PATIENT HEALTH INFORMATION FORM

(PLEASE PRINT)

NAME_____DATE OF BIRTH_____SEX_____RACE_____

PLEASE CHECK ONE: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED

MAILING ADDRESS_____
STREET, ROUTE, OR P. O. BOX (Where you get mail.) CITY STATE ZIP

PHYSICAL ADDRESS _____
STREET, ROUTE, OR P. O. BOX (Where you live.) CITY STATE ZIP

EMAIL ADDRESS_____

SOC SEC #_____-____-_____ PREFERRED CONTACT METHOD: ☐ MAIL ☐ PHONE ☐ PATIENT PORTAL

HOME PHONE # _____CELL # _____CARRIER_____WORK #_____

You **MAY or MAY NOT** (*please circle one*) **leave information** on my **answering machine/voicemail**.

INSURANCE

1. INSURANCE NAME: _____ POLICY # _____

   INSURED'S NAME _____ INSURED'S BIRTH DATE_____

2. INSURANCE NAME: _____ POLICY # _____

   NAME _____ INSURED'S BIRTH DATE_____

Addendum Signature Page for the Standard of Operations Charges

There is a $10.00 Charge for ANY Forms or Letters **completed outside** of an **office visit**. This includes FMLA Paperwork, Any Forms, FMLA Handicap Forms, Any Letters, etc.

There is a $15.00 Charge for ANY Prescriptions requiring to be called, e-prescribed, faxed, etc to any pharmacy **outside** of a **routine scheduled office visit**.

There is a $25.00 **NO SHOW & CANCELLATION** fee if you do not show up for your appointment or if you don't cancel within 24 hours prior to appointment.

We **strongly** encourage you to ask for your refills on your routine medications **during** your **office visits** with your **doctor**. This will prevent any delays. Another option is for you to notify your pharmacist and have your pharmacist to fax in a refill request to your doctor.

To the best of my knowledge the above confidential information is true. I give my permission for treatment. If the patient is a minor, I am authorized to give my permission for treatment. I also authorize the release of information needed to process this insurance claim and request payment of medical benefits to be sent to this physician. I agree to be fiscally responsible for this patient's account. Until my accounts are finally settled, I give my direct consent to receive communications regarding my accounts for any services and any collectors of my accounts

through various means such as 1. any cell or landline phone; 2. any email address I provide; 3. auto dialer systems; 4. voicemail messages and other forms of communications.

Signature _____ Date_____

Pickens County Primary Care, PC
P O Box 1000, 108 4th Ave. Suite A, Reform, Alabama 35481
(205) 375-6251 Phone (205) 375-9064 Fax

CONSENT FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ DOB: _____

1. I hereby request and authorize Pickens County Primary Care to:
   ☐ Release Information TO ☐ Obtain Information FROM

2. Name of Provider / Facility _____
   Address _____
   Telephone _____ Contact Person _____

3. The PURPOSE of this release is: (check all that apply)
   ☐ Moving ☐ Insurance Purpose ☐ Transferring Care ☐ Second Opinion
   ☐ Personal Review ☐ Other (please specify) _____

4. The FOLLOWING Protected Health Information (PHI) may be released: (please check one)

   ☐ I consent to the release of **all medical records** including records, reports or tests concerning alcoholism and/or drug abuse or treatment information, sexually transmitted disease related and/or psychological or psychiatric treatment. I also understand that the release of information related to the diagnosis or treatment of HIV requires an additional authorization.

   ☐ I consent to the release of **all medical records** with the following exceptions. (Specifically describe the information you do not wish to have released.)
   _____
   _____

   ☐ I consent to the release of **all medical records** relating to the following treatment or condition:
   _____
   _____

   ☐ I consent to the release of **all medical records** from _____ to _____.
   date date

5. **This authorization will automatically expire within one year from the date of signature.** I understand that I have the right to revoke this authorization in writing at any time, except where information has already been released in response to this authorization.

NOTICE TO PATIENT: For copy of records to patient there will be a charge for copying, $1 per page for the first 25 pages then $0.50 for each page thereafter**. Payments are due before receipt of records.**

_____ _____

Signature of Patient/ Representative/ or Legal Guardian Date

_____ _____

Witness Date

NOTICE TO RECIPIENT OF RECORDS: This information has been disclosed to you from confidential records that are protected by law. State law prohibits you from making any future disclosures of this information without specific written authorization of the person to whom it pertains, or as otherwise permitted by Federal or State law.

Pickens County Primary Care, PC
PO Box 1000, 108 4th Ave. SW, Suite A Reform, Alabama 35481
(205) 375-6251 Phone (205) 375-9064 Fax
You may email completed form to cwright@pc3med.com

PERMISSION TO COMMUNICATE MEDICAL INFORMATION (HIPAA)

I, _____, authorize Pickens County Primary Care to contact me regarding clinical services (i.e. appointments) at the number and /or alternative means checked below.

☐ My HOME telephone: _____ ☐ Ok to leave message on answering machine.
☐ My CELL phone: _____ ☐ Ok to leave voice-mail; ☐ Ok to text. ☐
My WORK phone: _____ ☐ Ok to leave voice-mail.

Please check the appropriate box below and sign & date at the bottom of the page.

☐ **I DO NOT** wish to have test results or other medical information released to any person other than myself.

☐ **I DO** give permission for the release of information, including test results or other information to myself and/or the following persons:

Name _____ Relationship _____

Date of Birth _____ Phone _____

Name _____ Relationship _____

Date of Birth _____ Phone _____

Name _____ Relationship _____

Date of Birth _____ Phone _____

Name _____ Relationship _____

Date of Birth _____ Phone _____

Name _____ Relationship _____

Date of Birth _____ Phone _____

You **MAY or MAY NOT** (*please circle one*) **leave information** on my **answering machine**.

Signature _____ Date _____

Pickens County Primary Care, PC
P O Box 1000, 108 4th Ave. Suite A, Reform, Alabama 35481
(205) 375-6251 Phone (205) 375-9064 Fax

LATEX ALLERGY SCREENING TOOL

DATE: _____

NAME: _____

A. YES or NO

_____ 1. Do you have (or think you Have) an allergy to latex or rubber?

_____ 2. Do you have an allergy to any of the following foods – bananas, chestnuts, avocados, kiwi, papayas, figs, passion fruit, or nectarines?

If both answers are NO, you are through with this form.
If either of the above answers is <u>YES</u>, answer the following questions.

B. YES or NO

_____ 1. Do your hands break out when you put on rubber gloves or after you have worn them for some time?

_____ 2. Do your lips swell or tingle when you blow up balloons?

If there was a YES on section A & B, you will need to institute Latex Sensitivity Precautions Protocol as per P&P.

DATE: _____

REVIEWED BY: _____

ACTION TAKEN:

_____ 1. Surgeon notified.

_____ 2. Latex-free bandage and tourniquet used.

_____ 3. Latex Sensitivity Precautions Protocol initiated.

_____ 4. Other: _____

Pickens County Primary Care, PC

PLEASE CHECK ALL THAT APPLY

Have **you** or a close relative **(father, mother, brother, sister, uncle, aunt, grandfather, grandmother)** had any of the following:

- ☐ **1 breast cancer** diagnosed **under age 50**
- ☐ **Ovarian cancer** diagnosed at any age
- ☐ **3 breast cancers** on the same side of family diagnosed at any age
- ☐ **1 colon and/or uterine cancer** diagnosed **under age 50**
- ☐ **3** or more **colon and/or uterine cancers** on the same side of family diagnosed at any age

Patient Name: _____

Provider you are seeing today: _____

Pickens County Primary Care, PC
Patient Portal Authorization
*(*required information)*

***Print Patient Name and Birthdate:** _____

***Responsible Party/Legal Guardian: _____*Phone:_____**
***Personal Email Address (please print clearly):_____**
(Please supply the personal email address and photo ID of the person who will be using the patient portal)
Purpose of this Form: The patient portal offers patients of Pickens County Primary Care, PC, a secure way to view parts of their healthcare records. Please read this form thoroughly before signing to request access to view your medical records on the patient portal.

How the Patient Portal Works: A secure web portal is a kind of webpage that uses computer security to keep unauthorized persons from reading information or attachments. Health information can only be read by someone who knows the right password to log into the portal site. Once you are logged into the portal, you will have access to only your records or those for whom you are legally responsible.

How to Participate in the Patient Portal: To participate, please provide a copy of your photo ID and this form. Once this form is signed and approved, you will receive an invitation to your personal email to set up your username and password for the patient portal.

Protecting Your Private Health Information and Risks: This method of communicating and viewing prevents unauthorized parties from being able to access your private health information. However, keeping health information secure depends on two important factors: we need you to make sure we have your correct email address, and you must inform us if it ever changes. We strongly suggest that you use a personal email account rather than a work email address as this information might be available to your employer. You need to keep unauthorized persons from learning your password. If you think someone has learned your password, you should promptly change it via the patient portal.

Conditions of Participating in the Patient Portal: We understand the importance of privacy with regard to your health care and will continue to protect the privacy of your medical information. Our use and disclosure of medical information is described in our Notice of Privacy Practices. Access to this secure web portal is an optional service, and we may suspend or discontinue it at any time for any reason. If we do, we will notify you as promptly as possible. As a user of the patient portal and by signing this form you agree NOT to: (1) Transmit any electronic information that violates the rights or privacy of any party; (2) Use the web portal in any way that would violate local, state or federal laws; (3) Transmit materials that are obscene, defamatory, abusive, slanderous or otherwise likely to result in harm to others; or (4) Intentionally distribute software/computer viruses or take any other action that could compromise the security of our computer system.
***Patient/Responsible Party/Legal Guardian Acknowledgement:**
Signature: _____ Date: _____
Please deliver, send, or fax this form and a copy of a photo ID to the Medical Record Department at: Pickens County Primary Care, PC, 108 4th Avenue SW, Suite A, Reform, Alabama 35481
Questions? Call 205-375-6251