Welcome To Pell City Internal & Family Medicine

Date: _____/_____/_____ **Chart #: _____**

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____/_____/_____

Address: _____

Street City State Zip Code

Home Phone #: ( ) _____-_____ Cell #: ( ) _____-_____ I want to receive text reminders: _____

Email: _____ (Required for Patient Portal Access)

Social Security Number: _____-_____-_____ Sex: ____ : Male ____ :Female

Race: _____ Ethnicity: _____ Primary Language: _____

Employer: _____ Work Phone: ( ) _____-_____

Marital Status: ____ :Single ____ :Divorced ____ :Widowed If married, spouse's name: _____

Spouse's Phone #: ( ) _____-_____ Spouse's Employer: _____

Do you have a Living Will? _____ :Yes _____ :No Do you have a Power Of Attorney? _____ :Yes _____ :No

If yes, who? _____ Relationship to Patient: _____

Emergency Contact: _____ Relationship to Patient: _____

Home Phone #: ( ) _____-_____ Cell #: ( ) _____-_____

INSURANCE INFORMATION

Primary Insurance

Insurance Company: _____

Subscriber Name: _____

Subscriber Date of Birth: _____/_____/_____

Policy Number/Plan ID: _____

Group Number: _____

Secondary Insurance

Insurance Company: _____

Subscriber Name: _____

Subscriber Date of Birth: _____/_____/_____

Policy Number/Plan ID: _____

Group Number: _____

FRONT & BACK

MEDICATIONS

LIST ALL MEDICATIONS YOU TAKE: INCLUDING - PILLS, INHALERS, HOME REMEDIES & OVER THE COUNTER MEDICATIONS.

YOU MAY ATTACH AN ADDITIONAL SHEET IF NECESSARY:

MEDICATION NAME:	DOSAGE (MG)	AMOUNT	HOW MANY TIMES A DAY?

ALLERGIES TO ANY MEDICATION? _____:NO _____:YES - IF YES, PLEASE LIST ALL ALLERGIES & REACTIONS BELOW:

_____

_____

_____

PHARMACY NAME: _____ LOCATION: _____ PHONE#: ( ) _____-_____

PELL CITY INTERNAL & FAMILY MEDICINE

NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGEMENT & HIPAA RELEASE

A Notice of Privacy Practices (NPP) is provided to all patients and explains:

(1) How your Protected Health Information (PHI) may be used or shared.
(2) Your rights to access or amend your PHI, request information on disclosure of your PHI, and request additional restrictions on our uses and disclosures of PHI.
(3) Your rights to complain if you believe your privacy rights have been violated.
(4) Our responsibilities for maintaining the privacy of your PHI.

Print Name of Patient/or (If Minor) Guardian: ____
Signature of Patient/ or Guardian: ____ **Date:** ______/______/__________

Patient Communication Consent:

We may need to contact YOU regarding our medical care. This is to acknowledge that you authorize Pell City Internal and Family Medicine to check all that apply:

______:Leave a detailed message on voice mail/machine.
______:Call my workplace phone number and leave a message.
______:Call my workplace phone number and speak only to me.
______:Transmit and Receive messages through Patient Portal.
______:None of the above.

I further authorize the disclosure of my PHI to the following Individuals or Family Members:

NAME: ____ **RELATIONSHIP TO PATIENT:** __________________________
PHONE #: (   ) ______________-__________________
PCIFM MAY CONTACT THE ABOVE NAME VIA: ______:CALL ______:LEAVE A VOICEMAIL ______:PATIENT PORTAL ______:OTHER
PCIFM MAY RELEASE INFORMATION REGARDING: _____:ALL _____:APPOINTMENTS _____:TEST RESULTS _____:FINANCIAL

NAME: ____ **RELATIONSHIP TO PATIENT:** __________________________
PHONE #: (   ) ______________-__________________
PCIFM MAY CONTACT THE ABOVE NAME VIA: ______:CALL ______:LEAVE A VOICEMAIL ______:PATIENT PORTAL ______:OTHER
PCIFM MAY RELEASE INFORMATION REGARDING: _____:ALL _____:APPOINTMENTS _____:TEST RESULTS _____:FINANCIAL

NAME: ____ **RELATIONSHIP TO PATIENT:** __________________________
PHONE #: (   ) ______________-__________________
PCIFM MAY CONTACT THE ABOVE NAME VIA: ______:CALL ______:LEAVE A VOICEMAIL ______:PATIENT PORTAL ______:OTHER
PCIFM MAY RELEASE INFORMATION REGARDING: _____:ALL _____:APPOINTMENTS _____:TEST RESULTS _____:FINANCIAL

NAME: ____ **RELATIONSHIP TO PATIENT:** __________________________
PHONE #: (   ) ______________-__________________
PCIFM MAY CONTACT THE ABOVE NAME VIA: ______:CALL ______:LEAVE A VOICEMAIL ______:PATIENT PORTAL ______:OTHER
PCIFM MAY RELEASE INFORMATION REGARDING: _____:ALL _____:APPOINTMENTS _____:TEST RESULTS _____:FINANCIAL

SIGNATURE OF PATIENT/GUARDIAN: ____ **DATE:** _______/_______/_________

FRONT & BACK

PELL CITY INTERNAL & FAMILY MEDICINE

PAPER WORK CHARGE/AUTHORIZATION & CONSENT TO TREAT/NO SHOW POLICY ACKNOWLEDGEMENT

PAPER WORK: There is a charge for filling out any forms (FMLA, VA Forms, Disability Forms & any letters) by your physician and/or staff when needed. ALL FMLA & DISABILITY FORMS ARE SENT TO A THIRD PARTY COMPANY that will contact you for payment once complete. If you have any questions regarding this policy, please reach out to your provider Monday - Thursday 8am - 4pm.

AUTHORIZATION & CONSENT TO TREAT

Assignment and Release: I hereby assign my insurance or other third party carrier benefits to be paid directly to the Physician Practice, realizing I am responsible for any resulting balance. I also authorize the Physician to release any information required to process this claim to my insurance carrier and/or to my employer or prospective employer. I acknowledge that I am financially responsible for services rendered, and failure to pay any outstanding balances may result in collection procedures being taken. Further, I agree that if this account results in a credit balance, the credit amount will be applied to any outstanding accounts of mine, or to a family member whose account I am guarantor for.

Consent for Treatment: I hereby authorize the physicians, midlevel providers, nurses, medical assistants, and other practice staff to conduct such examinations, and to administer treatment and medications as they deem necessary and advisable.

No Show Policy: I understand if I fail to come for a scheduled appointment or cancel less than 24 hours prior to the appointment, I will be considered a "no show". A no show fee of $25.00 per occurrence may be charged. Ongoing occurrences of no shows may result in dismissal from the Practice.

I understand the Financial and No Show Policy, Authorization and Consent for Treatment, and hereby agree to them:

SIGNATURE OF PATIENT OR GUARDIAN: _____ DATE: _____/_____/_____

SSN: _____-_____-_____

PELL CITY INTERNAL & FAMILY MEDICINE

PAYMENT POLICY

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. INSURANCE: We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. CO-PAYMENTS & DEDUCTIBLES: All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. NON-COVERED SERVICES: Please be aware that some - and perhaps all - of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other Insurers. You must pay for these services in full at the time of visit.

4.PROOF OF INSURANCE: All patients must complete our patient information forms before seeing the doctor, and these forms must be updated yearly. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance at every visit. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. CLAIMS SUBMISSION: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.

6. COVERAGE CHANGES: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. NON-PAYMENT: If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. MISSED APPOINTMENTS: Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____/_____/_____

Signature of Patient or Responsible Party Date