

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

PELL CITY INTERNAL & FAMILY MEDICINE
NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGEMENT

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.

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

SIGNATURE OF PATIENT/GUARDIAN: _____ **DATE:** ____/____/____

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 \$50.00 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:** ____/____/____

FRONT & BACK

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 GUARDIAN: _____ **DATE:** ____/____/____

PELL CITY INTERNAL & FAMILY MEDICINE
MEDICATION POLICY

Effective 5/1/2021 Pell City Internal & Family Medicine providers will **no longer** be prescribing Narcotics, Class C Drugs or medication for ADD/ADHD.

If you require chronic pain management, or treatment for ADD/ADHD, we will provide a referral to a provider of your choice for an evaluation and treatment.

If you are injured and require pain relief, we will prescribe the necessary medication, this will be determined on a case-by-case basis, at the providers discretion. If you have any questions about this policy, please contact us at 205-884-9000 Monday - Friday, 8am - 4pm and we will be happy to discuss this with you.

Thank you,
Management

SIGNATURE OF PATIENT OR GUARDIAN:	DATE:
	/ /
PATIENT PRINTED NAME:	GUARDIAN PRINTED NAME:

PELL CITY INTERNAL & FAMILY MEDICINE

PATIENT AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize the disclosure of my individually identifiable health information as described below, I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the release information may no longer be protected by federal privacy regulations.

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

Persons/Organizations providing the information:

Sending or Receiving: _____

Pell City Internal & Family Medicine

CIRCLE YOUR PROVIDER:

Dr. Rick Jotani / Dr. Barry Collins / Dr. Ilinca Prisacaru / Dr. Jeffrey Jackson

41 Eminence Way, Suite A

Pell City, Alabama 35128

Phone: (205) 884-9000 Fax: (844)689-2691

Specific description of information (including patient demographics and dates of treatment/office visits).

- All medical records and office notes from the last 3 years (including HIV/AIDS, STDs, mental illness records and alcohol and/or drug abuse).
- Other: _____.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Officer at 41 Eminence Way, Suite A, Pell City, Alabama 35128. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information, or if my authorization was obtaining insurance coverage and the insurer has a legal right to contest a claim.

Pell City Internal & Family Medicine will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

I understand I have the right to:

- Inspect or copy the health information to be used or disclosed as permitted under the law.
- Refuse to sign the authorization.

The use or disclosure requested under this authorization may result in financial gain to my physician from a third party.

This authorization will expire on ____/____/____. After this date Pell City Internal & Family Medicine can no longer disclose the patient's protected health information without first obtaining a new authorization form.

I fully understand and accept the terms of this authorization.

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

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#: () _____ - _____

FRONT & BACK

PHYSICIAN(S) INFORMATION

Primary Care Physician: _____ Phone #: () _____ - _____

Referring Physician: _____ Phone #: () _____ - _____

Other Physicians involved in your care: _____

PATIENT MEDICAL HISTORY

DO YOU HAVE ANY HISTORY OF THE FOLLOWING? PLEASE CHECK ALL THAT APPLY.

_____ :ADHD	_____ :COPD/Emphysema	_____ :High Cholesterol
_____ :Alcoholism	_____ :Diabetes __ :Type 1 __ :Type 2	_____ :HIV Positive (AIDS)
_____ :Allergies, Seasonal	_____ :Depression	_____ :Irritable Bowel (IBS)
_____ :Angina/Chest Pain	_____ : Diverticulitis	_____ :Kidney Disease
_____ :Anemia	_____ :DVT (Blood Clot)	_____ :Kidney Stone
_____ :Anxiety	_____ :Emphysema	_____ :Liver Disease
_____ :Arrhythmia (irregular heart beat)	_____ :Epilepsy	_____ :Lupus
_____ :Arthritis	_____ :Fractures	_____ :Migraines
_____ :Asthma	_____ :Gallstones	_____ :Neuropathy
_____ :Bipolar Disorder	_____ :GERD (Acid Reflux)	_____ :Osteopenia/porosis
_____ :Bladder Problems/Incontinence	_____ :Glaucoma	_____ :Parkinson's Disease
_____ :Bleeding Problems	_____ :Headaches	_____ :PVD
_____ :Cancer	_____ :Heart Disease	_____ :Peptic Ulcer
_____ :Chronic Bronchitis	_____ :Heart Attack (MI)	_____ :Positive TB Test
_____ :Cirrhosis	_____ :Heavy Murmur	_____ :Psoriasis
_____ :Clotting Disorder	_____ :Hepatitis	_____ :Pulmonary Embolism

PATIENT MEDICAL HISTORY (continued)

DO YOU HAVE ANY HISTORY OF THE FOLLOWING? PLEASE CHECK ALL THAT APPLY.

_____ :Rheumatic Fever	_____ :Rheumatoid Arthritis	_____ :Seizure Disorder
_____ :Sleep Apnea	_____ :Stroke	_____ :Thrombophlebitis
_____ :Thyroid Disease	_____ :Tuberculosis	_____ :Ulcerative Colitis
_____ :MRSA	_____ :Toxic Shock Syndrome	_____ :Endometriosis
_____ :Fibromyalgia	_____ :Celiac Disease	_____ :OTHER _____

FAMILY MEDICAL HISTORY

HAS ANYONE IN YOUR FAMILY HAD ANY OF THE FOLLOWING? PLEASE CHECK ALL THAT APPLY.

_____ :Anemia	Relationship to you: _____	Living or Deceased? _____
_____ :Bleeding Disorders	Relationship to you: _____	Living or Deceased? _____
_____ :Blood Clots	Relationship to you: _____	Living or Deceased? _____
_____ :Cancer/Polyps	Relationship to you: _____	Living or Deceased? _____
_____ :Diabetes	Relationship to you: _____	Living or Deceased? _____
_____ :Allergies	Relationship to you: _____	Living or Deceased? _____
_____ :Heart Attack	Relationship to you: _____	Living or Deceased? _____
_____ :Heart Disease	Relationship to you: _____	Living or Deceased? _____
_____ :High Blood Pressure	Relationship to you: _____	Living or Deceased? _____
_____ :High Cholesterol	Relationship to you: _____	Living or Deceased? _____
_____ :Hepatitis	Relationship to you: _____	Living or Deceased? _____
_____ :Kidney Disease	Relationship to you: _____	Living or Deceased? _____
_____ :Lung Disease	Relationship to you: _____	Living or Deceased? _____
_____ :Migraine	Relationship to you: _____	Living or Deceased? _____
_____ :Stroke	Relationship to you: _____	Living or Deceased? _____

FRONT & BACK

OPERATIONS AND/OR HOSPITALIZATIONS

LIST ANY OPERATIONS, PROCEDURES OR HOSPITALIZATIONS BELOW w/APPROXIMATE DATE

PROCEDURE/HOSPITAL STAY:	WHAT LOCATION:	DATE:

REVIEW OF SYMPTOMS

CHECK ANY SYMPTOMS THAT YOU MAY BE HAVING (CURRENTLY OR RECENTLY):

RESPIRATORY:

_____ :shortness of breath
_____ :congestion
_____ :cough
_____ :shortness of breath caused by exertion

CARDIOLOGY:

_____ :chest pain
_____ :palpitations
_____ :varicose veins
_____ :sweating
_____ :swelling
_____ :fluttering sensation

GENERAL:

_____ :weight gain
_____ :weight loss
_____ :loss of appetite
_____ :fevers
_____ :weakness
_____ :fatigue

ENDOCRINE:

_____ :cold intolerance
_____ :heat intolerance
_____ :increased thirst

FEMALE REPRODUCTIVE:

_____ :pregnant
_____ :menopause

MALE REPRODUCTIVE:

_____ :difficulty with erection

OPHTHALMOLOGY:

_____ :diminished vision
_____ :blurring of vision
_____ :loss of vision
_____ :vision floaters

REVIEW OF SYMPTOMS (continued)

CHECK ANY SYMPTOMS THAT YOU MAY BE HAVING (CURRENTLY OR RECENTLY):

GASTROENTEROLOGY:

_____ :nausea
_____ :heartburn
_____ :constipation
_____ :diarrhea
_____ :difficulty swallowing
_____ :indigestion
_____ :abdominal pain

HEMATOLOGY:

_____ :easy bruising
_____ :bleeding

PSYCHOLOGY:

_____ :depression
_____ :anxiety
_____ :high stress

NEUROLOGY:

_____ :headaches
_____ :tingling
_____ :fainting
_____ :dizziness
_____ :difficulty walking
_____ :memory loss

UROLOGY:

_____ :frequent urination
_____ :difficulty or painful urination
_____ :blood in urine

DERMATOLOGY:

_____ :rash
_____ :flushing
_____ :wound
_____ :dry skin
_____ :cystic acne

MUSCULOSKELETAL:

_____ :joint pain
_____ :leg cramps
_____ :back pain
_____ :arm pain
_____ :neck pain
_____ :leg pain
_____ :muscle pain

HABITS

PLEASE CHECK ALL THAT APPLY:

_____ :Smoking	_____ :Packs Daily?	_____ :Coffee	_____ :Cups Daily	Do you routinely
	_____ :How Long?	Other Caffeine? _____		exercise? __:Yes __:No
_____ :Vaping	_____ :Puffs Daily?	_____ :Alcohol	_____ :Type	What do you do for
	_____ :How Long?	_____ :Frequency	_____ :Amount	exercise? _____
_____ :Dipping	_____ :Dips Daily?	_____ :Diet	_____ :Salt Intake	Have you ever used
	_____ :How Long?	_____ :Fat Intake _____		illegal drugs? __:Yes __:No
				If yes, what type of
				drugs? _____

Are you interested in stopping any of the above habits? _____ :Yes _____ :No

If you have already quit, when did you quit? _____

FRONT & BACK

WELLNESS SCREENINGS/VACCINATIONS

PLEASE CHECK ANY SCREENINGS, DIAGNOSTIC TESTING OR VACCINATIONS YOU HAVE HAD WITH THE DATE & LOCATION OF WHERE THESE WERE ADMINISTERED.

FEMALES ONLY:

MAMMOGRAM: _____ WHEN? _____ WHERE? _____

DEXA (BONE DENSITY): _____ WHEN? _____ WHERE? _____

PAP SMEAR: : _____ WHEN? _____ WHERE? _____

BIRTH CONTROL METHOD? _____:NONE NEEDED _____:OTHER - PLEASE SPECIFY: _____

LAST MENSTRUAL CYCLE: _____

MALES ONLY:

PSA/PROSTATE EXAM: _____ WHEN? _____ WHERE? _____

ABDOMINAL AORTA ULTRASOUND: _____ WHEN? _____ WHERE? _____

MALES & FEMALES:

COLONOSCOPY/SIGMOIDOSCOPY: _____ WHEN? _____ WHERE? _____

INFLUENZA VACCINE (FLU SHOT): _____ WHEN? _____ WHERE? _____

PNEUMONIA VACCINE: _____ WHEN? _____ WHERE? _____

TD/TDAP VACCINE (TETANUS): _____ WHEN? _____ WHERE? _____

COVID VACCINE: _____ WHEN? _____ WHERE? _____

OTHER VACCINES: _____ PLEASE LIST: _____

_____ WHEN? _____ WHERE? _____