

Have you ever received a blood transfusion? ☐ Yes ☐ No

Have you had a bone density/DEXA scan? ☐ Yes ☐ No When? _____

When was your last female check or PAP smear? _____ When was your last male prostate check? _____

PAST MEDICAL HISTORY: (HAVE YOU EVER HAD?)

☐ Chicken pox ☐ Mumps ☐ Whooping cough ☐ Measles ☐ Scarlet fever ☐ Mono	☐ Hiatal hernia ☐ Gall bladder problems ☐ Bleeding ulcers ☐ Inflammatory bowel disease ☐ Diverticular disease ☐ Abdominal cancer	☐ Kidney stones ☐ Bladder infections ☐ Kidney failure ☐ Bladder cancer ☐ Prostate cancer ☐ Sexually transmitted conditions	☐ Abnormal moles ☐ Skin cancers ☐ Skin allergies ☐ Rashes ☐ Hives
☐ Heart problems ☐ Rhythm problems ☐ Blocked blood vessels ☐ Blood clots ☐ Strokes ☐ Angina ☐ Heart failure ☐ High blood pressure	☐ Problems with surgeries ☐ Blood clots after surgery ☐ Free bleeding ☐ Anemia ☐ Low iron ☐ Frequent infections	☐ Neurologic problems ☐ Parkinson's disease ☐ Stroke ☐ Neuropathy ☐ Seizures ☐ Epilepsy ☐ Migraine headaches	☐ Lung problems ☐ Pneumonias ☐ Recurrent bronchitis ☐ Lung cancer ☐ Clots in lungs ☐ Asbestosis exposure ☐ TB ☐ Asthma
☐ Heavy periods ☐ Lost pregnancies ☐ Difficulty becoming pregnant ☐ Menopausal issues	☐ Diabetes ☐ Low blood sugar ☐ Steroid use	☐ Arthritis ☐ Rheumatism ☐ Bursitis ☐ Rheumatoid	☐ X-ray therapy ☐ Chemotherapy ☐ Depression ☐ Nervous breakdown ☐ Anxiety

Other: _____

INJURIES: Have you ever had any?

Broken bones? ☐ Yes ☐ No If yes, Year _____ Surgery _____ Cuts / Sprains or dislocations? ☐ Yes ☐ No Year? _____ Other serious injuries? ☐ Yes ☐ No Year? _____ Do you have metal in your body or have a pacemaker? ☐ Yes ☐ No Year? _____	Concussion or head injury? ☐ Yes ☐ No Year _____ Whiplash or neck injury? ☐ Yes ☐ No Year _____ Serious car wreck? ☐ Yes ☐ No Year _____ Injuries? _____

MEDICATIONS:

_____ _____ _____

_____ _____ _____

_____ _____ _____

ALLERGIES:

What medicines or foods are you allergic to? What reaction do you have? (Example: Penicillin/Hives-Rash)

_____

_____

FAMILY HISTORY:

	Age	If living, health status	Age at Death	If deceased, Cause?
Father				
Mother				
Brother/Sister				
Husband/Wife				
Son/Daughter				

Have any blood relatives ever had?		How are/were they related?
Cancer	☐ Yes or ☐ No **Type:**	
Diabetes	☐ Yes or ☐ No	
Heart Trouble	☐ Yes or ☐ No	
Tuberculosis	☐ Yes or ☐ No	
Stroke	☐ Yes or ☐ No	
Emphysema	☐ Yes or ☐ No	
High Blood Pressure	☐ Yes or ☐ No	
Mental Illness	☐ Yes or ☐ No	
Suicide	☐ Yes or ☐ No	
Thyroid Problems	☐ Yes or ☐ No	
High Cholesterol	☐ Yes or ☐ No	
Alcohol/Substance Abuse	☐ Yes or ☐ No	
Epilepsy	☐ Yes or ☐ No	
Birth defects	☐ Yes or ☐ No	
Other:		