

INTERNAL MEDICINE  
AND PEDIATRICS  
OF CULLMAN

# WELCOME

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

**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)**

	<u>Mother (stepmother/guardian)</u>	<u>Father (stepfather/guardian)</u>
<u>Name</u>	_____	_____
<u>Birthday</u>	_____	_____
<u>SS #</u>	_____	_____
<u>Employer</u>	_____	_____
<u>Work Phone</u>	_____	_____

<u>Spouse Name</u>	_____
<u>Spouse Birthday</u>	_____
<u>Spouse SS #</u>	_____

**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 & PEDIATRICS OF CULLMAN, P.C.

## CONSENT FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PAYMENT, TREATMENT AND HEALTH CARE OPERATIONS

By signing below, you hereby consent for this Practice to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purposes of treatment, payment and health care operations. You may refuse to sign this consent form.

You should read the Notice of Privacy Practices for PHI attached to this form before signing the Consent. The terms of the Notice may change from time to time, and you may always get a revised copy of it by asking the Privacy Officer for this Practice.

You have the right to request that the Practice restrict how PHI is used or disclosed to carry out treatment, payment, or health care operations. The Practice is not required to agree to requested restrictions, however; if the Practice agrees to your requested restrictions, the restriction is binding on it.

Information about you is protected under federal law, and you have the right to revoke this Consent, unless we have taken action in reliance on your authorization (as determined by our Privacy Officer). By signing below, you recognize that the protected health information used or disclosed pursuant to this Consent may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

You may communicate with the following individuals regarding my condition or course of treatment: \_\_\_\_\_

You may communicate confidential information to me, including invoices for services, to the following address and/or phone numbers: \_\_\_\_\_

\_\_\_\_\_  
Individual Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date of Birth

# Internal Medicine and Pediatrics of Cullman, P.C.

1890 AL Hwy 157, Suite 430

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

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. We must obtain your authorization before the use and disclosure of any psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosure that constitute a sale of PHI. Uses and disclosures not described in this Notice of Privacy Practices will be made only with authorization from the individual.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the Practice may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the Practice or the hospital. For example, we may disclose medical information about you to people outside the Practice who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.

For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the Practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other Practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts. WHO WILL FOLLOW THIS NOTICE. This notice describes our Practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other Practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the Practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the Practice, whether made by Practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; and others; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the Practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.

Right to Request Removal from Fundraising Communications. You have the right to opt out of receiving fundraising communications from the Practice.

Right to Restrict Disclosures to Health Plan. You have the right to restrict disclosures of PHI to a health plan if the disclosure is for payment of health care operations and pertains to a health care item or service for which the individual has paid out of pocket in full.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the Practice's waiting room. COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact \_\_\_\_\_, Privacy Officer, [Phone Number], [Practice Address]. All complaints must be submitted in writing. You will not be penalized for filing a complaint. OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.

[Practice Administrators: If you choose to have patients or their personal representatives sign this Notice, please use the lines below. Otherwise, the lines below should be removed.]

I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights.

\_\_\_\_\_  
Patient or Patient's Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's name

\_\_\_\_\_  
D.O.B.

Patient Name: \_\_\_\_\_

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

	Yes	No		Yes	No
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	Neck pain	<input type="checkbox"/>	<input type="checkbox"/>
Loss of interest/pleasure in activities	<input type="checkbox"/>	<input type="checkbox"/>	Neck stiffness	<input type="checkbox"/>	<input type="checkbox"/>
Anxious feelings	<input type="checkbox"/>	<input type="checkbox"/>	Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Back pain	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty breathing when lying down	<input type="checkbox"/>	<input type="checkbox"/>
Bedwetting	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness or lightheadedness on standing	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding tendencies	<input type="checkbox"/>	<input type="checkbox"/>	Ear pain	<input type="checkbox"/>	<input type="checkbox"/>
Blood in stool	<input type="checkbox"/>	<input type="checkbox"/>	Ear drainage	<input type="checkbox"/>	<input type="checkbox"/>
Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>	Heart fluttering/racing	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain with a deep breath	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	Having to get up to breathe at night	<input type="checkbox"/>	<input type="checkbox"/>
Cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>
Concerning skin lesions	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Rash	<input type="checkbox"/>	<input type="checkbox"/>
Daytime sleepiness	<input type="checkbox"/>	<input type="checkbox"/>	Runny nose	<input type="checkbox"/>	<input type="checkbox"/>
Decreased appetite	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Decreased energy	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath with exercise	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty taking liquids	<input type="checkbox"/>	<input type="checkbox"/>	Sleep problems	<input type="checkbox"/>	<input type="checkbox"/>
Decreased sexual function	<input type="checkbox"/>	<input type="checkbox"/>	Slow urine stream	<input type="checkbox"/>	<input type="checkbox"/>
Decreased sleep	<input type="checkbox"/>	<input type="checkbox"/>	Snoring	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Sore throat	<input type="checkbox"/>	<input type="checkbox"/>
Diaper rash	<input type="checkbox"/>	<input type="checkbox"/>	Spitting up	<input type="checkbox"/>	<input type="checkbox"/>
Cold sweats	<input type="checkbox"/>	<input type="checkbox"/>	Morning stiffness	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Thrush	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty with swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Mouth ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty urinating	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Trouble controlling bladder	<input type="checkbox"/>	<input type="checkbox"/>
Dry eyes	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Pain on urination	<input type="checkbox"/>	<input type="checkbox"/>	Weight gain	<input type="checkbox"/>	<input type="checkbox"/>
Swelling	<input type="checkbox"/>	<input type="checkbox"/>	Weight loss, unintentional	<input type="checkbox"/>	<input type="checkbox"/>
Eye redness or drainage	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Eye crusting	<input type="checkbox"/>	<input type="checkbox"/>			
Fever	<input type="checkbox"/>	<input type="checkbox"/>			
Localized areas of weakness	<input type="checkbox"/>	<input type="checkbox"/>			
Forgetfulness	<input type="checkbox"/>	<input type="checkbox"/>			
Hair loss	<input type="checkbox"/>	<input type="checkbox"/>			
Headaches	<input type="checkbox"/>	<input type="checkbox"/>			
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>			
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>			
Heat intolerance	<input type="checkbox"/>	<input type="checkbox"/>			
Problems with male sexual function	<input type="checkbox"/>	<input type="checkbox"/>			
Joint pains	<input type="checkbox"/>	<input type="checkbox"/>			
Lymph node swelling	<input type="checkbox"/>	<input type="checkbox"/>			
Dark stools	<input type="checkbox"/>	<input type="checkbox"/>			
Muscle pain/aches	<input type="checkbox"/>	<input type="checkbox"/>			
Nasal congestion	<input type="checkbox"/>	<input type="checkbox"/>			
Nausea	<input type="checkbox"/>	<input type="checkbox"/>			

  

Family History		
Breast cancer	<input type="checkbox"/>	<input type="checkbox"/>
Colon cancer	<input type="checkbox"/>	<input type="checkbox"/>
Prostate cancer	<input type="checkbox"/>	<input type="checkbox"/>
Congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>
Coronary artery disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Heart attacks	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack at age under 50	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>

Please explain any yes answers:

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