COMPREHENSIVE PRIMARY AND URGENT CARE

707 West Market Street, Athens, AL 35611
Phone: (256)444-1815, Fax: (256)444-0385

PATIENTS REGISTRATION FORM

Last Name: _____First Name: _____

DOB: ___/___/___ Social #: ___-___-____ Sex (F/M) Marital Status (S, M, D, W)

Address: _____City: _____ State: ____ Zip Code: _____

Cell Phone: _____ Home #: _____Work#: _____

Email (**REQUIRED FOR LAB TESTING**): _____

EMERGENCY CONTACT

Name: _____

Phone#: _____ Relation to patient: _____

INSURANCE INFORMATION

Primary Insurance Name: _____ Policy ID: _____

Insured's Name: _____ DOB: ___/___/___

Secondary Insurance Name: _____ Policy ID: _____

Insured's Name: _____ DOB: ___/___/___

EMPLOYER INFORMATION

Employers Name: _____ Name of Business: _____

Work#: _____ EXT: _____

Address: _____City: _____ State: _____ Zip Code: _____

Please Read and Sign Below

I authorize any holder of medical or other information about me to release to my insurance company or the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment or medical insurance benefit to my physician. Regulation pertaining to medical assignment or that which is above the usual and customary as determined by my insurance company. I also voluntarily consent to treatment for myself or my child from the physician and his/her staff.

Signature: _____ Date: ___/___/___

Pharmacy Name: _____ Phone: _____

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HIPAA PRIVACY AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

Many of our patients allow family member such as their spouse, parents or other to call and request medical or billing information. Under the requirement of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released or discussed to family members or to others, please do so by indicating and signing below. I, _____authorize Comprehensive Primary and Urgent Care to release my medical and/or billing information to the following individual(s).

1._____ Relation to patient_____

2. _____ Relation to patient _____

3. _____ Relation to patient _____

I understand I have the right to revoke this authorization at any time and that I also have the right to inspect or copy the protected health information to be disclosed. I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient. You have the right to revoke this consent in writing.

Patients Signature or personal representative: _____

Relation to the patient: _____

Date: _____

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Statement of Financial Responsibility

Patient: _____ DOB: _____

CPAUC appreciates the confidence you have shown in choosing us to provide for your healthcare needs. The service you have elected to participate implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for your bill.

You are responsible for payment of your deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at the time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered by insurer. If your insurance company denies any part of your claim, or if your physician elects to continue past your approved period, you will be responsible for your balance in full. For every 30 days a balance is not paid after the first statement is given, a $15- non- payment fee will apply. After 90 days 40% collection fee will be add it and the account will be sent to a collection agency.

I have read the above policy regarding my financial responsibility to **CPAUC**, for providing service o me or the above name patient. I authorize my insurer to pay my benefits directly to **CPAUC**, the full entire amount of bill incurred by me or the above name patient; or, if applicable any amount due after payment has been made by my insurer.

Patient/Guarantor Signature:_____ Date_____

Self-Pay without Insurance

I do not have health insurance and will be responsible for the services rendered here at **CPAUC**. I agree to pay **CPAUC** the full entire amount of treatment give to me or the above name patient at each visit.

Patient/Guarantor Signature: _____ Date: _____

Pay with Insurance/Medicaid

I freely choose to bill my insurance for services rendered at **CPAUC**.

Patient/Guarantor Signature: _____ Date: _____

Motor Vehicle or Workman's Compensation Insurance

I request my claims be submitted to my motor vehicle/workman's compensation insurance carrier, I understand I will be responsible for bills incurred by me in the event my motor vehicle/workman's compensation insurance benefit exhausts or denies.

Patient/Guarantor Signature: _____ Date: _____

Consent for Treatment and Authorization to Release Information

I hereby authorize **CPAUC,** through its appropriate personnel, to perform or have performed on me, or the above name patient appropriate assessment and treatment procedures. I further authorize **CPAUC**, to release to the appropriate agencies any information acquired in the course of my or the above name patient's examination and treatment

Patient/Guarantor Signature: _____ Date: _____

YOUR HEALTH INFORMACION PRIVACY RIGHTS

Most of us feel that our health information is private and should be protected. That is why there is a federal law that rules for health care provider and health insurance companies about who can look and receive our health information. This law, called Health Insurance Portability and Accountability Act of 1996 (HIPPA), gives you rights over your health information including the right to get a copy of your information, make sure it is correct and known who has it.

Get It.
You can ask to see or get a copy of your medical record and other health information. If you want a copy, you may have to put your request in writing and pay pro the cost of copying and mailing. In most cases, your copies must be given to you within 30 days.

Check It.
You can ask to change any wrong information in your file or add information to your file if you think something is missing or incomplete. For example, if you and your hospital agree that your file has the wrong results for a test, the hospital must change it. Even if the hospital believes the test results is correct, you still have the right to have disagreement noted in your file. In most cases, the record should be updated within 60 days.

Know Who Has Seen It.
By law, your health information can be used and shared by specific reasons not directly related to your care, like making sure doctors give good care, making sure nursing homes are clean and safe, reporting when is in your area or reporting as required by state or federal law. In many of these cases, you can find out who has seen your health information. You can:

- Learn how your health information is used and shared by your doctor or health insurer. Generally, your health information cannot be used for purposes not directly related to your care without your permission. For example, you doctor cannot give it to your employer, or share it for things like marketing and advertising, without your written authorization. You probably received a notice telling you how your health information may be used on your first visit to a new health care provider or when you got a new health insurance, but you can ask for another copy anytime.

- Let your providers or health insurance companies know if there is information you do not want to share. You can ask that your health information not be shared with certain people, groups or companies. If you go to a clinic, for example, you can ask the doctor not to share your medical records with other doctors or nurses at the clinic. You can ask for other kinds of restrictions, but they do not always have to agree to do what you ask, particularly if it could affect your care. Finally, you can also ask your health care provider or pharmacy no to tell your health insurance company about care you receive or drugs you take, if you pay for the care of drugs in full and the Provider or pharmacy does not need to get paid by your insurance company.

- Ask to be reached somewhere other than home. You can make reasonable requests to be contacted at any different places or in a different way. For example, you can ask to have nurse call you at your office instead of your home or to send mail to you in an envelop instead of on a postcard.

If you think your rights are being denied or your health information is not being protected, you have the right to file a complaint with your provider, health insurer, or the U.S. Department of Health and Human Services.

To learn more, visit www.hhs.gov/ocr/privacy/

_____
Patients signature

Office For Civil Rights
US. Department of Health & Human Services

ADULT HEALTH HISTORY

Name: _____ DOB: ___/___/___ Age:_____ Sex: (F/M)

What is the reason for your visit today?: _____
_____

Have you been hospitalized? Yes/ No, if yes explain why: _____
_____

List all of your previous surgeries: _____
_____
_____

When was your last tetanus shot? _____ Not sure Don't remember

Have you had a TB test done? If so, when was it_____ Negative/Positive

Are you allergic to any medication? If yes, what? _____

Please list all of your medical problems:

1._____ 4._____
2._____ 5._____
3. _____ 6._____

Current Medications: (Please list all the medications that you are currently taking)

Medicine	**Dose (mg/mcg)**	**Directions**

Family History
Have any of your relative had (list the family members and the age diagnosed)

Alcoholism_____ High Blood Pressure_____ Stroke _____
Arthritis _____ High Cholesterol _____ Suicide _____
Asthma _____Mental Illness _____TB _____
Breast Cancer _____ Obesity _____Other _____
Colon Cancer _____ Migraine _____
Diabetes _____ Osteoporosis _____
Glaucoma _____ Ulcers Disease_____
Hay Fever _____ Ovarian Cancer _____
Heart Disease _____Prostate Cancer _____

GYN History

# of pregnancy___ #of vaginal delivery ___# of C-Section ___# of miscarriages___
# of termination ___

Menstrual History

Date of last Menstrual Period: ___/___/___ Date of Last Pap Smear: ___/___/__

Frequency of Periods _____ Self Breast Exam: YES/ NO

Birth Control Method: _____ Date of Last Mammogram: __/__/__

Social History

Marital Status ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Are you sexually active? ☐Yes ☐No

Do you smoke? If Yes, what and how often: _____

Do you drink? If Yes, what and how often: _____

Do you drink coffee? Tea? Or Pop sodas? If Yes, what and how often: _____

_____

Do you exercise? If Yes, how often: _____

Occupational History

Employer Status: ☐Working ☐Unemployed ☐Retired ☐Disabled ☐Student ☐Other

Starting with your most recent job, list the type of work you have done

Type of work	Number of Years	Exposure
1._____	_____	☐Fumes & Dust ☐Coal or Abestos
2. _____	_____	☐Radiation ☐Lead or Mercury
3. _____	_____	☐Heavy Lifting ☐Other:_____
		_____