INTERNAL MEDICINE
AND PEDIATRICS
OF CULLMAN

WELCOME

to our practice. We are excited you have chosen us for you and your family's healthcare.

- ☐ Michael J. Lunsford, M.D.
- ☐ Brian C. Corliss, M.D.
- ☐ Marybeth Lee, C.R.N.P.
- ☐ Tara M. Fales, M.D.

Patient:

Full Name _____ Single Married Widowed Divorced

Sex: M / F Age _____ Birthday ____/___/____ S.S. Number _____ Race _____

Address _____

City _____ State _____ Zip Code _____

Primary Number (____) _____ Secondary Number (____) _____

Responsible Party / Parents (If applicable)

	Mother (stepmother/guardian)	Father (stepfather/guardian)
Name		
Birthday		
SS #		
Employer		
Work Phone		

Spouse Name _____

Spouse Birthday _____

Spouse SS # _____

Insurance Information:

PRIMARY INSURANCE COMPANY _____ CONTRACT # _____

INSURED'S NAME AND DOB _____ COPAY _____

SECONDARY INSURANCE COMPANY _____ CONTRACT # _____

INSURED'S NAME _____ COPAY _____

Email address: _____

Emergency contact: _____ **Phone:** _____

I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I realize that failure to keep this account current may result in you being unable to provide additional services except for emergencies or where there is prepayment for additional services. In the case of default on payment of this account. I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this account or any future outstanding account balances.

I also understand that unless a cancellation of an appointment is made 24 hours in advance of said appointment, I will be subject to charge for the time reserved.

_____ _____

Signed Patient / Responsible Party Date

Internal Medicine and Pediatrics of Cullman
Privacy Notice

Internal Medicine and Pediatrics of Cullman is dedicated to protecting your privacy. It is your right to receive quality care without the concern that your personal health information will be shared or disclosed to others. Your medical information is protected by law and will only be used in treatment, payment, and healthcare operation scenarios. Employees of *Internal Medicine and Pediatrics of Cullman* and affiliated business associates have signed confidentiality statements and contractual agreements and agree to follow the policies and procedures of our practice in protecting your privacy. While disclosures of personal health information to doctors, nurses, and specialists is often necessary for treatment, your medical information will not be sold to any outside agency or pharmaceutical company nor will it be released for any reason, other than treatment, payment, health care operations, or when required by state or federal laws, without your written authorization. You have the right to access and request changes to your medical record, find out what disclosures have been made, and request restrictions on uses and disclosures of your health information. Your signature below indicates that you understand that it is customary for *Internal Medicine and Pediatrics of Cullman* to leave messages on your answering machine. If at any time you have any questions or concerns, you may contact our Compliance Officer at **256-739-1575**. This privacy notice is subject to change. It will require written withdrawal from the patient.

It is presumed that any acquisition, access, use or disclosure of personal health information not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

I have been offered a copy of the Privacy Notice.

Signed _____ Date _____

Patient's name _____ DOB _____

Please list any authorized person(s) who can accompany the patient, call with questions or pick anything up.

_____

_____

*If no one is listed above, we can only talk to you regarding your account.

Witness: _____ Date _____

Patient Name: _____

Please answer the following questions related to the symptoms the patient is currently experiencing.

	Yes	No	N/A
Abdominal pain	❑	❑	❑
Loss of interest/pleasure in activities	❑	❑	❑
Anxious feelings	❑	❑	❑
Back pain	❑	❑	❑
Bedwetting	❑	❑	❑
Bleeding tendencies	❑	❑	❑
Blood in stool	❑	❑	❑
Easy bruising	❑	❑	❑
Chest pain	❑	❑	❑
Chills	❑	❑	❑
Cold intolerance	❑	❑	❑
Concerning skin lesions	❑	❑	❑
Constipation	❑	❑	❑
Daytime sleepiness	❑	❑	❑
Decreased appetite	❑	❑	❑
Decreased energy	❑	❑	❑
Difficulty taking liquids	❑	❑	❑
Decreased sexual function	❑	❑	❑
Decreased sleep	❑	❑	❑
Depression	❑	❑	❑
Diaper rash	❑	❑	❑
Cold sweats	❑	❑	❑
Diarrhea	❑	❑	❑
Difficulty with swallowing	❑	❑	❑
Double vision	❑	❑	❑
Dizziness	❑	❑	❑
Dry eyes	❑	❑	❑
Pain on urination	❑	❑	❑
Swelling	❑	❑	❑
Eye redness or drainage	❑	❑	❑
Eye crusting	❑	❑	❑
Fever	❑	❑	❑
Localized areas of weakness	❑	❑	❑
Forgetfulness	❑	❑	❑
Hair loss	❑	❑	❑
Headaches	❑	❑	❑
Hearing loss	❑	❑	❑
Heartburn	❑	❑	❑
Heat intolerance	❑	❑	❑
Problems with male sexual function	❑	❑	❑
Joint pains	❑	❑	❑
Lymph node swelling	❑	❑	❑
Dark stools	❑	❑	❑
Muscle pain/aches	❑	❑	❑
Nasal congestion	❑	❑	❑
Nausea	❑	❑	❑

Please explain any yes answers:

_____

_____

_____

_____

	Yes	No	N/A
Neck pain	❑	❑	❑
Neck stiffness	❑	❑	❑
Numbness	❑	❑	❑
Difficulty breathing when lying down	❑	❑	❑
Dizziness or lightheadedness on standing	❑	❑	❑
Ear pain	❑	❑	❑
Ear drainage	❑	❑	❑
Heart fluttering/racing	❑	❑	❑
Chest pain with a deep breath	❑	❑	❑
Having to get up to breathe at night	❑	❑	❑
Frequent urination	❑	❑	❑
Itching	❑	❑	❑
Rash	❑	❑	❑
Runny nose	❑	❑	❑
Shortness of breath	❑	❑	❑
Shortness of breath with exercise	❑	❑	❑
Sleep problems	❑	❑	❑
Slow urine stream	❑	❑	❑
Snoring	❑	❑	❑
Sore throat	❑	❑	❑
Spitting up	❑	❑	❑
Morning stiffness	❑	❑	❑
Thrush	❑	❑	❑
Mouth ulcers	❑	❑	❑
Difficulty urinating	❑	❑	❑
Trouble controlling bladder	❑	❑	❑
Vomiting	❑	❑	❑
Weight gain	❑	❑	❑
Weight loss, unintentional	❑	❑	❑
Wheezing	❑	❑	❑

Family History

Breast cancer	❑	❑	❑
Colon cancer	❑	❑	❑
Prostate cancer	❑	❑	❑
Congestive heart failure	❑	❑	❑
Coronary artery disease	❑	❑	❑
Diabetes	❑	❑	❑
High cholesterol	❑	❑	❑
High blood pressure	❑	❑	❑
Heart attacks	❑	❑	❑
Heart attack at age under 50	❑	❑	❑
Stroke	❑	❑	❑

Please explain any yes answers:

Internal Medicine and Pediatrics of Cullman, P.C.

1948 Alabama Hwy. 157, Suite 360
Cullman, AL 35058
256-739-1575

CONSENT FORM FOR ePRESCRIBE PROGRAM

ePrescribe Program

ePrescribing is a way for doctors to send electronically an accurate, error free, and understandable prescription from the doctor's office to the pharmacy. The ePrescribe Program also includes:

- **Fill status notification** - Allows the health care provider to receive an electronic notice from the pharmacy telling them if your prescription has been picked up, not picked up, or partially filled.
- **Medication history transaction** - Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy.

The medication history information would include medications prescribed by your health care provider at Internal Medicine and Pediatrics of Cullman, P.C. as well as other health care providers involved in your care and may include sensitive information including, but not limited to, medications related to mental health conditions, venereal diseases/sexually transmitted diseases, abortion(s), rape/sexual assault, substance (drug and alcohol) abuse, genetic diseases, and HIV/AIDS. ***As part of this Consent Form, you specifically consent to the release of this and other sensitive health information.***

Consent

By signing this consent form you are agreeing that your provider at Internal Medicine and Pediatrics of Cullman, P.C. may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or to deny consent may not be the basis for denial of health services. You also have a right to receive a copy of this form after you have signed it.

This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing, but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

Understanding all of the above, I hereby provide informed consent to Internal Medicine and Pediatrics of Cullman, P.C. to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____ Print Patient Name _____ Patient DOB

_____ Signature of Patient or Guardian _____ Today's Date

_____ Relationship to Patient