



ALMC PATIENT INFORMATION FORM/FACESHEET

Patient Information Name _____ Also Known As _____

SSN _____ Date of Birth _____ Sex • Male • Female

Marital Status: • Single • Married • Divorced • Widowed • Separated Preferred Language _____

<p>Patient Race: Race – a human population considered distinct based on physical characteristics:</p> <p><input type="checkbox"/> American Indian Alaska Native</p> <p><input type="checkbox"/> Asian Black or African American</p> <p><input type="checkbox"/> White Native Hawaiian or Other Pacific Islander</p>	<p>Ethnicity: Ethnicity a term which represents social groups with a shared history, sense of identity, geography and cultural roots which may occur despite racial difference.</p> <p><input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino</p> <hr/> <p>Religion _____</p>
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Home Address: _____

City, St _____ County _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work/Other Phone _____

Employment Status _____ Email _____

Employer Name _____ Employer Phone Number _____

Employer Address _____

Employer City, St _____ Zip Code _____

Primary Physician _____ Primary Physician Phone _____

Preferred Pharmacy _____ Pharmacy Phone _____

Pharmacy Address, City, St, Zip _____

Parent/Guardian(s) or Spouse Information

Name _____

Relationship to Patient _____ SSN _____ Date of Birth _____

Address (If Different) _____ Zip Code _____

Employer _____ Employer Phone Number _____

Employer Address _____ Zip Code _____

Home Phone _____ Cell Phone _____ Email _____

Continued on back, please complete and sign



Patient Name: _____ Patient DOB _____

Emergency Contact (someone other than a parent and who does not live with the patient or a parent)

Name _____ Relationship _____ Phone _____

Parent/Guardian #2

Name _____

Relationship to Patient _____ SSN _____ Date of Birth _____

Address (If Different) _____ Zip Code _____

Employer _____ Employer Phone Number _____

Employer Address _____ Zip Code _____

Home Phone _____ **Cell Phone** _____ **Email** _____

Medical Insurance Info.	Primary Insurance	Secondary Insurance
Subscriber ID		
Group or Plan Number		
Plan/Program Code		
Insurance Co. Name		
Insurance Co. Phone Number		
Patient Relation to Subscriber		
Subscriber Name		
Subscriber Street Address		
Subscriber City and State		
Subscriber Zip Code		
Subscriber Date of Birth		
Subscriber Sex		
Subscriber Social Security #		
Subscriber Employer		
Co-pay Amount		

Patient/Parent/Legal Guardian/Legal Authorized Representative Signature

Date

If Parent/Legal Guardian/Legal Authorized Representative, Print Name



ALMC HEALTH INFORMATION FORM

Name _____ Date of Birth: _____

PLEASE LIST ALL medications, supplements / vitamins and over-the-counter-medications you are currently taking:

PLEASE LIST ALL allergies to medications, food and/or latex:

Please check conditions you have had in the past:

AIDS	Lupus	HIV Positive	Polio
Appendicitis	Diabetes Type 1 Type 2	Kidney Disease	Prostate Problem
Arthritis	Emphysema / COPD	Liver Disease	Rheumatic Fever
Asthma	Epilepsy / Seizures	Scarlet Fever	Bleeding Disorders
Stroke	Chicken Pox or Shingles	Breast Lump	Migraine Headaches
Cancer	Glaucoma or Cataracts	Heart Disease	Multiple Sclerosis
Skin Cancer	Thyroid Problems	Tuberculosis	Raynaud's Disease
Ulcers	Hepatitis A / B / C (circle one)	Herpes	Pacemaker
Bipolar	Alcohol or Drug Abuse	Pneumonia	High Blood Pressure
Reflux	Depression / Anxiety	High Cholesterol	Sexually Transmitted Diseases

HOSPITALIZATIONS / SURGERIES / FRACTURES

Year	Diagnosis / Issue

Dates for last: Tetanus Shot _____ Pneumonia Vax _____ Shingles Vax _____ Flu Vax _____

Family History: M-Mother, F-Father, S-Sister, B-Brother,C-Child. Please circle appropriate letter in boxes below

Diabetes: F/ M/ B/ S/ C	Stroke: F/ M/ B/ S/ C	Tuberculosis: F/ M/ B/ S/ C	Kidney Disease: F/ M/ B/ S/ C
Emphysema: F/ M/ B/ S/ C	Hypertension: F/ M/ B/ S/ C	Mental Illness: F/ M/ B/ S/ C	Cancer: F/ M/ B/ S/ C

Continued on back, please complete and sign

Check Symptoms you currently have or have had recently within the past 6 months:

General	Gastrointestinal	Eye / Ear / Nose / Throat	Women ONLY
<input type="checkbox"/> Chills	<input type="checkbox"/> Poor Appetite	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Extreme Menstrual Pain
<input type="checkbox"/> Fever	<input type="checkbox"/> Stomach Pain	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Bleeding between Periods
<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Bloating	<input type="checkbox"/> Vision Flashes / Halos	<input type="checkbox"/> Abnormal Pap Smear
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Dry Eyes	<input type="checkbox"/> Painful Intercourse
<input type="checkbox"/> Forgetfulness	<input type="checkbox"/> Vomiting Blood	<input type="checkbox"/> Itchy Eyes	<input type="checkbox"/> Vaginal Discharge
<input type="checkbox"/> Sleep Issues	<input type="checkbox"/> Nausea	<input type="checkbox"/> Earache / Ear Discharge	<input type="checkbox"/> Nipple Discharge
<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Indigestion / Heartburn	<input type="checkbox"/> Loss of Hearing	<input type="checkbox"/> Breast Lump
<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Bowel Changes	<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Hot Flashes
<input type="checkbox"/> Excess Thirst	<input type="checkbox"/> Constipation	<input type="checkbox"/> Sinus Problems	Date of Last Menstrual Period
Muscular / Bone / Joints	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Nosebleeds	Date of Last Pap Smear
<input type="checkbox"/> Leg Cramps	<input type="checkbox"/> Excess Gas	<input type="checkbox"/> Hayfever / Allergies	Date of Last Mammogram
<input type="checkbox"/> Back Pain	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Are you Pregnant? Yes No
<input type="checkbox"/> Muscle Pain	<input type="checkbox"/> Blood in Stool	<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Number of pregnancies _____
<input type="checkbox"/> Joint Pain	Cardiovascular	<input type="checkbox"/> Difficulty Swallowing	Mental Health
<input type="checkbox"/> Joint Swelling	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Bleeding Gums	<input type="checkbox"/> Depression
Other: _____	<input type="checkbox"/> High / Low Blood Pressure	Skin & Nails	<input type="checkbox"/> Anxiety
Urinary	<input type="checkbox"/> Irregular / Rapid Heart Rate	<input type="checkbox"/> Easy Bruising	<input type="checkbox"/> Thoughts of Suicide
<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Poor Circulation	<input type="checkbox"/> Easy Bleeding	<input type="checkbox"/> Alcohol Abuse
<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Swelling of Lower Legs	<input type="checkbox"/> Rash	<input type="checkbox"/> Substance Abuse
<input type="checkbox"/> Lack of Bladder Control	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Hives	<input type="checkbox"/> Thoughts of hurting yourself
<input type="checkbox"/> Painful Urination	<input type="checkbox"/> Calf Pain with Walking	<input type="checkbox"/> Abnormal Scarring / Keloids	Pulmonary
Neuro		<input type="checkbox"/> Sores that Won't Heal	<input type="checkbox"/> Coughing up Blood
<input type="checkbox"/> Headache		<input type="checkbox"/> Change in Moles	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Dizziness		<input type="checkbox"/> Acne	<input type="checkbox"/> Cough
<input type="checkbox"/> Fainting		<input type="checkbox"/> In-Grown Toe Nails	<input type="checkbox"/> Shortness of Breath w/Exertion
<input type="checkbox"/> Seizures		<input type="checkbox"/> Fungal Infections	<input type="checkbox"/> Snoring
<input type="checkbox"/> Numbness/ <input type="checkbox"/> Tingling			<input type="checkbox"/> Wheezing

Tobacco Use: • Yes • No How much? _____ per day/ week / month **Desire to Quit?** • Yes • No • Maybe	Alcohol Use: • Yes • No How many drinks? _____ per day/ week / month	Caffeine Use: • Yes • No How many drinks? _____ per day/ week / month	Exercise: • Yes • No How many times? _____ per day/ week / month
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Signatures

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ Date: _____

Reviewed by: _____ Date: _____



ALMC AUTHORIZATION FORM

PATIENT NAME: _____ Date of Birth: _____

Payment. I authorize Abundant Life Medical Clinic (ALMC) to submit claims on my behalf directly to Medicare/Medicaid/my private health insurance carrier. This means that ALMC will direct payment for supplies and services provided. I understand that I am financially responsible to the provider(s) for the charges not paid or payable. I authorize you to release any information necessary to insurance carriers regarding illnesses and treatment to process claims.

Initials: _____

Consent for Treatment. I consent for ALMC to administer treatments, tests and/or diagnostic tests to treat my/the patient's injury/illness on an outpatient basis. I acknowledge there is no guarantee as to the outcome of any treatment I/the patient receives. In compliance with state law, as part of the care to be given a test may be performed for human immunodeficiency virus infection (HIV/AIDS), hepatitis, or other blood-borne infectious or communicable diseases if the doctor, APRN, or Physician Assistant orders the test for diagnostic purposes because of my/the patient's medical history, symptoms, or conditions.

Initials: _____

Electronic Prescription. I understand ALMC utilizes electronic prescribing technology and participates with Practice Fusion. Practice Fusion provides prescription data on any medications, known as medication history, which are prescribed to me/the patient.

Initials: _____

Cell Phone Calls. As a service to our patients, we provide a courtesy appointment reminder call and possibly other important calls that may be placed using a prerecorded message. By providing your cell phone number, you consent to receiving such calls at this number.

Name	Date of Birth	Relationship	Phone

Involvement of Others in Care. I authorize ALMC to provide and discuss my/the patient's care and medical needs with the following persons:

Patient Rights and Responsibilities

I acknowledge receipt of the Patient Rights and Responsibilities _____ Declined _____

Notice of Privacy Practices

I acknowledge receipt of the Notice of Privacy Practices _____ Declined _____

Minor Patient Photograph

I consent for ALMC to photograph the patient for identification purposes only _____ Declined _____

Patient/Parent/Legal Guardian/Legal Authorized Representative Signature

Date

If Parent/Legal Guardian/Legal Authorized Representative, Print Name _____



ALMC OFFICE ACKNOWLEDGEMENT AND POLICIES CONSENT FORM

1. I am aware of the policy regarding diagnostic tests. Abundant Life Medical Care, PC (ALMC) will attempt to inform me of the results within 14 days. If I have not received a call or notification by mail in 14 days, it is my responsibility to contact the office. **I WILL NOT** assume that results are normal if I have not heard from the office.
2. If I need to cancel or reschedule an appointment I will do so **24 hours in advance**.
3. Please arrive **15 minutes** early to your appointment. If I arrive late, I may be asked to reschedule or wait until scheduled patients have been seen.
4. I understand that all co-payments and account balances are due at the time of service.
5. I understand that I will be charged **\$25** for any returned checks.
6. I am aware that medications will be filled **only during regular office**. Please allow 48-72 hours for refills to be processed.
7. I agree to turn off or silence my cell phone while in the office.
8. I will bring **all of my medication in its original bottle** to every visit.
9. I understand that **no narcotic pain medication will be prescribed**.

By signing below, I acknowledge that I have been informed of these policies.

Patient or Guardian Signature

____/____/____
Patient Date of Birth

Today's Date

I, the undersigned, certify that I (or my dependent) have the insurance coverage on record at ALMC and assign these benefits directly to ALMC. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the release of and the use of my signature on all insurance submissions. In Medicare assigned cases, the physician agrees to accept the charge determination of the carrier as full charge, and the patient is responsible for the deductible, coinsurance, and non-covered services. Coinsurance and deductibles are based upon the charge determination of the Medicare carrier.

PRINT Name of Patient

Signature of Patient, Parent, or Guardian

Relationship to Patient

Date



Phone: 334-624-2553

Fax: 855-301-8116

GENERAL REQUEST FOR RELEASE OF MEDICAL RECORDS

To be used for release of information to the patient, whoever the patient designates release to, or to a provider of their choice; or to request the patient's records from another provider.

In order to release your/the patient's records, you must sign a request for release. This form must include the patient's name and date of birth. It is your responsibility to read this form in full and to ask any questions before the record is released. No phone call requests will be honored.

Designate Who You Want To Release Your Records:

Abundant Life Medical Care, PC (ALMC) Release Your Records

The following information explains our policy for releasing protected health information:

- Medical records will be released only to the patient or to whoever the patient designates them to be released to.
- Law office/attorney medical records requests must have valid patient authorization with the request.
- Please be prepared to show ID when picking up records in person. This is for the protection of your personal health information.
- Patient's legal representatives must provide appropriate documentation to demonstrate their legal status.
- HIV, STD, substance abuse, and psychiatric records are not released without specific separate authorization.
- Please allow up to 30 days for records stored off site; however, ALMC may take up to 60 days to process the request, if necessary.
- First copy provided free of charge.

Release Records to (provide information below): •Patient's Designee •Provider Office

Name _____ Phone _____ Fax: _____

Address _____
Street _____ City _____ State _____ Zip _____

Another Provider Release Your Records To ALMC

Provider Name _____ Phone _____ Fax: _____

Provider Address _____
Street _____ City _____ State _____ Zip _____

Patient Information, Signature, and Records Being Released:

Patient's Name (Please Print) Date of Birth SSN

Patient/Parent/Legal Guardian Signature Date

If Parent/Legal Guardian, Print Name _____

Records Being Released: Date Range From: _____ To _____

•Entire Chart •Labs •Office Notes •Other (Specify Below)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

**PLEASE REVIEW IT CAREFULLY
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US**

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you, or to family and friends you approve.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization : In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of PHI (Personal Health Information), or alternative means of communication to ensure privacy.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law or national security activities.

Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (Such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. If you request copies, we will charge you a reasonable fee to locate and copy your information, and postage if you want the copies mailed to you.

Amendment: You have the right to request that we amend your health information.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us with the U.S. Department of Health and Human Services. A Privacy/Contact Officer has been designated for this office. The Privacy Officer can be contacted by simply contacting the office and asking to speak to the Office Manager who serves as the Privacy Officer.