**TUSKALOOSA INTERNAL MEDICINE, LLC**
**PATIENT INFORMATION**
**CHART COVER**

Dr. _____

Name: _____

Address: _____ DOB: _____

_____

_____

Home Phone: _____

Cell Phone: _____ **Marital Status:** _____

**Race:** _____

**Ethnic Group:** Hispanic/Non-Hispanic

**E-Mail Address:** _____ **Language:** _____

**Preferred Contact Method**

☐ Home Phone ☐ Cell Phone ☐ Email ☐ Mail

***Preferred Appointment Reminder Method***

☐ *Home Phone* ☐ *Cell Phone* ☐ *Email*

Do you have a Living Will? Yes ☐ No ☐

Have You Appointed a Durable Power of Attorney Yes ☐ No ☐

Employer: _____ Phone: _____

☐ Employed Full Time ☐ Employed Part Time ☐ Not Employed ☐ Self Employed ☐ Retired

☐ Full Time Student ☐ Part Time Student ☐ Not a Student ☐ Active Military ☐ Unknown

**Person to Notify in Case of Emergency:** _____ **Relationship:** _____

**Phone No.** _____

**INSURANCE POLICY INFORMATION:**

Person Responsible for Account: _____

**Primary Insurance:** _____ Policy Holder's Name: _____

**Secondary Insurance:** _____ Policy Holder's Name _____

**AGREEMENT TO PAY**

In consideration of medical services rendered, the undersigned accepts all fees charged as lawful debt and agrees to pay Tuskaloosa Internal Medicine, LLC insurance notwithstanding, for all said charges. Furthermore, undersigned agrees to pay the costs of collection including reasonable attorney's fees and court costs if such be necessary, waiving now and forever the right of exemption allowed to the constitution of laws of the State of Alabama or any other state. Undersigned further understands that Tuskaloosa Internal Medicine, LLC does not accept insurance assignment as a guarantee of full payment.

**Assignment of Insurance Benefits and Release of Information**

My signature below authorizes my insurance company to mail payment of authorized benefits for any medical services rendered directly to Tuskaloosa Internal Medicine, LLC. Furthermore, my signature below authorizes Tuskaloosa Internal Medicine, LLC to release to my insurance company medical information regarding treatment for the purposes of determining eligibility for and payment of charges for services rendered in connection with care.

**Health Insurance Portability and Accountability Act (HIPAA)**

I consent to the use or disclosure of my protected health information (PHI) by Tuskaloosa Internal Medicine, LLC for the purpose of diagnosis or providing treatment to me, obtaining payment for my healthcare bills, or to conduct healthcare operations. I have received a copy of the Company's Notice of Privacy Practices. The Notice describes the types of disclosures of my PHI that will occur in my treatment, payment of my bills, or in the performance of healthcare operations of the Company.

_____ _____

Patient Signature Dated

# TUSKALOOSA INTERNAL MEDICINE
# PERSONALIZED HEALTH HISTORY

Date: _____

Name: _____ Date of Birth _____

Reason for Visit & Current Problems: _____

_____

_____

_____

_____

**ALLERGIES** or Reactions to Medications:

| Name of Medication Allergic To | Reaction |
|---|---|
| | |
| | |
| | |
| | |

**CURRENT MEDICATIONS** (Prescription, nonprescription, vitamins, home remedies, herbs, etcetera):

| Name of Medication | Dosage | How Many Times per Day |
|---|---|---|
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Name of Pharmacy/Drug Store you use: _____

Location: _____

Name of Mail Order Pharmacy: _____

Mail Order Pharmacy ID# (Usually different from your medical insurance): _____

If you have Medicare D, what is the name of your company and ID#: _____

Do you use a DME company, for diabetic testing supplies, oxygen, CPAP, walkers, etcetera? _____

Company and Location: _____

What Type of Equipment:: _____

Name: _____ Date of Birth _____

**PAST MEDICAL HISTORY:** Have you ever had the following:

___ Measles
___ Mumps
___ Chickenpox
___ Whooping Cough
___ Scarlet Fever
___ Diphtheria
___ Smallpox
___ Pneumonia
___ Rheumatic Fever
___ Tuberculosis
___ Polio
___ Epilepsy/Seizure

___ Anemia
___ Blood/Plasma Transfusion
___ Infectious Mono
___ Hepatitis/Jaundice
___ Bleeding Tendency
___ Blood Clots
___ Heart Disease
___ Low Blood Pressure
___ High Blood Pressure
___ Mitral Valve Prolapse
___ Stroke/TIA
___ Heart Murmur

___ Back Trouble
___ Arthritis
___ Gout
___ Diabetes
___ Glaucoma
___ Bronchitis
___ Asthma
___ Emphysema
___ Migraine Headaches
___ Cancer
___ Venereal Disease
___ AIDS/HIV

___ Hemorrhoids
___ Hernia
___ Ulcer
___ Irritable Bowel Syndrome
___ Frequent Bladder Infections
___ Kidney Disease
___ Liver Disease
___ Thyroid Disease
___ Gallbladder Disease
___ Alcoholism
___ Mental Illness
___ Hives/Eczema

**OTHER TREATING PHYSICIANS**

| Physician Name | Specialty |
|---|---|
| | |
| | |
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**IMMUNIZATIONS:** Please provide the dates.

Influenza (Flu) _____ Tetanus (Td) _____ Pneumococcal _____ Shingles _____

Hepatitis A _____ Hepatitis B _____ Measles (MMR) _____ Other _____

**HEALTH SCREENING:**

Colonoscopy Date: _____ Findings Normal? **Yes / No** Next Due Date _____ Performed By: _____

Bone Density Test Date: _____ Findings Normal? **Yes / No** Sigmoidoscopy Date _____ Eye Exam Date: _____

TB Skin Test Date: _____ Findings Normal? **Yes / No**

***Ladies***:

Last Pap Smear Date _____ Findings Normal? **Yes / No** Last Mammogram Date _____ Findings Normal? **Yes / No**

***Gentlemen:***

Last PSA Screening Date _____ Findings Normal? **Yes / No**

**PAST SURGICAL HISTORY:**

| Operations | Date |
|---|---|
| | |
| | |
| | |
| | |

Name: _____ Date of Birth _____

**PAST HOSPITALIZATIONS:**

| Reason for Hospitalization | Date/Place |
|---|---|
| | |
| | |
| | |
| | |

**PAST SERIOUS ILLNESSES"**

| Illness | Date |
|---|---|
| | |
| | |
| | |
| | |

**FAMILY HISTORY:**

Is your ***mother*** still living? **Yes / No** If deceased, at what age? _____ Is your ***father*** still living? **Yes / No** If deceased, at what age? ___

What health problems does/did your ***mother*** have? _____

What health problems does/did your ***father*** have? _____

Does/did any other close blood relative have any health problems such as heart disease, high blood pressure, diabetes, cancer, etc.?

Please list and describe: _____

_____

_____

**SOCIAL HISTORY**

Relationship Status: ___ Single ___ Married ___ Divorced ___ Separated ___ Widowed

Caffeine (cups/day): ___ Coffee ___ Tea ___ Soda ___ Energy drinks

Exercise regularly? **Yes / No** Do you follow a regular diet? **Yes / No** Recreational Drug Use? **Yes / No**

**TOBACCO HISTORY**

Do you currently use tobacco? **Yes / No** ___ Cigarettes ___ Cigars ___ Pipe ___ Smokeless Tobacco

Have you ever used tobacco? **Yes / No** How much do/did you smoke per day _____ For how many years _____

Did you quit? **Yes / No** When? _____ Do you wish to quit? **Yes / No** Have you ever tried to quit? **Yes / No**

**ALCOHOL HISTORY**

Do you drink alcohol? **Yes / No** If so, how much do you drink per week? _____

Is your drinking a concern for you or others? **Yes / No** Explain: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform my physician's office of any changes in my medical status.

_____ _____

Signature of Patient Dated

Tuskaloosa Internal Medicine, LLC
Patient Portal Authorization Form

Patient Name_____DOB_____

Email address:_____

**If you do not have an email address you are welcome to use a family member or caregiver's email address so they can access your information for you.**

☐ **I do not wish to sign up for the portal**

Our patient portal offers patients of Tuskaloosa Internal Medicine a secure way to view parts of their healthcare records. Please read this form and sign below to request access to use our patient portal. Once this form is signed and approved, you will receive an e-mail within a few days explaining how to set up your user name and password for the patient portal.
The patient portal will allow you to view your health summary information in your electronic record. You can also view your medication list, allergies, medical problem list, and some of your lab results. The portal will not give you access to your entire medical record.

**Protecting Your Private Health Information and Risks:**
We understand the importance of privacy with regard to your healthcare and will continue to protect the privacy of your medical information. 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, or at any time you wish to change your password, please call us at 759-2582.

**Patient/Responsible Party/Legal Guardian Acknowledgement:**

Signature:_____ Date_____

# TUSKALOOSA INTERNAL MEDICINE, LLC

## ACKNOWLEDGEMENT & CONSENT TO USE AND DISCLOSURE OF HEALTH INFORMATION

### FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

You are receiving healthcare services from TUSKALOOSA INTERNAL MEDICINE, LLC (TIM). You agree that all records concerning your care within TIM shall remain the property of TIM. You understand and agree that such information is used for: (1) your treatment – the provision and coordination of your healthcare which may require disclosure of all or any portion of your medical record information to your attending physician, consulting physician(s) and other health care providers who have a legitimate need for such information in the care and continued treatment of the patient, (2) payment for your services – billing, claims management, medical data processing, reimbursement and for determining coverage which may necessitate disclosure of such information to any insurance company, third party payer or other entity (or their authorized representatives), including any copies or excerpts of your medical record which are necessary for payment of patient's account, (3) routine healthcare operations – including, but not limited to, quality assurance, utilization review, medical review, internal auditing, accreditation, certification, licensing or credentialing activities of TIM; and (4) medical research and educational purposes. You acknowledge that you have been provided with a TIM Notice of Health Information Practices (Notice of Privacy Practices) that provides a more complete description of the uses and disclosures of the patient's healthcare information, and that the Notice has been reviewed prior to the signing of this consent. You understand that TIM reserves the right to change the Notice and that TIM will provide you with a revised Notice when you come to TIM. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Restrictions Requested: _____

_____

Patient Signature: _____ Date: _____

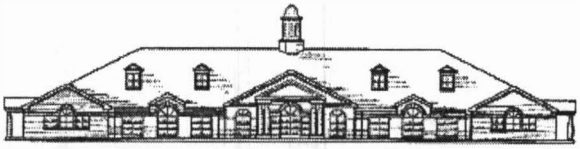
_____ _____

Patient Name (Printed) Date of Birth

FOR TIM PURPOSES ONLY

TIM: _____Agree _____ Not Agree_____N/A

GEORGE P. MILLER, M.D. F.A.C.P.
JOHN P. SUMMERFORD, M.D., F.A.C.P.
ROSS A. VAUGHN, M.D., F.A.C.P.
LEONARD W. JONES, III, M.D.
SCOTT R. FULGHAM, M.D.
JOHN S. WARREN, M.D.
JOHN P. MILLER, M.D.
SCOTT L. ARNOLD, M.D.
OMER A. BAKER, M.D., EMERITUS



TUSKALOOSA INTERNAL MEDICINE, LLC

1100 RUBY TYLER PARKWAY
TUSCALOOSA, AL 35404

205-759-2582
FAX 205-759-2985
OR 205-759-1404

JOHN F. BURNUM, M.D. M.A.C.P., (1922-2005)
MAXWELL MOODY, JR., M.D., (1921-2012)

# Missed Appointment Policy

Effective January 1, 2018, Tuskaloosa Internal Medicine, LLC will begin to charge patients when they do not present for scheduled appointments. Failure to cancel or re-schedule the appointment within 24 hours of the scheduled appointment time will result in a fee for a missed appointment. Any missed appointment without notice will be charged at $50 to your account and is not covered by insurance.

A "missed appointment" is an occurrence where someone does not show up for an appointment and does not cancel the appointment in advance of the scheduled date and time. If you do not show up for your appointment and you do not cancel the appointment 24 hours in advance, we will record this in the medical record as a "missed appointment".

_____ _____

Signature DOB

_____

Print

_____

Date