Taylorville Family Medicine

Let our family take care of yours.

New Patient Form Cover Page

CONFIDENTIAL

📌7700 Highway 69 S, Ste C, Tuscaloosa, AL 35405 📞(205)349-1040 📠(205)349-4015
🔗www.taylorvillefamily.com 🖥️frontdesk@taylorvillefamily.com

Taylorville Family Medicine

Demographic

Patient's Full Name: _____
First Name Middle Last Name

Preferred Name: _____

Date of Birth: _____/_____/_____
MM DD YYYY

Age: _____

Gender: ☐ Male ☐ Female

Race: ☐ American Native ☐ Asian ☐ Black/African American ☐ Hispanic or Latino ☐ White

SSN#: _____

Mobile Phone: _____

Work Phone: _____

Email: _____

Address: _____

Emergency Contact: _____ _____ _____
Name Relation Phone#

Guarantor: ☐ Self ☐ Other >> If other, fill in the guarantor information below:

_____ _____ _____ _____
Guarantor Full Name DOB Relationship Race

☐ M ☐ F _____ _____ _____
Gender SSN Phone Email

Address: ☐ Same as patient ☐ _____

Do you have any notes to our office or providers? _____

How do you know about us? _____

Insurance

| Please Note: Taylorville Family Medicine is not a provider of Medicaid.

Does the patient have health insurance? ⬜ Yes ⬜ No/Self Pay

Primary Insurance	Secondary Insurance	Tertiary Insurance
_____ Insurance Company	_____ Insurance Company	_____ Insurance Company
_____ Contract/Policy#	_____ Contract/Policy#	_____ Contract/Policy#
_____ Group#	_____ Group#	_____ Group#
_____ Effective Date	_____ Effective Date	_____ Effective Date
Insurance Holder: ⬜ Self ⬜ Other >> if other, fill in the following info	Insurance Holder: ⬜ Self ⬜ Other >> if other, fill in the following info	Insurance Holder: ⬜ Self ⬜ Other >> if other, fill in the following info
_____ Name of Policy Holder	_____ Name of Policy Holder	_____ Name of Policy Holder
_____ Date of Birth	_____ Date of Birth	_____ Date of Birth
_____ Relation	_____ Relation	_____ Relation
_____ SSN	_____ SSN	_____ SSN

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Health History

| To ensure we provide you with the best care possible, please take a moment to answer the questions as much as you can.

Social History

Alcohol usage: ☐ None ☐ Occasional ☐ Regularly ☐ Decline to answer

Tobacco usage: ☐ Never-Smoker ☐ Ex-Smoker ☐ Ex-user of moist powdered tobacco
☐ Unknown if ever smoked ☐ Current non-smoker but past smoking ☐ History unknown
☐ Current everyday smoker ☐ Light cigarette smoker (1-9 cigs/day)
☐ Moderate cigarette smoker (10-19 cigs/day) ☐ Heavy cigarette smoker (20-39 cigs/day)

Drug usage: ☐ None ☐ Past ☐ Current ☐ Decline to answer

Marijuana usage ☐ Never ☐ Past ☐ Current user ☐ Decline to answer

Caffeine usage ☐ No ☐ Yes If yes, how much and how often? _____

Special Diet: ☐ No ☐ Yes If yes, what kind? _____

Exercise: ☐ Never ☐ 1-2x/week ☐ 3-4x/week ☐ 5 or more x/week ☐ Decline to answer

If yes, what kind?_____

Employment Status: ☐ Employed ☐ Retired ☐ Student ☐ Unemployed ☐ Decline to answer

If employed, name of employer and your occupation:_____

Occupational Concerns: ☐ Hazardous material ☐ Hazardous environment ☐ Heavy Lifting ☐ Stress ☐ Decline to answer
☐ Other _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Decline to answer

Gender Identity: ☐ Male ☐ Female
☐ Transgender Male/Trans Man/Female-to-Male ☐ Transgender Female/Trans Woman/Male-to-Female
☐ Genderqueer, neither exclusively Male nor Female ☐ Additional gender category or other
☐ Decline to specify

Sexual Orientation: ☐ Straight or heterosexual ☐ Lesbian, gay, or homosexual ☐ Bisexual ☐ Don't know
☐ Something else ☐ Declines to specify

Highest Education Level: _____

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Family Health History

Please note the relationship.

- ⬜ Don't know
- ⬜ Decline to answer
- ⬜ High blood pressure _____
- ⬜ Diabetes _____
- ⬜ Stroke _____
- ⬜ Heart disease _____
- ⬜ High cholesterol _____
- ⬜ Thyroid problems _____
- ⬜ Kidney Disease _____
- ⬜ Depression _____
- ⬜ Bipolar disorder _____
- ⬜ Dementia _____
- ⬜ Alcoholism _____
- ⬜ Cancer (sepcify) _____
- ⬜ Other (specify) _____

_____

Medical History

Preferred Pharmacy: Name and location

_____

Allergies:
⬜ No known Allergies
⬜ Yes. >>> List any Medication, Food, or Environmental allergies and reactions

_____

Immunization: Childhood immunization shots up to date?

⬜ Yes ⬜ No ⬜ Not Sure

Major Events: List any surgeries, hospitalizations, and injuries you have had in the past with the event year.

_____

_____

Implantable Devices: ⬜ No ⬜ Yes

>> If yes, please specify: _____

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▼ Have you ever been diagnosed with any of the following?

- ⬜ AIDS/HIV
- ⬜ ADHD
- ⬜ Anxiety
- ⬜ Alcoholism/substance abuse
- ⬜ Anemia
- ⬜ Anorexia/Bulimia
- ⬜ Arthritis-Osteo/Rheumatoid
- ⬜ Asthma/COPD/Emphysema
- ⬜ Bleeding Disorder
- ⬜ Bronchitis/Pneumonia
- ⬜ Breast Lump
- ⬜ Cancer _____
- ⬜ Cataract/Glaucoma
- ⬜ Diabetes
- ⬜ Depression
- ⬜ Goiter
- ⬜ Epilepsy/Seizure disorder
- ⬜ Heart Disease
- ⬜ Hernia
- ⬜ Hepatitis
- ⬜ High Cholesterol
- ⬜ Kidney Disease
- ⬜ Liver Disease
- ⬜ Migraine
- ⬜ Mononucleosis
- ⬜ MS
- ⬜ Pacemaker/Defibrillator
- ⬜ Polio
- ⬜ Psychiatric care
- ⬜ Prostate Problem
- ⬜ Stroke/TIA
- ⬜ STD
- ⬜ TB
- ⬜ Ulcers/GERD
- ⬜ Vaginal Infections
- ⬜ Other Medical Condition

>>> Specify

_____

Please list any **specialist** you have seen for any of the above: _____

▼ Are you currently taking any medications, including OTC, supplements? ⬜ Yes ⬜ No

List all the medications you currently take, including over-the-counter, indicating each medication's dosage and frequency (number of times per day).

Medication	Dosage	Frequency	Reason for taking

Notice: If you have not disclosed all medications, you may possibly be dismissed as a patient.

If you are taking controlled substances, please attach related paperwork (e.g. ADHD Diagnosis Document).

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Health Concerns

I think my health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

My biggest health concerns are: _____

My goal for my health is: _____

Check any symptoms/illness you have/have had in the past year:

General: ☐ Recent weight gain more than 10 lb ☐ Recent weight loss more than 10 lb ☐ Fever ☐ Fatigue ☐ Daytime sleepiness ☐ Loss of sleep ☐ Forgetfulness ☐ Chronic pain

HEENT: ☐ Blurry vision ☐ Double vision ☐ Hoarse voice ☐ Snoring ☐ Hearing problem ☐ Bleeding gums ☐ Ear drainage/earache/ringing in ears

Endocrine: ☐ Cold intolerance ☐ Heat intolerance ☐ Excessive thirst ☐ Excessive hunger ☐ Excessive sweating ☐ Frequent urination

Cardiovascular/Respiratory: ☐ Chest pain ☐ Palpitations ☐ Abnormal heart rhythm ☐ Shortness of breath ☐ Cough ☐ Wheezing ☐ Blood Clots ☐ Fainting/blacking out

Gastrointestinal: ☐ Abdominal pain ☐ Acid reflux ☐ Difficulty swallowing ☐ Bowel irregularity ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Bloating ☐ Blood in stools

Genitourinary: ☐ Incontinence ☐ Frequent urination ☐ Infertility ☐ Sexual difficulties ☐ Nighttime urination ☐ Blood in urine ☐ Kidney stones/infection ☐ Erection difficulties ☐ Breast lump/nipple discharge ☐ Vaginal sores/infections/discharge

Extremities: ☐ Joint pain ☐ Muscle aches/pain ☐ Back pain ☐ Mobility issues ☐ Swelling in legs/ankles ☐ Gout

Neurologic: ☐ Headaches ☐ Balance issues ☐ Coordination issues ☐ Dizziness ☐ Numbness ☐ Local weakness ☐ Seizures ☐ Memory loss

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Psychiatric: ⬜ Anxious/nervous ⬜ Depressed mood ⬜ High stress level ⬜ Sleep problems ⬜ Insomnia ⬜ Suicidal thoughts ⬜ Mood changes ⬜ Loss of interest

Skin: ⬜ Hair loss ⬜ Acne ⬜ Skin tags ⬜ Striae (stretch marks) ⬜ Excess skin ⬜ Intertrigo (inflammation between skin folds) ⬜ Skin rash

Other: Specify_____

_____

Men only

Have you ever been diagnosed with low testosterone?

⬜ Yes ⬜ No

Last prostate exam? _____

Last PSA blood test? _____

Women only

Do you have any of the following:

⬜ Heavy periods ⬜ Irregularity ⬜ Spotting, pain ⬜ Discharge ⬜ Menopausal symptoms/hot flashes ⬜ None

Have you ever been diagnosed with PCOS? ⬜ Yes ⬜ No

Age at onset of menstruation: _____

Last Pap smear exam? _____

Last Mammogram and where? _____

Are you currently pregnant or breastfeeding? ⬜ Yes ⬜ No

Are you currently using a form of birth control?

⬜ Yes ⬜ No >> If yes, what type? _____

***This form will be retained in your medical record.**

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NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time, and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.
- Email and standard SMS messaging are not confidential methods of communication. They may be insecure and read by a third party.

I consent that the practice:

- can communicate with me by phone calls, emails, or standard SMS messaging regarding various aspects of my medical care, which may include, but shall not be limited to, test results, prescriptions, appointments, and billing.
- may leave a message on my answering machine at home or cell phone;
- may discuss my medical condition with members of the patient's family

Please name the members allowed:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

This consent was signed by: _____
Print Patient Name &/or Patient Representative

_____ _____
Signature Patient Name &/or Patient Representative Date
Description of Patient Representative Authority: _____

PATIENT EMAIL AND SMS MESSAGING INFORMED CONSENT

Completion of this document authorizes the disclosure and /or use of health information about you. The purpose is to give permission to communicate with you about your health using either method. We use these methods as they are efficient convenient ways to communicate. You will receive information in real time and is readily accessible at the touch of a button. It also saves you time waiting on the phone to get through to the practice.

I hereby consent and state my preference to have the providers and other staff at Taylorville Family Medicine communicate with me by email or standard SMS messaging regarding various aspects of my medical care, which may include, but shall not be limited to, test results, prescriptions, appointments, and billing.

I understand that email and standard SMS messaging are not confidential and may be insecure. Because of this, there is a risk that email and standard SMS messaging regarding my medical care might be intercepted and read by a third party.

You have the right to opt out of this service at any time. To do so, simply text stop to our main office number, (205)349-1040. Please also let our office know of your preferences so we can update your record accordingly. If you wish to opt in again at a later date, text unstop.

This consent was signed by: _____
Print Patient Name &/or Patient Representative

_____ _____
Signature Patient Name &/or Patient Representative **Date**

Description of Patient Representative Authority: _____

Authorization for Insurance Assignment and Consent to Pay the Physician

I hereby assign all insurance benefits to Taylorville Family Medicine. I understand that I am responsible to Taylorville Family Medicine for my charges and my family's individual charges incurred during the course of treatment, even though I may have insurance or third-party coverage. I recognize that the cost of the medical care may exceed the amount reimbursed by my insurance carrier. I promise to pay this amount when due. In the event of default, I agree to pay reimburse Taylorville Family Medicine the fees of any collection agency, which may be based on a percentage at a maximum of **33.3%** of the debt, and all cost and expenses, including reasonable attorneys' fees.

I understand that certain insurance carriers and health maintenance organizations require a referral from designated primary care physician prior to being seen by Taylorville Family Medicine. It is patient's responsibility to secure this authorization. It is understood that if the referral was not secured or approved, that patient is responsible for all charges. Any charges that rejected as "non-covered" are also the responsibility of patient. It is the patient's responsibility to determine if Taylorville Family Medicine is a preferred provider for your insurance carrier. Any charges rejected as "non-covered" are the responsibility of the patient.

I authorize the clinic and all clinical providers who have provided care or interpreted my test, along with any billing service and their collection agency or attorney who may work on their behalf, to contact me on my cell phone and/or home phone using pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication.

By my signature below, I acknowledge that I was offered a copy of **Taylorville Family Medicine's Authorization for Insurance Assignment and Consent to Pay the Physician** and agree the above Authorization and Consent.

This consent was signed by: _____
Print Patient Name &/or Patient Representative

_____ _____
Signature Patient Name &/or Patient Representative Date

Description of Patient Representative Authority: _____

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MEDICAL APPOINTMENT CANCELLATION POLICY

Dear Patient,

We strive to provide excellent medical care to you, your family and all of our patients. In order to do so effectively and efficiently, we have developed an appointment system that sets asides ample time for a patient.

"No-shows" and late cancellations inconvenience those individuals who need access to medical care in a timely manner. In an effort to reduce the number of such occurrences, we have implemented a Medical

Appointment Cancellation Policy and it is effective immediately. Our policy is as follows:

1. We require you to give our office a **24-hour notice** in the event you need to reschedule your appointment.
2. If you miss an appointment and do not contact us with at least a 24-hour prior notice, we will consider this a missed appointment and a **$50.00 no-show fee** will be assessed to you. This applies to late cancellations and "no-shows".
3. If you are more than **10 minutes late** for an appointment, it may be considered to be a "No-show". We will make an effort to work you into the schedule. However, we may need to reschedule your appointment
4. Our office makes reminder calls for appointments. If you are registered for the patient's portal, you will receive e-mail reminders as well. **It is ultimately the patient's responsibility to remember their scheduled appointments.**

The fee will be billed to you directly and is not covered by your insurance. **This balance must be paid prior to your next appointment.** If you don't have a scheduled appointment, the balance is expected in a timely fashion and if not, will be subject to collections.

ALL COPAYS AND PAST BALANCES ARE DUE AT THE TIME OF SERVICE.

We thank you for trusting Taylorville Family Medicine with your medical care.

This consent was signed by: _____
Print Patient Name &/or Patient Representative

_____ _____
Signature Patient Name &/or Patient Representative Date

Description of Patient Representative Authority: _____

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AUTHORIZATION FOR RELEASE OF INFORMATION FOR PURPOSES REQUESTED BY PHYSICIANS OFFICE FROM ANOTHER COVERED ENTITY

I hereby authorize _____ ((Name of patient's current or previous caring office) to disclose the following protected health information to Taylorville Family Medicine

Specific description of Information to be disclosed (including date(s)):

⬜ Prior Treatments and relative documents ⬜ Other: _____

This protected health information is being used or disclosed to carry out treatment, payment and/or health care operations of Taylorville Family Medicine, in the following manner:

⬜ Further Clinical Treatments ⬜ Other: _____

This authorization shall be in force and effect until

⬜ Treatment complete or _____ at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by notifying Taylorville Family Medicine at 7700 HWY 69 S, Ste B, Tuscaloosa, AL 35405. I understand that a revocation is not effective to the extent that Taylorville Family Medicine has relief on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Taylorville Family Medicine will not condition my treatment, payment, enrollment (if applicable) in a health plan, or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to refuse to sign this authorization.

This consent was signed by: _____
Print Patient Name &/or Patient Representative

_____ _____
Signature Patient Name &/or Patient Representative Date

Description of Patient Representative Authority: _____