Central Alabama
PRIMARY CARE

New Patient Intake Form

Today's Date: _____

Please complete the below information, to the best of your knowledge, and bring this form to your appointment.

NAME: _____ **BIRTHDATE** _____

ADDRESS: _____

PHONE: *HOME* ( ) _____ *WORK:* ( ) _____ *CELL:* ( ) _____

EMAIL ADDRESS: _____

Sex: _____ **Race:** _____ **Ethnicity:** _____ **Social Security #:** _____

Employer: _____ **Occupation:** _____

Retired: ☐ Yes ☐ No **Disabled:** ☐ Yes ☐ No **Retirement Date:** _____

Your Preferred Language: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse's Name: _____ **Birthdate:** _____

Spouse's Social Security #: _____ **Spouse's Cell Phone #:** _____

Person To Contact In Case of Emergency: _____

Relationship To You: _____ **Phone #:** _____

LOCAL PHARMACY

NAME/ ADDRESS: _____

PHARMACY PHONE # ( ) _____ **FAX #** ( ) _____

MAIL ORDER PHARMACY

NAME/CITY/STATE: _____

PHARMACY PHONE # ( ) _____ **FAX #** ( ) _____

MEDICATIONS:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

DRUG ALLERGIES- _____

Medical History

Central Alabama
PRIMARY CARE

CIRCLE MEDICAL HISTORY & YEAR DIAGNOSED:

A-Fib _____
Anemia_____
Anxiety_____
Arthritis_____
Asthma_____
Bipolar _____
Blood Clots_____
BPH _____
Cancer _____
COPD _____
Depression_____
Diabetes _____
Glaucoma_____
Gout_____
Heart Disease_____
Heart Failure _____
Hepatitis _____
High BP _____
High Cholesterol____
IBS/IBD _____
Kidney Disease _____
Liver Disease _____
Lung Disease_____
Lupus _____
Migraines _____
Neuropathy _____
Osteoporosis _____
Rheumatoid Arthritis _____
Schizophrenia _____
Seizures _____
Sleep Apnea _____
Stroke _____
Thyroid Disease _____
Vein Trouble _____

Other Medical Conditions:

_____

_____

_____

_____

PREVIOUS SURGERIES/INJURIES (and date):

_____

_____

_____

Father: Alive? Y or N Illnesses: Diabetes Stroke High BP Heart Attack Cancer Other _____

Mother: Alive? Y or N Illnesses: Diabetes Stroke High BP Heart Attack Cancer Other _____

Number of Children_____ Health Issues: _____

SOCIAL HISTORY: Lives with: _____

Smoking: YES NO How Much? _____

Alcohol: YES NO How Much? _____

HOSPITALIZATIONS (list reason/date):

_____

_____

_____

Other Physicians seeing you and their specialty: _____

_____

_____

Authorization to Release Information:

I authorize the release of medical information and records concerning my treatment to Medicare, Medigap, and/or other insurance companies and assign my claim for medical benefits to the Practice to the extent permitted under applicable law or insurance agreements. I agree to allow the Practice to request and release my medical records from the other physicians or medical institutions as it deems necessary for my medical care and I further authorize the release of my medical records by such parties for such purpose. I agree to allow the Practice to use my medical information and photography in an anonymous manner for the purpose of teaching or publication. I release the Practice from all legal responsibility or liability that may arise from above authorizations and agreements.

FMLA and Medical Forms Policy:

Most forms may be completed during your scheduled appointment. Please bring all forms to your appointment, or you may sched-ule a separate appointment. Please let our office know what forms you will be bringing for us to complete. For forms completed during your appointment, with the exception of FMLA forms, you are only responsible for your regular Office Visit copay/ cost-sharing. Due to the time and medical expertise involved, we charge a fee of $35 per form completed outside of a scheduled appointment – which will be collected prior to completing the form(s). All FMLA forms completed, regardless of if it is done during an appointment or not, will incur a $35 forms completion charge. We require a signed Authorization to Release Medical Information and it must accompany the form. It will be your responsibility to complete your portion of the form and return it to the appropriate institution. We will mail the completed forms to your home address, or you may request to pick them up during regular office hours.

No Show and Cancellation Policy:

Patients who fail to show up to their scheduled appointment without 24-hour notification will be charged a $75.00 No-show fee. Patients are required to provide 24 hours' notice if they can't make their appointment. If a patient cancels within that time frame, they won't be charged. Patients who cancel their appointment with less than 24 hours' notice will be charged a $75.00 Cancellation fee.

Appointment Reminder Policy:

I authorize this Practice and their agent to place appointment reminder phone calls or text messages to the phone I have listed on my patient form.

Consent to Treatment:

I authorize the physicians of the Practice, their associates, technical assistants, and other health care providers under their direction to provide diagnostic evaluation and treatment. I understand that no guarantee has or will be made to me regarding any pos -sible result or cure based on my examination and/or treatment.

Patient Signature: _____ Date: _____

Central Alabama
PRIMARY CARE

Peter Krothapalli, D.O.
4163 Lomac St.
Montgomery, AL 36106

PRIVACY PRACTICES

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

EFFECTIVE DATE: 11/4/2024

The policy of Central Alabama Primary Care, LLC is to protect the confidentiality, integrity and security of the protected health and personal information of our patients and to prevent unauthorized access to, or the use or disclosure of such information. We are required by law to maintain the privacy of your health information and provide you with this notice of our duties and obligations. This policy applies to patients who are current or former patients of Central Alabama Primary Care, LLC.

Individually identifiable health and personal information are any information obtained by Central Alabama Primary Care, LLC in connection with providing healthcare treatment, obtaining payment and related health care operations. This relates to past, present or future information that Central Alabama Primary Care, LLC receives from you as our patient.

Central Alabama Primary Care, LLC collects personal information in order to learn about your medical history, medical conditions, render treatment and collect payment for our services. We gather this information from your patient forms, health questionnaires and other forms you will be asked to complete from time-to-time. In addition, we will assemble information based on our discussions and conversations with you, your personal representative, and your family members. Your healthcare plan or insurance carrier may provide information to our office.

We will use this information to provide caring and quality medical care to you. Examples include diagnosis, treatment, and communications such as follow up and appointment reminders, as well as treatment alternatives or other health-related benefits that may be of interest to you or your particular medical condition. As part of our standard treatment and healthcare operations, we may share information with a facility such as a hospital, laboratory, diagnostic service, or healthcare provider to efficiently coordinate your treatment plan. We will obtain your written authorization before using your information for marketing purposes. For contracted insurers, your information will be used for claims management and to obtain payment from your insurance carrier. We will exchange paper and electronic data with your insurance carrier for activities such as eligibility, benefit and coverage determinations, precertification, utilization review and related activities. For worker's compensation, information about a work-related condition can be exchanged with the employer.

Your information is maintained in our office in our computer system. We also maintain information about you in your medical chart. Central Alabama Primary Care, LLC limits the access to your protected health information to those employees and business associates who need to know that information. With some limitations, you have the right to inspect, amend, copy and receive an accounting of disclosures of your medical and billing records.

We do not disclose personal information to third parties unless one of the following exceptions applies:

- We will receive an explicit authorization from you to release individually identifiable information. This authorization must be in writing and give exact details regarding to whom the disclosure applies, the nature of the data to be released, the applicable dates and signed by the patient (or guardian). You may revoke this authorization by providing a written statement to Peter Krothapalli D.O., Central Alabama Primary Care, LLC, 4163 Lomac Street, Montgomery, AL 36106.
- Federal, state or other applicable law requires us to share protected information or records. Your information may be disclosed to a health agency for purposes such as licensure, certification, audits, investigations and inspections. As required for law enforcement purposes or in response to a valid subpoena or court order, your information may be disclosed. Other disclosures could be required by law for military duty, national security activities or for coroners or funeral director to carry out their duties.
- We are obligated to abide by the terms of this notice. We will obtain a signed, written authorization from you for permission to use and disclose your information for reasons not described in this Notice of Privacy Practices. The authorization will have an expiration date and a description of the purpose or the event you are authorizing. You will be provided with a copy of the signed authorization. You have the right to revoke the authorization in writing, at any time, and mail to Peter Krothapalli D.O., Central Alabama Primary Care, LLC, 4163 Lomac Street, Montgomery, AL 36106.

Central Alabama
PRIMARY CARE

Peter Krothapalli, D.O.
4163 Lomac St.
Montgomery, AL 36106

Acknowledgement of Receipt of Notice of Privacy Practices with Restrictions

Patient Name: _____ Patient Date of Birth: _____

I have been presented with a copy of Central Alabama Primary Care, LLC's Notice of Privacy Practices, detailing how the above-named patient's information may be used and disclosed as permitted under federal and state law.

In the event of a medical emergency or if I am otherwise unavailable, I hereby allow Central Alabama Primary Care, LLC to discuss billing, appointments, treatment, diagnosis, test results, and other protected health information regarding the above-named patient with the following persons who are involved with the patient's health care and/or payment related to the patient's health care:

Name	**Relationship**	**Contact #**

Contact Methods:

May we leave information on your answering machine at home?	Yes	No
May we leave information on your voicemail at work?	Yes	No
May we leave information on your cell phone?	Yes	No

I understand the contents of the Notice of Privacy Practices, and I request the following restriction(s) concerning the use and/or disclosure of my personal medical information (*include type of information covered and the parties who should not receive the information*):

_____

_____

_____

I understand that Central Alabama Primary Care, LLC will carefully consider my request, but is not obligated to accept the request unless the request is to restrict the disclosure of information to a health plan for purposes of carrying out payment or other health care operations and the information pertains solely to a health care item or service for which Central Alabama Primary Care, LLC has been paid in full other than by the health plan.

The request stated herein ☐ **does or** ☐ **does not** restrict the disclosure of information to a health plan for purposes of carrying out payment or other health care operations with the information pertaining solely to a health care item or service for which Central Alabama Primary Care, LLC has been paid in full other than by the health plan

My signature below is acknowledgment that I have received a copy of Central Alabama Primary Care, LLC 's Notice of Privacy Practices and that I agree to the conditions stated in the Notice of Privacy Practices and contained in this form.

_____ _____

Printed Name of Patient Date

_____

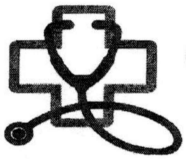
Signature of Patient

_____

Printed Name of Parent/Patient's Representative (If Applicable)

_____

Signature of Parent/Patient's Representative (If Applicable)



Central Alabama
PRIMARY CARE

Peter Krothapalli D.O.
4163 Lomac St,
Montgomery, AL 36106

Patient Name: _____ DOB: _____

1. I authorize Central Alabama Primary Care to Request, Use or Disclose the above named individual's health information as described below.

2. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

_____

_____

_____

Specified Dates and Providers to be Included:
From (date) _____ to (date) _____
From (date) _____ to (date) _____
From (doctors' names) _____

Other: _____

3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

4. This information may be ☐ **Requested From** ☐ **Disclosed To and Used by** the following individual or organization:
Name: _____

Address: _____

For the purpose: _____

☐ At the request of the individual Phone number _____ Fax Number _____

5. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Privacy/Security Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition _____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CRF 164.524 of the Federal Register Rules and Regulations. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure or my health information, I can contact Peter Krothapalli D.O., Privacy Officer.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If signed by Legal Representative, Relationship to Patient Signature of Witness

STAFF MEMBER REQUESTING RECORDS: _____