



**Guarantor Information:**

If someone other than the patient will be responsible for payment of the patient's medical bills, then the guarantor information requested below must be completed and signed by the responsible person.

Please list your full name: \_\_\_\_\_  
First Middle Maiden Last Suffix

Date of birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Please list your street address (no post office boxes, please):

\_\_\_\_\_  
Apt # Street # Street P.O. Box City State Zip Code

Email: \_\_\_\_\_ Home Telephone #: \_\_\_\_\_

Are you employed full-time: \_\_\_\_\_ Work Telephone #: \_\_\_\_\_

Please list your primary employer: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

\_\_\_\_\_  
Employer Name Street or P.O. Box City State Zip Code

**Insurance Information:**

We will need to make a photocopy of all of your currently effective insurance cards - be sure to bring these with you at the time of your visit and present them to the receptionist. Please list the names of all insurance coverages currently in effect which will be used to pay patient's medical bills (list your primary insurance first).

Primary Insurance (we will file first to this insurance):

\_\_\_\_\_  
Insurance Name Insured Person Policy # Group #

\_\_\_\_\_  
Cardholders Name Cardholders Date of Birth

Other Insurance (we will file amounts not paid by primary insurance to these insurances):

\_\_\_\_\_  
Insurance Name Insured Person Cardholders Date of Birth Policy # Group #

\_\_\_\_\_  
Insurance Name Insured Person Cardholders Date of Birth Policy # Group #

**NOTICE TO PATIENT AND GUARANTOR**

Please read the following statements carefully and sign and date in the spaces provided. All medical services rendered are charged to the person responsible for the patient's account, as identified above. Our business office staff will file insurance claims for you to the above identified insurances unless you indicate below that you wish to file your own insurance claims. The Anniston Medical Clinic participates in the Medicare and Blue Cross PMD programs and, as such, are required to file your claims directly with these insurers. The patient and the patient's guarantor are responsible for payment to the Anniston Medical Clinic any amounts billed but not paid by insurance no later than 90 days after the date of service. Unless otherwise provided in your insurer's contract with the Anniston Medical Clinic, we expect payment for all services provided at the time they are rendered, unless alternative payment arrangements have been made with our Patient Financial Counselor. By signing below, the patient authorizes representatives of the Anniston Medical Clinic, P.C. to release any medical records pertinent to the patient's care by doctors of the clinic to insurance carriers identified by the patient or guarantor for the purpose of evaluation of eligibility for insurance coverage and payment of medical services rendered. Patient and guarantor agree to assign to the Anniston Medical Clinic P.C. all payments made by insurance carriers for services rendered to patient by Anniston Medical Clinic doctors and staff.

I have read the above Notice to Patient and Guarantor and I agree to be bound by its provision:

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Guarantor Signature (if not patient)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date





## Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

**Please review it carefully.**

### Your Rights

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

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#### Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

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#### Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

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#### Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

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## Your Rights *continued*

### Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
  - We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
  - We will say “yes” unless a law requires us to share that information.

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### Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

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### Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

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### Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

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### File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **[www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/)**.
- We will not retaliate against you for filing a complaint.

## Your Choices

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

**In these cases, you have both the right and choice to tell us to:**

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory
- Contact you for fundraising efforts

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

**In these cases we never share your information unless you give us written permission:**

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

**In the case of fundraising:**

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

## Our Uses and Disclosures

**How do we typically use or share your health information?** We typically use or share your health information in the following ways.

**Treat you**

- We can use your health information and share it with other professionals who are treating you.

**Example:** A doctor treating you for an injury asks another doctor about your overall health condition.

**Run our organization**

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

**Example:** We use health information about you to manage your treatment and services.

**Bill for your services**

- We can use and share your health information to bill and get payment from health plans or other entities.

**Example:** We give information about you to your health insurance plan so it will pay for your services.

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**How else can we use or share your health information?** We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

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**Help with public health and safety issues**

- We can share health information about you for certain situations such as:
  - Preventing disease
  - Helping with product recalls
  - Reporting adverse reactions to medications
  - Reporting suspected abuse, neglect, or domestic violence
  - Preventing or reducing a serious threat to anyone’s health or safety

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**Do research**

- We can use or share your information for health research.

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**Comply with the law**

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.

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**Respond to organ and tissue donation requests**

- We can share health information about you with organ procurement organizations.

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**Work with a medical examiner or funeral director**

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

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**Address workers’ compensation, law enforcement, and other government requests**

- We can use or share health information about you:
  - For workers’ compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services

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**Respond to lawsuits and legal actions**

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

## Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

### Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

**This Notice of Privacy Practices applies to the following organizations.**





# ANNISTON MEDICAL CLINIC, P.C.

1010 Christine Avenue  
P.O. Box 2127  
Anniston, Alabama 36202  
(256) 236-5631

## Acknowledgement of Receipt

### **ELECTRONIC PRESCRIBING (ePrescribing) and MEDICATION HISTORY**

ePrescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These are:

- **Formulary and Benefit Transactions** - Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication History Transactions** - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill Status Notification** - Allows the prescriber to receive an electronic notice from the pharmacy to let them know the medication has been filled successfully and is ready for patient pickup.

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By signing this consent form you are agreeing that Anniston Medical Clinic, P.C. can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

I also understand that Anniston Medical Clinic utilizes healthcare technology and participates with SureScripts™. SureScripts™ operates the Pharmacy Health information Exchange, which facilitates the electronic transmission of prescription information between providers and pharmacists. SureScripts™ also facilitates notifying providers of any medications prescribed to me (medication history).

Patient Name (Please Print) : \_\_\_\_\_

Date of Birth: \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Parent or Legal Representative  
(If Patient is under 19)

\_\_\_\_\_  
Date

**ANNISTON MEDICAL CLINIC  
PATIENT PORTAL SIGN UP FORM**

- YES I WOULD LIKE TO SIGN UP FOR THE PATIENT PORTAL (PLEASE READ AND FILL OUT THE FORM BELOW)
- NO I WOULD NOT LIKE TO SIGN UP FOR THE PATIENT PORTAL AT THIS TIME (PLEASE SIGN BELOW AND DATE)

**PLEASE USE THE FORM BELOW TO SIGN UP FOR OUR PATIENT PORTAL.**

Patient Name (First & Last): \_\_\_\_\_

Patient Birth Date: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

The patient portal is designed to enhance secure patient-physician communications and is provided as a courtesy to our valued patients. This secure portal uses encryption to keep unauthorized persons from reading communications, information or attachments. Secure messages and information can only be read by someone who knows the right password to log into the portal site.

**Via the Patient Portal you will be able to:**

- Use the message function to communicate with our staff
- Communicate results from staff of laboratory and diagnostic results
- View medication list and request refills on those prescribed by our office
- View and print health summary
- View demographic/insurance information and sent staff requests to update information
- View upcoming scheduled appointments

We will respond to portal inquiries within 1 business day. The patient portal is **not** intended for emergency communications or services. If you have an emergency please go to the nearest phone and call 911 or go to your nearest emergency room.

Please fill out this form and return it to the front desk. Once this is complete you will receive an email notification from Follow My Health that will give you instructions on how to register. We also have instruction sheets at the front desk on how to sign up for the patient portal. If you have any questions please call the office at **256-236-5631**.

**PATIENT SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

**Do you have any of the following health problems:**

High Blood Pressure

Diabetes

Heart Problems

Seizures

Stroke

Fatigue

**When was the last time you had any of the following:**

	Month	Day	Year
Bone Density			
Mammogram (F)			
Pap Smear (F)			
Colonoscopy			
PSA levels (M)			
Prostate exam (M)			
EKG			
Echocardiogram			
Chest x-ray			
Stress test			
Nuclear Stress Test			
TB skin test			
Eye exam			

FLU Shot (Current Year) - \_\_\_\_\_ Yes \_\_\_\_\_ No

Pharmacy Name \_\_\_\_\_

# Adult Medical History Form

\_\_\_\_\_ Name

Your answers on this form will help your clinician understand your medical concerns and conditions better. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details. **Thank you!**

**PRESENT HEALTH CONCERNS:** \_\_\_\_\_

**MEDICATIONS:** Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs:

Medication	Dose	Times per day

Medication	Dose	Times per day

**ALLERGIES or REACTIONS TO MEDICINES/FOODS/OTHER AGENTS:**

Medication	Reaction or Side Effect

**PERSONAL MEDICAL HISTORY:**

Please indicate whether you have had any of the following medical problems (with approximate date of illness or diagnosis):

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Congenital Heart disease:<br><i>specify type</i> _____<br><hr/> <input type="checkbox"/> Myocardial Infarction (Heart attack)<br><input type="checkbox"/> Hypertension (High blood pressure)<br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> High cholesterol _____<br><input type="checkbox"/> Stroke<br><input type="checkbox"/> Thyroid problem<br><i>specify type</i> _____ | <input type="checkbox"/> Coagulation (bleeding/clotting) disorder<br><input type="checkbox"/> Cancer (Malignancy)<br><i>specify type</i> _____<br><input type="checkbox"/> Depression/suicide attempt<br><input type="checkbox"/> Alcoholism<br><input type="checkbox"/> If you have ever had a blood transfusion, please specify date _____<br><input type="checkbox"/> Abnormal Pap smear | Other problems<br>_____<br>_____<br>_____<br>When was your last Tetanus shot?<br>_____ |
|---|---|--|

**SURGICAL HISTORY:** (Please list all prior operations and dates):

Operation	Date

Operation	Date

## WOMEN'S GYNECOLOGIC HISTORY:

For Women: # pregnancies: \_\_\_\_\_ # deliveries: \_\_\_\_\_ # abortions: \_\_\_\_\_ # miscarriages: \_\_\_\_\_  
 1st day, most recent period: \_\_\_\_\_ Age at 1st period: \_\_\_\_\_ Frequency of periods: \_\_\_\_\_ Length of each: \_\_\_\_\_  
 Do you have any concerns about your periods?  No  Yes: \_\_\_\_\_  
 Do you have any concerns about menopause?  No  Yes: \_\_\_\_\_

## FAMILY HISTORY:

Please indicate with a check (✓) family members who have had any of the following conditions:

Medical Condition	Mom	Dad	Sist.	Bro.	Daug.	Son	Other close relatives
Alcoholism							
Anemia							
Anesthesia problem							
Arthritis							
Asthma							
Birth Defects							
Bleeding problem							
Cancer, Breast							
Cancer, Colon							
Cancer, Melanoma							
Cancer, skin (except melanoma)							
Cancer, Ovary							
Cancer, Prostate							
Cancer (not noted)							
Depression							
Diabetes, Type 1 (childhood onset)							
Diabetes, Type 2 (adult onset)							
Eczema							
Epilepsy(seizures)							
Genetic diseases							
Glaucoma							
Hay fever (Allergic Rhinitis)							
Hearing problems							
Heart Attack (Coronary Artery Disease)							
High Blood Pressure (Hypertension)							
High cholesterol (Hyperlipidemia)							
Kidney diseases							
Lupus (Systemic Lupus Erythematosus)							
Mental retardation							
Migraine headaches							
Mitral Valve Prolapse							
Osteoarthritis							
Osteoporosis							
Rheumatoid Arthritis							
Stroke							
Thyroid disorders							
Tuberculosis							
Other:							

## SOCIAL HISTORY:

### SUBSTANCES

#### Tobacco Use

Cigarettes

Quit: Date \_\_\_\_\_

Never

Current: Smoker: packs/day \_\_\_\_\_ # of yrs \_\_\_\_\_

Other Tobacco:  Pipe  Cigar  Snuff  Chew

Are you interested in quitting?  No  Yes

#### Alcohol Use

Do you drink alcohol?  No  Yes: # drinks/week \_\_\_\_\_

Is alcohol use a concern for you or others?  No  Yes

#### Drug Use

Do you use any recreational drugs?  No  Yes

Have you ever used needles?  No  Yes

#### EXERCISE:

Do you exercise regularly?  No  Yes

**ANNISTON MEDICAL CLINIC**  
**PATIENT'S MEDICAL QUESTIONNAIRE**  
(Confidential)

Appointment Date: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_

(Please print or type)

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Your Physician's name: \_\_\_\_\_ Chart No: \_\_\_\_\_

Type of practice (internist, surgeon, etc.): \_\_\_\_\_

Were you referred by your physician: \_\_\_\_\_ Yes \_\_\_\_\_ No

Shall we send a report to your physician? \_\_\_\_\_ Yes \_\_\_\_\_ No

Marital status:      Single      Married      Remarried      Divorced      Widowed      Separated

How many years? \_\_\_\_\_

Primary occupation: \_\_\_\_\_ Location: \_\_\_\_\_ Years: \_\_\_\_\_

Previous/other occupations, hobbies: \_\_\_\_\_

Exposure to hazardous materials: \_\_\_\_\_ Yes \_\_\_\_\_ No      Type: \_\_\_\_\_

Last worked: \_\_\_\_\_ Are you disabled from work? \_\_\_\_\_ Yes \_\_\_\_\_ No

Reason: \_\_\_\_\_

Spouses Occupation: \_\_\_\_\_

Number of Children: \_\_\_\_\_ Ages: \_\_\_\_\_

What is the chief problem that brings you to the clinic? \_\_\_\_\_

How long have you had the problem? \_\_\_\_\_

What do you think might be causing it? \_\_\_\_\_

**PAST MEDICAL HISTORY:**

Year	Illness or Operations	Place Hospitalized
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had any blood transfusions? \_\_\_\_\_ Yes \_\_\_\_\_ No      Dates: \_\_\_\_\_