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**_______________________

Patient Race: Race – a human population considered distinct based on physical characteristics: ☐ American Indian Alaska Native ☐ Asian Black or African American ☐ White Native Hawaiian or Other Pacific Islander	**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. ☐ Hispanic or Latino ☐ Not Hispanic or Latino **Religion** ________________________________

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

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.

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

Name	Date of Birth	Relationship	Phone

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

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 ____________________

Address ____

Street City State Zip

Another Provider Release Your Records To ALMC

Provider Name ______________________________ Phone ____________________

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.