FAMILY HEALTH OF HARTSELLE

K. Eric Mashburn, M.D.

Mary Virginia Halbrooks, CRNP

Phone: 256 • 773 • 9756
Fax: 256 • 773 • 9401
1006 Hill Street SW
Hartselle, Alabama 35640

Patient Information

Last Name	First	Middle	
Your Billing Address	City	State	Zip
Street Address	City	State	Zip
Birthdate	Occupation	Primary Physician	
Employer		Employer's Address	
Home Telephone #	Work Telephone #	Cell Phone #	Email Address
Married / Divorced / Single / Widowed	Social Security #	Driver's License # / State	Sex M / F / Age
Emergency Contact (outside of the home)		Phone Number	

Insurance Information

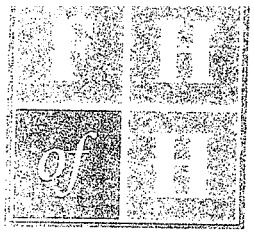
Name of Insurance Company		Policy Number	
Group Number	Effective Date	Subscriber's Name	Relationship/DOB
Additional Insurance		Policy Number	
Group Number	Effective Date	Subscriber's Name	Relationship/DOB
Primary Care Physician with Insurance Carrier			

Insured / Spouse / Parent

Name	Birthdate	Social Security Number
Employer		Work Telephone Number
Employer's Address		

I hereby authorize ***Family Health of Hartselle, P.C.*** to realease my medical records and other necessary information to any known medical practioner and/or any other agency who will be present for my subsequent care. I further authorize ***Family Health of Hartselle, P.C.*** the release of necessary medical information to Medicare or other insurer to process any insurance claims for payment of any bill incurred for this hospitalization or outpatient visit. I understand that I am totally responsible for payment of all expenses incurred. I hereby assign to ***Family Health of Hartselle, P.C.*** payment by medicare or other insurance for any and all benefits to which I may be entitled according to my insurance policy/ies. I agree to pay any charges not covered by my insurance, in which I will be responsible to ***Family Health of Hartselle, P.C.*** for the entire bill. I undertand I am responsible for any health insurance deductables and coinsurance. I further agree, in the event of non- payment, to bear the cost of collection and /or court cost and legal fees. I understand payment is due at time of service.

Insured or Guardian Signature _____ Patient's Signature _____ Date _____



PATIENT INFORMATION SHEET

NAME: _____ GENDER: _____ DOB: _____ DATE: _____

ALLERGIES: _____

List ALL MEDICATIONS you take, including over-the-counter (OTC) medications and vitamins. Include specific doses and when taken. If you don't know, please call your pharmacist to confirm.

_____ _____ _____

_____ _____ _____

_____ _____ _____

PERSONAL MEDICAL HISTORY: (Please circle all that apply)

ADHD
Alcoholism
Allergies, Seasonal
Anemia
Anxiety
Arrhythmia (irregular heart beat)
Arthritis
Asthma
Bipolar
Bladder Problems / Incontinence
Bleeding Problems
Cancer: _____
Headaches
Crohn's Disease
COPD/ Emphysema
Dementia
Depression
Diabetes: 1 or 2
Diverticulitis
DVT (Blood Clot)
GERD (Acid Reflux)
Glaucoma
Heart Disease
Heart Attack (MI)
Hiatal Hernia
High Blood Pressure
Kidney Stones
Kidney Disease
High Cholesterol
HIV
Hepatitis
Irritable Bowel Syndrome
Lupus
Liver Disease
Macular Degeneration
Neuropathy
Osteopenia/Osteoporosis
Parkinson's Disease
Peripheral Vascular Disease
Peptic Ulcer
Psoriasis
Pulmonary Embolism (PE)
Rheumatoid Arthritis
Seizure Disorder
Sleep Apnea
Stroke
Thyroid Disorder
Ulcerative Colitis

Last Menstrual Period	Date:	Normal Abnormal
Colonoscopy	Yes/No Date:____	Normal Abnormal
Mammogram	Yes/No Date:____	Normal Abnormal
Dexa (Bone Density)	Yes/No Date:____	Normal Abnormal
Pap	Yes/No Date:____	Normal Abnormal

Other medical problems not listed above:

_____

Surgical History: Please list all prior surgeries and approximate dates performed.

_____ _____

_____ _____

SOCIAL / CULTURAL HISTORY:

Education Level: ☐ Elementary ☐ High School ☐ Vocational ☐ College ☐ Graduate / Professional

Are there any vision problems that affect your communication? ☐Yes ☐ No

Are there any hearing problems that affect your communication? ☐Yes ☐ No

Are there any limitations to understanding or following instructions (either written or verbal)? ☐Yes ☐ No

Current Living Situation (Check all that apply):

☐ Single Family Household ☐ Multi-generational Household ☐ Homeless ☐ Shelter ☐ Skilled Nursing Facility ☐ Other: _____

Smoking/ Tobacco Use: ☐ Current ☐ Past ☐ Never Type: _____ Amount/day: _____ Number of Years: _____

Alcohol: ☐ Current ☐ Past ☐ Never Drinks/week: _____

Recreational Drug Use: ☐ Current ☐ Past ☐ Never Type: _____

Are you sexually active? ☐Yes ☐ No

Are there any personal problems or concerns at home, work, or school you would like to discuss? ☐Yes ☐ No

Are there any cultural or religious concerns you have related to our delivery of care? ☐Yes ☐ No

Are there any financial issues that directly impact your ability to manage your health? ☐Yes ☐ No

How often do you get the social and emotional support you need?

☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

Comments (Please feel free to comment on any answers marked "yes" above):

_____

_____

FAMILY HISTORY:

FATHER: Living: Age _____ Deceased: Age _____

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: _____	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Heart Disease	Migraines	

Other: _____

MOTHER: Living: Age _____ Deceased: Age _____

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: _____	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Heart Disease	Migraines	

Other: _____

SIBLINGS:

_____

_____

List other medical providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, Dentist, etc.)

_____

_____

Patient Signature: _____ Date: _____

For Medicare patients only and Medigap Assignment Authorization

I request payment of authorized Medigap benefits to be made on my behalf to Family Health of Hartselle, P.C. the release of necessary medical information to the following Medigap Insurer (_____) to process any insurance claims for payment of any bill incurred for this hospitalization or outpatient visit.

_____ _____

Patient Signature Date

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. If you have any questions about this notice please contact our office at 256-773-9756.

This is a summary of our Notice of Privacy Practices which describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. We are required by law to maintain the privacy of your protected health information and provide you with a notice of your legal duties and privacy practices with respect to protect health information.

We are required to abide by the terms of this Notice of Privacy Practices. We may change terms of your notice, at any time, and reserve the right to do so. The new notice will be effective for all protected health information that we maintain at that time.

We will use your protected health information as part of rendering patient care, including treatment, payment, and other healthcare operations.

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

We may use or disclose your protected health information in certain situations without your authorization or opportunity to agree or object.

You have the right to request restriction of your protected health information.

You have the right to request to receive confidential communications of your protected health information.

You have the right to inspect and copy your protected health information.

You have the right to amend your protected health information.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

You have the right to obtain a paper copy of this notice from us.

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filling a complaint.

This summary was published along with the Notice of Privacy Practices.

Family Health of Hartselle, PC
Notice of Privacy Practice Acknowledgment

I,_____, acknowledge I have received a copy of the notice of privacy practices.

_____

Signature of patient or personal representative name of patient or personal representative (please print)

_____ _____

Date Relationship to patient

If patient or personal representative is unable or refuses to sign this form, document the reasons on this form. Place form in the patient's medical record.

Our Financial Policy

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions, please do not hesitate to contact our staff.

1. On arrival, please sign in at the front desk and present your current insurance card at ever visit. You will be asked to sign and date the file copy of the card. This is your verification of the correct insurance and consent to bill them on your and/or your child's behalf. **If the insurance company that you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to correct plan.**
2. If we are primary care physician, make sure our name or phone number appears on your card. If your insurance company has not been informed that we are your primary care physicians as of this date, you may be financially responsible for any and all co-payments, deductibles, and coinsurances.
3. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.
4. We do submit to secondary insurance plan. If you have secondary insurance, we will submit for reimbursement. If your secondary insurance sends a reimbursement check directly to you, **YOU ARE RESPONSIBLE FOR ANY BALANCE ON YOUR ACCOUNT**.
5. It is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialists, if preauthorization is required prior to a procedure, and what service is covered.
6. If your physicians do not participate in your insurance plan, payment in full is expected from you at the time of your office visit. For scheduled appointments, prior balances must be paid prior to the visit.
7. If you have no insurance, payment for an office visit is to be paid at the time of the visit.
8. Co-payments are due at the time of service.
9. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within 10 business days of your receipt of your bill.
10. If previous arrangements have not been made with our finance office, any account balance over 60 days will be forwarded to a collection agency, which will have additional charges added to your account.
11. If you participate with a high deductible health plan, we require a copy of the health savings account debit/credit card or a person credit card remain on file. There are addenda to this financial policy, which are signed separately.
12. **We require 24 hour notice for canceling any appointments. If failed to cancel appointment and no show, there will be a $20 no show fee.**
13. A $30 fee will be charged for any checks returned for insufficient funds, plus any bank fee incurred.
14. We charge $1 per page to copy medical records for personal use.
15. If your child has school, camp, or sport forms to be completed, there is a $25 charge per form.
16. Advance notice is needed for all non- emergent referrals, typically 3-5 business day. It is your responsibility to know if a selected specialist participates in your plan. Remember your primary care physician must approve referrals before being used. ALL MEDICAL RECORD REQUEST REQUIRE 24/48 HOURS NOTICE.
17. Before making an annual physician appointment, check with your insurance company whether the visit will be covered as a well visit. Not all plans cover annual well physician visit, hearing, and vision screenings. It is your responsibility to know your insurance plan benefits. If it is not covered, you will be responsible for payment at the time of service.
18. Not all services provided by our office are covered by every plan. Any service determined to not be covered by your plan will be your responsibility.

I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient name(s)_____

Responsible Party Member's Name _____ **Relationship** _____

Responsible Party's Signature/ Date _____ __/__/____

Family Health of Hartselle

1006 Hill Street SW
Hartselle, Alabama 35640
256-773-9756

Patient's Authorization to Release Medical Information

I understand that my family members, friends, and co-workers may ask questions about my medical condition over the telephone or in person. I also understand it is a breech of physician-patient confidentiality for my doctor to discuss my medical information in any way with anyone without my expressed written consent. By signing this form I am designating the parties below with whom I wish Family Health of Hartselle to be able to discuss my medical condition.

I understand this form will be updated every calendar year. If I change my mind regarding the release of information to any of the listed people, it is my responsibility to inform Family Health of Hartselle in writing of my decision.

In accordance with the above, I _____, hereby authorize Family Health of Hartselle to discuss with and release my medical information to the following individuals:

_____ _____

_____ _____

Notify in case of Emergency

_____

_____

The below individuals are authorized to pick up any prescriptions, medications samples, or medical papers on my behalf:

_____ _____

_____ _____

Furthermore, I understand that if there is any information in my medical record I do not want discussed with or released to the above, I must designate it here by stating what information is to be excluded.

_____ _____

_____ _____

Patient's signature: _____

Date: _____

Witness: _____

Family Health of Hartselle
K. Eric Mashburn, M.D.
Mary Virginia Halbrooks, NP
1006 Hill Street SW
Hartselle, Alabama 35640
Phone: 256-773-9756
Fax: 256-773-9401

DO NOT FAX MORE THAN 20 PAGES

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I authorize the use or disclosure of my protected health information as describes. I understand that the information I authorize a person or entity to receive may be re-disclosed and is no longer protected by federal privacy regulations. I understand that Family Health of Hartselle cannot be held responsible for this action.

Patient Name: _____

Date of Birth: _____

Sex: M / F Social Security Number: _____/_____/_____

Address: _____

Phone Number: _____

Name of Physician or Facility to release records TO _____ FROM _____

_____

Address: _____

Phone: _____ Fax: _____

I authorize the release of my patient chart, including all medical information on me as well as surgical information, recent progress notes, labs and x-ray report.

Reason for release of records:

_____

I understand that the information in my health records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services for alcohol and drug use. I understand that the authorizing of the disclosure is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand the physician has the right to postpone treatment of long-term illnesses prior to reviewing records. I understand I have the right to inspect the health information provided. I understand that I may revoke the release of confidential health information in writing. I agree that my health information may be distributed by mail or fax.

Signature of Patient/ Representative: _____ Date: _____

Relationship to Patient: _____

Witness: _____ Date: _____

Family Health of Hartselle
K. Eric Mashburn, M.D.
Mary Virginia Halbrooks
1006 Hill Street SW
Hartselle, Alabama 35640
Phone: 256-773-9756
Fax: 256-773-9401

FAMILY HEALTH of HARTSELLE

Patient's Authorization for Communication

Family Health of Hartselle has requested my consent to communicate through their EHR program to notify me with information regarding my healthcare:

____Text

____ Voice- mail message

____ Email

____ Telephone

Patient Signature: _____

Date: _____

Witness: _____