Pell City Internal & Family Medicine

Date: ____________________ Age: __________ Dr: ____________________________

First: ____________________ Middle: _____________ Last: ________________________

Address: ____

City: _________________________ State: _________ Zip: ______________________

Social Security Number: ______________________ Date of Birth: _______________________

Would you like a text to remind you of your appointment? Y/N Carrier: ______________________

Home phone: ___________________________ Cell phone: _________________________

E-Mail Address: ____

Sex: M/F Marital Status: S M D W Sep Race: _____ Driver's License #: ___________________

Retired: Y/N Student: FT/PT Disabled: Y/N Employer: ______________________________

Pharmacy Name: ________________________ **Pharmacy City:** ________________________

Responsible Party: ____

Relationship: _________________________________ DOB: _________________________

Primary Insurance Company: ____

Policy Holder: ____________________________________ DOB: ___________________

Contract Number: _________________________________ Group # ___________________

Relationship to Policy Holder: ____

Secondary Insurance Company: ____

Policy Holder: ____________________________________ DOB: ___________________

Contract Number: _________________________________ Group # ___________________

Relationship to Policy Holder: ____

******************CONTINUED ON BACK********************

Pell City Internal & Family Medicine

Emergency contact: ______________________ Relationship: ____________________

Primary Phone: __________________ Secondary Phone: ________________________

Emergency Contact: ________________________ Relationship: _________________

Primary Phone: __________________ Secondary Phone: ________________________

If patient are younger than 18, who is the custodial or legal guardian?

Name: _______________________________ Phone: ________________________

Relationship: ____

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Medications List:

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Please list any/all allergies to medications: _____________________________________

Date of Last Pap smear and/or Mammogram: ____________________________________

Date of last Colonoscopy: ____

Living will and/or advanced directive? ____

MEDICAL HISTORY: BELOW PLEASE LIST YOUR CHRONIC MEDICAL CONDITIONS

1) ____

2) ____

3) ____

4) ____

5) ____

6) ____

7) ____

8) ____

9) ____

10) ____

SURGERY HISTORY: BELOW PLEASE LIST ANY AND ALL SURGERIES YOU HAVE HAD

1) ____

2) ____

3) ____

4) ____

5) ____

6) ____

7) ____

8) ____

9) ____

10) ____

Pell City Internal and Family Medicine
Dr. Rick Jotani Dr. Barry Collins
7067 Veterans Parkway Suite 130 Pell City, Alabama 35125
Office (205)884-9000 Fax (205)884-8111

HIPAA's Privacy Rule is all about the use and disclosure of PHI. Obviously, physicians, nurses, therapists, dietitians, and others use this information about patients to determine how to treat them. Independently contracted have access to confidential patient information in order to bill patients, their insurance companies, Medicare and Medicaid. Staff preforming quality improvement activities may review confidential information to make sure patients are receiving high quality care.

What is Minimum Necessary?

HIPAA requires health care employees to use or share only the "minimum necessary" information they need to do their job effectively. Covered entities must develop policies and practices to make sure the least amount health information is shared. Each employee must be identified who regularly access PHI along with the types of PHI needed and the conditions for access.
The minimum necessary requirement does not apply to treatment. Clinical staff can look at their patient's entire record and freely share information with other clinicians caring for the patients.

When is Authorization required?

The Privacy Rule requires a signed authorization from the patient to use or disclose their PHI for purposes other than treatment, payment, or healthcare operations. An authorization must be written in specific terms. It may allow use and disclosure of PHI by the covered entity seeking the authorization or by a third party. The authorization must include:

- A description of the PHI to be used/ disclosed, in clear language
- Who will use/ disclose PHI and for what purpose.
- Whether or not it will result in financial gain for the covered entity.
- The patient's right to revoke the authorization.
- An expiration date

When is the authorization not required?

PHI can be used/ disclosed without an authorization, but require patient agreement, for the following reasons:

- To maintain a facilities patient directory
- To inform family members or other identified persons involved in the patient's care or notify them on patient location, condition or death.
- To inform appropriate agencies during disaster relief efforts

Other permitted use/ disclosures that do not require patient authorization include:

- Public Health activities related to disease prevention or control.
- To report victims of abuse, neglect, or domestic violence.
- Health oversight activities such as audits, legal investigations, licensure or for certain law enforcement purposes or government functions.
- For coroners, medical examiners, funeral directors, or tissue/ organ donations
- To avert serious threat to health and safety.

What is the Notice of Privacy Practices?

Patients have the right adequate notice concerning the use/ disclosure of their PHI on the first date of service delivery or as soon as possible after an emergency. A new notice must be issued when a facility changes their privacy practices. Registration staff at Pell City Internal and Family Medicine will ask all patients at the time if registration if they would like a printed copy of our HIPAA statement.

Once a patient has received notice of his or her rights, covered entities must take an effort to get written acknowledgement of receipt of notice from the patient, or document reasons why it was not obtained. Copies must be kept of all notices and acknowledgements.

The notice also tells patients that they have the right to see their own records, obtain copies of them and request amendments to them. HIPAA calls for covered entities to designate a contact person or office for receiving complaints of privacy violations. To obtain further information on these topics, please contact our office manager.

What are the consequences for not complying?

Breaking HIPPA privacy or security rules can bring civil and/ or criminal penalties. Civil penalties are fines of up to$100 for each violation of the law per person to a limit of $25, 000 for each identical requirement. Criminal penalties can include not only legal fines, but also jail time. The penalties increase with the seriousness of the offenses. These penalties can be as high as $250,000 fine or up to 10 years in prison.

HIPAA protects our patient's fundamental rights to privacy and confidentiality. At Pell City Internal and Family Medicine, the privacy rule is everyone's business, from the practice owners to the healthcare professionals, all employees and all onsite vendors.

Upon my request I have received this HIPAA notice from the Pell City Internal and Family Medicine

______________________________ ____________________

Signature Date

Pell City Internal and Family Medicine
Dr. Rick Jotani   Dr.Barry Collins
7067 Veterans Parkway Suite130
Pell City, Alabama 35125
(205)884-9000   (205) 884-8111 Fax

Patient Name: ___________________________________

Consent to Treatment

Consent to necessary treatment, including drugs, medicine, performance of an operation, and x-rays or other studies that may be used by the attending physician, his nurse, or staff. Authorization for release of information: I authorize Pell City Internal & Family Medicine to furnish any medical information requested by insurance companies with whom I have coverage, any public agency which may be assisting in payment of my case, or my employer who is providing payment of my medical bills due to an on-the-job injury.

Assignment of the benefits: I hereby authorize payment directly to Pell City Internal & Family Medicine of benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits, but not to exceed the Pell City Internal & Family Medicine's charges for these services. I understand that I am financially responsible to Pell City Internal & Family Medicine for charges not covered by this assignment. I authorize the refund of overpaid insurance benefits where my coverage's are subject to coordination of benefits.

Guarantee of accounts: For services furnished by Pell City Internal & Family Medicine, I hereby guarantee the payment of all accounts for services rendered. For payment of said accounts for services hereby waive all claims of exemption State of Alabama law and agree to pay, if necessary, all costs of collections, including attorney's fees. If this account is assigned to any attorney for collection and/or suit, the practice shall be entitled to reasonable attorney fees and cost of collection.
I authorize the release of any information to determine liability for payment and to obtain reimbursement of any claim
We reserve the right to charge for appointments cancelled or broken without a twent-four hour advance notice.
This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an orginal.

I understand that I am financially responsible for all charges, whether or not paid by said insurance. I agree to these assignments and financial responsibilities shown on these forms.

___________________________________   ____________________
Signature (Patient or parent/legal guardian if under 19 years of age)   Date