PINNACLE PHYSICIAN GROUP, LLP
SUMMIT PHYSICIAN GROUP, LLP
1837 Commons North Drive, Tuscaloosa AL 35406

PATIENT FORMS

LAST NAME ____

FIRST NAME ____

MIDDLE NAME ____

DOB ____
(m/d/Y)

GENDER ◯ MALE ◯ FEMALE ◯ UNKNOWN

RACE ◯ AFRICAN AMERICAN ◯ CAUCASIAN/WHITE ◯ HISPANIC
◯ ASIAN ◯ AMERICAN INDIAN ◯ OTHER

MARITAL STATUS ◯ MARRIED ◯ SINGLE

DRIVER LICENCE STATE__________________ NUMBER ______________________

SOCIAL SECURITY NUMBER ____

PHONE NUMBER (______)____________________ ◯ HOME ◯ MOBILE ◯ WORK

EMAIL ____
(your email is needed for your patient's portal activation)

ADDRESS LINE 1 ____

ADDRESS LINE 2 ____

CITY ____

STATE ____

ZIP ____

EMERGENCY CONTACT

FULL NAME ____

RELATION TO CONTACT ____

PHONE NUMBER ____

ADDRESS LINE 1__________________________ADDRESS LINE 2______________________

CITY____________________________STATE____________ZIP________________

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PRIMARY INSURANCE POLICY

INSURANCE COMPANY ____

INSURANCE PLAN ____

POLICY NUMBER ____

INSURANCE PHONE # ____

GROUP # ____

INSURANCE ADDRESS ____

RELATION TO POLICY HOLDER____

SECONDARY INSURANCE POLICY

INSURANCE COMPANY ____

INSURANCE PLAN ____

POLICY NUMBER ____

INSURANCE PHONE # ____

GROUP # ____

INSURANCE ADDRESS ____

RELATION TO POLICY HOLDER____

PREFERRED PHARMACY

PHARMACY NAME ____

PHARMACY ADDRESS ____

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HIPAA Authorization Form

Pinnacle Physician Group, LLP (Summit Physician Group, LLP) has taken measures to protect all our patients' private medical information.

We will not release any information to anyone unless you have provided the requested information below.

These would be people other than what is covered in this form. HIPAA (Health Insurance Privacy & Accountability Act) does allow us to release information to outside entities on your behalf. Example: Another medical office when making you an appointment, your insurance company when trying to get your claims paid, your pharmacy or hospital.

Please see the receptionist with any questions prior to signing this authorization form.

I, ____, am authorizing the person/people listed below to obtain medical information about myself.

I understand that Pinnacle Physician Group is not responsible for the information provided if it is given to a person that I have listed below.

Date of Birth must be provided so that our office can verify that we are speaking to the correct person.

Name:____ Date of Birth:_____________________

Name:____ Date of Birth:_____________________

Name:____ Date of Birth:_____________________

I do not authorize Pinnacle Physician Group, LLP (Summit Physician Group, LLP) to release any of my protected medical information to anyone other than the entities that are discussed in the Notice of Privacy Practices.

Patient's Signature: __________________________________ Date:________________

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CREDIT CARD AUTORIZATION FORM

☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other

Cardholder name (as shown on the card): ____

Card Number ________________________________CVC_____________________________

Expiration Date (mm/yy) ____

Card Holder ZIP Code (from Credit Card Billing Address) _________________________________

I, ____
authorize Pinnacle/Summit Physician Group to charge my credit card above for agreed upon purchases: insurance copay if applicable/ no show fee. I understand that my information will be saved to file for future transaction on my account.

___________________________ ______________________
Customer Signature Date

*Insurance copay is a subject of insurance plane and will be processed according to your policy.

* No show fee will be applied if patient was not show for an appointment without notification. If appointment was canceled/rescheduled 6 hours prior to an appointment fee will not be applied.