PFSH

Patient's Name: _____ **DOB:** _____

Medications- _____

_____

Past Surgical History- _____

_____

Past Medical History- (Hypertension, diabetes, cholesterol, etc.) _____

_____

Family History- _____

_____

Social History-

Advanced directive- □YES OR □ NO
Exercise- □ YES (how often) _____ OR □ NO
Alcohol- □ YES (how often) _____ OR □ NO

Occupation-

□ Disabled
□ Full time
□ Part time
□ Student
□ Retired
□ Unemployed

Recreational drugs □ YES OR □ NO

Tobacco □ YES (how often) _____ OR □ NO

Health Maintenance History-

Last Colonoscopy: _____
Last Mammogram: _____
Last Prostate Exam: _____
Last Echo: _____
Last EGD: _____
Last Pap Smear: _____
Last Stress Test: _____
Last Spirometry: _____

Vaccines-

Flu Vaccine: _____
TDAP Vaccine: _____
Tetanus Vaccine: _____
Shingles: _____
Pneumonia PCV13: _____
Pneumonia PPSV23: _____
Zostavax: _____

Any specialist Doctors-_____

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

PATIENT HEALTH INFORMATION FORM

(PLEASE PRINT)

Name _____ **Date of Birth** _____ **Sex**_____ **Race**_____

Marital Status: **(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 #_____-___-_____ **Contact Method: (Check one)** ☐ MAIL ☐ PHONE ☐ PATIENT PORTAL

Home Number # _____**Cell #** _____**Carrier** _____**Work #**_____

Emergency Contact (list at least one person) Name: _____ **Number:** _____

INSURANCE

1. **Insurance Name** _____ **Policy #** _____

   Insured's Name _____ **Insured's Date of Birth** _____

2. **Insurance Name** _____ **Policy #** _____

   Insured's Name _____ **Insured's Date of Birth** _____

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_____

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Medical Release Consent

1. I hereby request and authorize Pickens County Primary Care to:

☐ Release Information TO ☐ Obtain Information **FROM**

2. Name of Provider / Facility _____

Address _____

Telephone _____ Fax _____ Contact Person _____

3. The PURPOSE of this release is: (check all that apply)

☐ Referral ☐ Insurance Purpose ☐ Second Opinion ☐ Transfer of Care ☐ Coordination of Care

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

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

☐ Complete Records
☐ Care Plan
☐ Pathology Reports
☐ Medication Records
☐ History & Physical
☐ Lab Reports
☐ Treatment Record
☐ Hospital Reports
☐ Progress Notes
☐ Radiology Reports
☐ Operative Reports
☐ Other (please specify) _____

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

5. **This authorization will automatically expire within one year of 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 patients there will be a charge for copying, $ 5 search fee, $1 per page for the first 25 pages then $0.50 for each page thereafter**. Payments are due before receipt of records.**

_____

Witness Date

NOTCE 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.

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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 voicemail; ☐ Ok to text.

☐ My **WORK** phone: _____ ☐ Ok to leave voicemail.

Please check the appropriate box & list name(s) & phone number(s)

☐ **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:

1. Name _____ Relationship _____

   Date of Birth _____ Phone _____

2. Name _____ Relationship _____

   Date of Birth _____ Phone _____

3. Name _____ Relationship _____

   Date of Birth _____ Phone _____

4. Name _____ Relationship _____

   Date of Birth _____ Phone _____

5. Name _____ Relationship _____

   Date of Birth _____ Phone _____

Signature _____ Date _____

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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

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

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

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

DATE: _____

REVIEWED BY: _____

ACTION TAKEN:

_☐_ 1. Surgeon notified.

_☐_ 2. Latex-free bandage and tourniquet used.

_☐_ 3. Latex Sensitivity Precautions Protocol initiated.

_☐_ 4. Other: _____

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PC3 Standard of Operation Policies and Additional Charges

There is a fee for the following Forms or Letters completed outside of an office visit: (initial)

- $50 for all FMLA forms _____
- $35 for letter or insurance form with only 1-page _____
- $15 for Handicap forms _____
- $10 for Blue Immunization cards _____

There is a **$15 charge** for **ANY** prescription refill outside of routine scheduled office visits. We send all refills to cover your medications until your next scheduled office visit. Please ask for refills on your routine medications and get any paperwork completed during your office visits with your doctor. This will prevent any delays. Another option is for you to notify your pharmacist to verify a refill is not on **HOLD** or have them fax in a refill request.
_____ (initial)

There is a **$35 NO SHOW** and **Cancellation fee** if you do not show up for your appointment or if there is not a cancellation 24 hours prior to your appointment. _____ (initial)
We now offer the following options to send us a message, cancel, reschedule or request an appointment, receive your lab/imaging results once the provider has reviewed them and have access to your medical records.

- Patient Portal - email address: _____
- Text us directly at 205-375-6251 for Dr. Boothe or Dr. Honea, 205-828-3435 for our Chronic Care Clinic, 205-828-3440 for our Illuminate Skin and Wellness

The services offered to our patients for their Primary Care health conditions include, but not limited to the following:

- Preventative and Screenings
- Primary Care and Urgent Care
- Telehealth and Phone Visits: Please initial if you consent to having some of your visits performed with a provider by phone or telehealth visits. _____(initial)

Your appointments are scheduled with the proper treatment and management. Please be prepared to ask all your questions before the provider leaves the room. If you feel the visit will be longer than usual, please ask for a longer visit at check-in. Such as, did you see a specialist recently or were you recently discharged from the ER or Hospital? Please have a list of all your medications you are currently taking; you may ask your pharmacist for this list.

Registration Requirements:

Paperwork must be completed entirely and updated each year in January. If your address, insurance or phone numbers change, we must know immediately. Copayments must be collected at the time of visit and balances must be paid monthly.

Test Results:

We will make every effort to notify you of your results within 7-10 business days. Critical results will be notified first, and normal results may be given at your next appointment.

PC3 Standard of Operation Policies and Additional Charges

Complaints:
Patient complaints should be voiced to your provider or Practice Manager during the office visit. We strive to provide excellent care and service.

Adult Supervision:
Children must always have adult supervision while in the clinic.

Business Environment:
Profanity or derogatory attitudes are prohibited while in the clinic. You will be asked to leave and/or terminated from being a patient of Pickens County Primary Care.

Termination of Services:
Delinquent outstanding balances, falsifying records or medical complaints, non-compliance with treatment, missed appointments, misuse of medication, rude or profane behavior may result int termination of services provided by your provider. The decision to terminate will be taken seriously, you will be given a letter of termination and may ask for an appeal within thirty days in writing. All services under the treatment of your provider will require compliance as a patient with the treatment designated by your physician.

We are proud of the outstanding care and attention we give our patients. Please excuse any delays. We promise to give you the same careful attention. Thank you for choosing us to be part of your health care. We look forward to our long-standing relationship. Failure to abide by the Standard of Operation policies will result in immediate termination of our practice.

_____ _____

Patient Signature Date