PATIENT INFORMATION

Patient Name: Last__________________________ First_________________________ Middle____________

Address: ______________________________City____________________ State_______ Zip Code________

Home: _________________________ Work: _________________________ Cell: ______________________

Email: ________________________________ Marital Status: __________ Birthdate: _____/_____/_____

Social Security #: _________________________ Race: _________________ Sex: ______________________

Employer: ____ Employer Ph#: ______________________

Spouse's Name (if married): _____________________________ Spouse's Employer: __________________

Relatives/friends who are patients here?__________________ Who referred you to us: _______________

Pharmacy Name: ___________________________________ Pharmacy Phone #: ______________________

Emergency Contact and Number: _____________________________________ Relationship: ____________

INSURANCE INFORMATION

Insurance Company (Primary): ____

Policy Holder's Name: ____ Birthdate _____/_____/_____

Contract Number: _______________________________________ Group Number: ____________________

Insurance Company (Secondary): ____

Policy Holder's Name: ____ Birthdate _____/_____/_____

Contract Number: _______________________________________ Group Number: ____________________

CONSENT FOR TREATMENT

I consent to necessary treatment, including drugs, medication, performance and operation of X-ray, or other studies that may be used by the attending physician, nurse, or staff.

CONSENT FOR ELECTRONIC COMMUNICATION

I consent to the use of electronic communication, including text messaging, email and Videoconferencing for Telehealth.

CONSENT FOR E-PRESCRIBING

I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

NON-COVERED SERVICE AGREEMENT

As your physician, I want to provide you with the best care possible. There may be certain routine services performed during your visit(s), such as dexa scans, pap smears, biopsies, ultrasounds/X-rays, lab work, injections, and/or other testing that I feel necessary for the maintenance of your good health that may not be covered by your insurance contract. By signing below, you agree that you will be responsible for costs not covered by your insurance.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I received a copy of the Notice of Privacy Practices.

SIGNATURE: ____ **DATE:** ______________

Patient Printed Name: ________________________________ Date of Birth: ____________

Patient Address: ____

City: ____________________ State: ____________ Zip Code: ____________

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that protects your Personal Health Information (PHI).

While you are under our care, you may want all or part of your medical information to be shared with a spouse, family member, relative or other caregiver.

- For instance, you may want to allow your spouse to call our offices and receive results from a lab or diagnostic test.

Because this information is considered Personal Health Information as part of the Health Insurance Portability and Accountability Act (HIPAA) – a federal law that protects your Personal Health Information (PHI) – we are obligated by Federal Law to have your permission BEFORE we allow a disclosure of this type.

Therefore, if you would like to allow us to provide Personal Health Information to other persons besides yourself, please list those individuals below and sign in the space provided.

Unless you specifically list otherwise, we will assume we have your permission to provide all types of information noted.

Name	Relationship	Phone number	Type of information (must be checked)		
			Clinical	Billing	Appointment

If you want to exclude any specific information from being released, please note below.

____

____

If there are any changes, please notify us.

Patient/Parent/Guardian/Legal Representative Signature	Date/Time
Relationship to Patient	

PPS Disclosing Protected Health Information to Family/Friends

Patient Label

Patient Name: ______________________________ **DOB** ________________ **Today's Date:**___________________

Pharmacy:____ **Pharmacy Phone:** _______________________________

Medications you are currently taking:

Medication	Dose	Frequency

Medication allergies: ____

Last Colonoscopy: __________________ Last DEXA/Bone Density Scan: _________________

Last Mammogram: _________________ Last Pap Smear: ________________________________

Last Vaccinations:

Influenza______________ Tetanus_______________ Pneumonia________________ Shingles___________________

Covid19 _____________________________________, Manufacturer Name____________________________________

Signature:____ **Date:** ____________________

PATIENT HISTORY INTAKE FORM

Patient Name: ____________________________ DOB: ___________ Age: _____ Today's Date: _______________

PAST MEDICAL HISTORY:

Please circle any of the following you have been diagnosed with

High blood pressure	ADD/ADHD	Seizure disorder	Cancer
Diabetes	Irritable Bowl Syndrome	Sleep Apnea	Anemia
Reflux/GERD	Asthma	Osteoporosis	Afib/Arrhythmia
Heart disease	Blood clots in legs/lungs	Stroke	COPD
Heart attack	Thyroid disease	Migraines	Anxiety/Depression
Mitral valve prolapse	Lupus	Elevated cholesterol/lipids	Arthritis

Other: ____

History of Injuries: ____

PAST SURGICAL HISTORY:

Please circle if you have ever had the following and include date

Gallbladder: ______________	Bladder Surgery: ____________	Hysterectomy: ________________
Appendectomy: __________	Orthopedic: _________________	C-Section: ____________________
Thyroid: _________________	Kidney Stones: ______________	Ovarian: ______________________
Colonoscopy: _____________	Coronary Cath: ______________	Mastectomy: __________________
Hernia: __________________	Prostate: ____________________	Endoscopy: ____________________
Tonsillectomy: ___________	Breast biopsy: _______________	Skin Cancer: ___________________

Other: ____

FAMILY MEDICAL HISTORY:

Has any immediate family member had any of the following? Which family member? M, F, B, S or GP

Anemia _______________________________	Blood clots in legs/lungs ________________
Cancer ________________________________	Thyroid disease ___________________________
Dementia ______________________________	Heart Disease _____________________________
Arthritis ______________________________	Diabetes __________________________________
Stroke ________________________________	High Cholesterol __________________________
High blood pressure ___________________	Depression ________________________________

Other: ____

SOCIAL HISTORY:

Marital Status: S M W D Sexual Orientation: Heterosexual Homosexual Bisexual

How many children?:___________Occupation: _____________________Do you exercise?:_______________

Tobacco use?: ____________ How much per day?: __________If not now, when did you quit?: ___________

Alcohol use: Beer Wine Liquor How much per week?: _______If not now, when did you quit?: ___________

Illegal Drugs: Marijuana Heroin Cocaine Other?: ___________If not now, when did you quit?:_____________

Signature: ____ **Date:** ____________________________

NARCOTIC NOTICE TO PATIENTS

Grandview Medical Group will NOT provide prescriptions for hypnotic sedatives, stimulants and other controlled drugs to new patients, unless it is deemed necessary by the physician for situations that include severe illness or injury that has occurred within 24-48 hours for the date of the office visit. New patients are given this notice at the time of the appointment and patients should understand that if long term pain management is needed as part of their total medical care, an appointment with a chronic pain management facility is recommended and should be scheduled by the patient. Records from the treating physician will be requested as we may not be able to accept any records brought in by the patient. New patients should be aware that all patients, new and established, are subject to query at the State of Alabama Department of Public Health Prescription Drug Monitoring Website for verification of narcotic/analgesic use and/or random drug screening.

If a new patient should request a narcotic/analgesic prescription for a chronic/long term condition after they have read, understood and agreed by signature to this policy, the request will be denied and possible dismissal of medical services will be enacted at the physician's discretion. Also, if at any time, Grandview receives a report that a patient, new or established, is receiving inappropriate or duplicate prescriptions of narcotics/analgesics from other physicians, the patient will be immediately dismissed from receiving medical services from Grandview Medical Group indefinitely.

I have read and understood the Narcotics Policy for Grandview Medical Group and agree to follow this policy as a patient of Grandview Medical Group.

Signature:____ **Date:** ______________________

Cancellation Policy/No Show Policy

We strive to promote the best quality healthcare for our patients. One of the ways we meet your healthcare needs is to provide appointments with our physicians in a timely manner, many times within the same day. In order to provide these appointments, we have the following No Show/Cancellation policy.

1. *Cancellation/ No Show Policy for Doctor Appointment*

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an Appointment, you may be preventing another patient from receiving much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment schedule.

If an appointment is not cancelled at least 24 hours in advance you may be subject to fees which are not covered by your insurance company. More than 3 no shows within a six month period will result in dismissal from the practice. Violators will receive a letter after the second no show as a reminder of the policy.

2. *Scheduled Appointments*

We understand that delays can happen however we must try to keep the other patients and our physicians on time.
If a patient is 10 minutes past their scheduled time, it may be necessary to reschedule your appointment.

3.*Cancellation/ No Show Policy for Surgery/Procedure*

Due to the large block of time needed for surgery and/or procedures, last minute cancellations can cause
problems and added expenses for the office.

If your are scheduled for a surgery/procedure is not cancelled at least 10 days in advance you may be subject to fees which are not covered by your insurance company.

4. *Account balances*

We will require that patients with self-pay balances do pay their account balances to zero (0) prior to receiving further services by our practice.
Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns.
Patients with balances over $100 must make payment arrangements prior to future appointments being made.

__________________________ ___________________________ _____/_____/_____

Print Name Patient Signature Patient/Guardian Date

PATIENT HISTORY INTAKE FORM

Patient Name: ___________________________________DOB/Age:_________________ Today's Date: ___________

Please circle any recent symptoms that you may be experiencing or may have experienced in the past year.

CONST
- Weight gain/loss
- Fever
- Fatigue
- Night Sweats
- Hot/Cold Intolerance
- Frequent Falls

EYES
- Dry eyes
- Vision Changes

ENT
- Mouth Sores
- Sore throat
- Ringing in ears

RESP
- Persistent cough
- Wheezing

CV
- Shortness of breath
- Difficulty breathing
- Chest pain
- Rapid heartbeat
- Swollen hands and feet

GI
- Persistent diarrhea
- Bloody stools
- Nausea and vomiting
- Constipation
- Abdominal Pain

ALL
- Hives, blisters
- Red itchy eyes

KIDNEY
- Pain or burning w/urination
- Strain to urinate
- Bladder infection

PSYCH
- Depression
- Mood swings
- Anxiety

MSK
- Joint or muscle pain
- Muscle weakness

LYMPH
- Swollen lymph nodes

NEURO
- Seizures
- Frequent headaches
- Dizziness
- Numbness

HEME
- Easy Bleeding
- Easy Bruising

ENDO
- Night Sweats
- Hot/cold Intolerance

SKIN
- Rash
- Easy Bleeding
- Easy Bruising

OTHER ________________________________

Signature: _____________________________________

Date: ____

1. **ASSIGNMENT OF INSURANCE BENEFITS/PROMISE TO PAY:**
   I hereby assign and authorize payment directly to the Physician Clinic all insurance benefits, sick benefits, injury benefits due because of responsibility of a third-party, or proceeds of all claims resulting from the responsibility of a third party, payable by any party, organization, et cetera, to or for the patient unless the account for this Physician Clinic, outpatient visit or series of outpatient visits is paid in full upon completion of the medical services. If eligible for Medicare, I request Medicare services and benefits. I further agree that this assignment will not be withdrawn or voided at any time until the account is paid in full. I understand I am responsible to pay any account balance for applicable coinsurance and deductible amounts and for those amounts not otherwise covered by my insurance company in accordance with the regular rates and terms of the Facility. I understand and acknowledge that I will be responsible for any co-payment or deductible amounts associated with treatment ordered by my physician.
   I understand that I am obligated to pay the account of the Physician Clinic in accordance with the regular rates and terms of the Physician Clinic. If I fail to make payment when due and the account becomes delinquent or is turned over to a collection agency or an attorney for collection, I agree to pay all collection agency fees, court costs and attorney's fees. I also agree that any patient or guarantor overpayments on the above Physician Clinic visit may be applied directly to any delinquent account for which I or my guarantor is legally responsible at the time of the collection of the overpayment. I consent for the Physician Clinic to work with my insurance company/ companies on my behalf on authorization, appeal on my behalf any denial for reimbursement, coverage, or payment for services or care provided to me.
2. **PATIENT CONSENT FOR E-PRESCRIBING (ELECTRONIC PRESCRIBING):**
   I understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.
3. **CONSENT TO RELEASE HEALTH INFORMATION:**
   I understand this Physician Clinic uses an electronic medical record. I understand that the electronic medical record contains information about my health from my past, current and future health care providers. I agree that this health information may be released through the Physician Clinic's electronic medical record or by other means (for example, fax, telephone, email, or hand delivery): (1) to the Physician Clinic; (2) to my past, current and future health care providers and other health care organizations that provide care to me; (3) to the health insurance company named in my medical record; and (4) to any other person named in my medical record or insurance payers who pay for my treatment . These people may use my health information: (1) to treat me; (2) to get paid for my treatment (for example, billing insurance companies), and (3) to do health care operations activities (for example, managing my care, providing quality care, patient safety activities, and other activities necessary to operate the Physician Clinic). I understand that these people will have access to all my health information in the medical record, including behavioral health and substance use disorder information (for example, drug and alcohol treatment), my medical history, diagnosis, hospital records, clinic and doctor visit information, medications, allergies, lab test results, radiology reports, sexual and reproductive health information, communicable disease related information (for example, sexually transmitted diseases), and HIV/AIDS related information. I understand that I may take back this consent at any time, except if my health information has already been released for these purposes. I also understand that I may request a list of the health care organizations that have received my substance use disorder information. This consent will not expire unless I revoke.
4. **NOTICE OF PRIVACY PRACTICES:**
   Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I have received a copy of the Physician Clinic's Notice of Privacy Practices. I hereby consent to the use and disclosure of my protected health information, including information generated through use of virtual health or telemedicine services, as described in the Notice of Privacy Practices. This will include all of my protected health information generated during hospitalization and outpatient treatment at the Physician Clinic, including but not limited to treatment for mental health, drug and alcohol abuse, communicable diseases such as HIV/AIDS, developmental disabilities, genetic testing, and other types of treatment received.
5. **GENERAL CONSENT FOR TESTS, TREATMENT, AND SERVICES:**
   I understand the provider will determine the treatment procedures considered necessary for me and that the treatments/ procedures will be directed by a physician or independent Advanced Practitioner, in accordance with state laws, scope of practice, and licensure of medical providers.

Patient Label

6. **CONSENT FOR VIRTUAL HEALTH/TELEMEDICINE SERVICES, & REMOTE PATIENT MONITORING:**
   I hereby consent to engaging in virtual health/telemedicine services, & remote patient monitoring where available, as part of my treatment. I understand that "virtual health" or "telemedicine services" includes the practice of health care delivery, diagnosis, consultation, treatment, transfers of medical data, and education using interactive audio, video, or data communications when the health care provider and patient are not in the same physical location. Remote Patient Monitoring includes use of digital devices to collect health data from me where I am located and electronically transmit that information to providers in a different location for assessment and recommendations. This type of service allows a provider to continue to track my health status and data outside of the Physician Clinic. The interactive electronic systems used for these services will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption. I understand that the potential benefits of receiving care in this manner include improved access to care and the ability to obtain the expertise of a specialist. The potential risks include problems with information transmittal, including but not limited to poor data transfer which may include a poor video and data quality experience, technical problems with the information, transmission or equipment failures that could result in lost information or delays in treatment, or lack of access to my complete medical record by the remote provider. I understand that all information, including images, will be part of my medical record available to me if requested and with the same restrictions on dissemination without my consent. I understand that telehealth should not be used for emergency medical conditions. I understand I may withdraw my consent at any time.
7. **ADVANCE DIRECTIVE ACKNOWLEDGEMENT:**
   Federal law requires that patients be provided information about their rights to make advanced health care decisions, including Living Will, Durable Medical Power of Attorney or designation of surrogate decision maker for health care decisions. By signing, you acknowledge awareness of these rights and understand the Physician Clinic can provide you with additional information and appropriate forms should you desire them.
8. **RESEARCH STUDIES:**
   If you are currently participating in any research studies or clinical trials, we ask you please notify Registration and your Provider. You will be asked to provide a description of what is being studied (drug, medical device or other) and the Research Coordinator's contact information should your Provider have questions about the Study.
9. **CONSENT TO PHOTO/VIDEO:**
   I consent to the photographing, videotaping and/or video monitoring, including appropriate portions of my body, for medical and medical record documentation purposes, provided said photographs or videotapes are maintained and released in accordance with protected health information regulations.
10. **CONSENT TO PHOTOGRAPH AT THE TIME OF REGISTRATION:**
    I, hereby give consent to the medical practice to take my photograph at the time of registration. I understand this photograph will be stored in the medical practice's ambulatory medical record electronically as my photo identification.
11. **COMMUNICATIONS:**
    I consent to this Physician Clinic, its successors or assignees contacting me via the methods I provide to the Physician Clinic. I understand the communications may occur in any manner, including phone calls to my cell phone or landline, voicemails on my cell phone or landline, use of automated telephone dialing systems, use of artificial or prerecorded voice messages, text messages to my cell phone, or email messages. I understand the communications may be about any matter, including, but not limited to, my medical treatment, prescriptions, insurance eligibility, insurance coverage, scheduling, billing or collection matters. I understand that these communications are not encrypted or secure, and I assume the risks of transmitting health information via unsecure means. If I incur any cost from being contacted at the telephone number(s) or email address(es) provided to the Physician Clinic, including but not limited to data, roaming, text messages, additional minutes or other fees, I understand that the Physician Clinic is not responsible for paying these charges. This consent also applies to any updated or additional contact information that I may provide. I understand that I will be able to change my preference at any time by contacting the Physician Clinic.
12. **VIDEOTAPING/RECORDING:**
    I understand and agree not to photograph, videotape, audiotape, record or otherwise capture imaging or sound on any device. I also understand it is my responsibility to assure those accompanying me comply with this requirement.

Patient Label

The undersigned certifies that s/he has read (or have had read to me) the foregoing, understands it, accepts its terms, and has received a copy of. I hereby agree to all terms and conditions set forth above and understand that any sections of this consent that I do not consent to, I have struck through and initialed the section that does not have my consent or permission.

Patient's Signature or Legal Representative				Date	Time
Relationship to Patient			Interpreter, if Utilized	Date	Time
Witness Signature	Date	Time	If Telephone Consent, Second Witness Signature	Date	Time

Patient Label