



South Baldwin Medical Group

at Orange Beach

LAST NAME: _____ FIRST NAME _____ MI _____

ADDRESS: _____ CITY _____ STATE _____ ZIP _____

HOME PHONE: _____ BUS PHONE _____ CELL PHONE _____

DATE OF BIRTH: _____ SOCIAL SECURITY # _____ MALE _____ FEMALE _____

CIRCLE ONE: SINGLE / MARRIED / DIVORCED / WIDOWED EMAIL ADDRESS _____

EMERGENCY CONTACT _____ PHONE _____ RELATIONSHIP _____

EMPLOYER NAME _____ OCCUPATION _____

EMPLOYER ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHARMACY NAME _____ TELEPHONE # _____

Patient Call Back Survey: Yes or No / Call: Home, Cell or Other: _____

Are you a member of SENIOR CIRCLE? Yes / No HEALTHY WOMAN? Yes / No
How did you hear about our clinic? Healthy Woman _____ Senior Circle _____ Physician Advertising _____
Hospital Advertising _____ Internet _____ Physician Referral _____ Insurance Referral _____
Family or Friend _____ Newspaper _____ Other, Please share your source _____

INSURANCE INFORMATION PRIMARY

INSURANCE COMPANY NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

ID# _____ GROUP # _____ CO-PAY _____

POLICY HOLDER _____ RELATION _____ DOB _____

SOCIAL SECURITY # _____ PHONE # _____

SECONDARY

INSURANCE COMPANY NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

ID# _____ GROUP # _____ CO-PAY _____

POLICY HOLDER _____ RELATION _____ DOB _____

SOCIAL SECURITY # _____ PHONE # _____

Who may we thank for referring you? _____

SIGNATURE _____ **DATE** _____

FINANCIAL AGREEMENTS
PLEASE INITIAL IF APPLIES TO PATIENT

_____ I **HAVE NO INSURANCE COVERAGE** I understand that I am responsible for payment of services rendered to myself or dependents at the time of service.

INSURANCE AUTHORIZATION AND ASSIGNMENT
PLEASE INITIAL ALL THREE

_____ I hereby authorize the **RELEASE OF ANY INFORMATION NECESSARY** to process insurance claims and request payment of benefits to be made for services rendered to my dependents or myself.

_____ I understand I am responsible **AT THE TIME OF SERVICE** for paying any required co-payment and/or deductible.

_____ Check with your insurance company to verify your eligibility; **WE BILL AS AN OFFICE VISIT.** Some insurance may require a referral from your primary care physician. .

MEDICARE/MEDIGAP
PLEASE INITIAL IF APPLIES TO PATIENT

FOR MEDICARE PATIENTS ONLY

_____ **MEDICARE NUMBER**

_____ I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Finance Administration or it's intermediaries or carriers 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 of medical insurance benefits either to myself or the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

MEDIGAP (Authorization Statement)

_____ **POLICY NUMBER**

_____ I authorize any holder of medical or other information about me to be released to process this Medigap claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to myself or to the party who accepts assignment.

I HAVE READ AND UNDERSTAND THE PAYMENT POLICY OF THIS OFFICE AND AGREE TO ABIDE BY THE SAID POLICY.

***** OTHER'S ALLOWED ACCESS TO MY MEDICAL RECORDS:** _____

SIGNATURE:

PATIENT/PARENT/GUARDIAN:

_____ **Date**

I will be paying by: _____ Check _____ Cash _____ MasterCard/Visa/Discover/American Express

There will be a \$30.00 charge on all returned checks.



at Orange Beach
PATIENT HEALTH QUESTIONNAIRE

A. Patient Information

Today's Date; _____ DOB: _____

Last Name _____ First Name _____

Marital Status: []Single []Married []Divorced []Common-law []Widow(er)

Number of Children _____ Occupation _____

What is your highest level of education? []High School []College []Post Graduate

Do you smoke? []Yes []No If so, how much a day? _____ Illicit Drug Use []Yes []No

On average, how many alcoholic drinks do you have over a one (1) week period? _____

B. Past Medical History

In the past have you ever had or is currently being treated for: (Please check all that apply)

- []Alcoholism []Depression []High cholesterol
[]Anemia []Diabetes []Lung disease
[]Angina []Heart disease []Stomach problems
[]Asthma []Heart attack []Seizures
[]Cancer []High blood pressure []Thyroid problems
[]Other _____

List any surgery you have had: _____

Have you had any difficulty with anesthesia? _____

ALLERGIES TO MEDICATIONS: _____

OTHER ALLERGIES: _____

List all your medications, strength and how often you take:

Table with 2 columns and 6 rows for listing medications, strength, and frequency.

C. Family History

Are there any diseases that run in your family (Check if applies):

Who carries the disease Father (F), Mother (M), Sibling(S) (Circle)

- []Alcoholism F, M, S []High Blood Pressure F, M, S []Alzheimer's F, M, S
[]Cancer F, M, S []Kidney Disease F, M, S Other: _____
[]Diabetes F, M, S []Liver Disease F, M, S
[]Heart attack F, M, S []Stroke F, M, S

Patient Consent for E-Prescribing (Electronic Prescribing)

I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

Parent, Patient's Signature or Authorized representative	Date	Time
Relationship to Patient	Interpreter, if utilized	
Witness' Signature		

1) **GENERAL CONSENT FOR TEST, TREATMENT AND SERVICES**

I hereby voluntarily consent for treatment. I permit the facility and its employees, physicians and others involved in my care to treatment in ways they judge to be beneficial to me. I understand that I have the right to ask questions and to receive information about my care and treatment, and the right to withdraw my consent for treatment or tests. I consent to examinations, blood tests (including blood tests for communicable diseases such as hepatitis and HIV/AIDS when healthcare personnel have been exposed to my blood and/or body fluids), laboratory and imaging procedures, medications, infusions, nursing care and other services or treatments rendered by my physician, consulting physicians and their associates and assistants, or rendered by Facility personnel under the instructions, orders or direction of such physician(s).

I agree and understand that no physicians, consulting physicians and their associates and Facility are responsible or liable for the acts or omissions of the aforementioned. Independent contractors who are not employed by the Facility may perform some services. I am aware that the practice of medicine is not an exact science and further understand that no guarantee has been or can be made as to the results of the treatments, care or examinations in the Facility.

2) **NURSING CARE**

The facility provides only routine care.

3) **PERSONAL VALUABLES**

I understand that the Facility does not maintain a safe for safekeeping of money and valuables, and the Facility shall not be liable for the loss or damage of any articles of personal property.

4) **ASSIGNMENT OF INSURANCE BENEFITS/PROMISE TO PAY**

I hereby assign and authorize payment directly to the facility, and to any facility-based physician, all insurance benefits, sick benefits, injury benefits due because of liability of a third-party or proceeds of all claims resulting from the liability of a third party, payable by any party, organization, et cetera, to or for the patient unless the account for this facility, outpatient visit or series of patient visits is paid in full completion of the services. If eligible for Medicare, I request Medicare services and benefits. I further agree that this assignment will not be withdrawn or voided at any time until the account is paid in full. I understand that I am responsible for any charges not covered by my insurance company.

I understand that I am obligated to pay the account of the Facility in accordance with the regular rates and terms of the Facility. If I fail to make payment when due and the account becomes delinquent or is turned over to a collection agency or an attorney for collection, I agree to pay all collection agency fees, court costs and attorney's fees. I also agree that any patient or guarantor overpayments on the above Facility visit may be applied directly to any delinquent account for which my guarantor or I is legally responsible at the time of the collection of the overpayment.

5) **WEAPON / EXPLOSIVES / DRUGS**

I understand and agree that if the Facility at any time believes there may be a weapon, explosive device, biohazard material, any type of illegal substance of drug, or any alcoholic beverage on my person or personal belongings, the Facility may conduct a search and confiscate any of the above items that are found, and dispose of them as it determines appropriate including delivery of any item to law enforcement authorities.

6) **NOTICE OF PRIVACY PRACTICES** [Required pursuant to Health Insurance Portability and Accountability Action of 1996 (HIPAA)]

I acknowledge that I have received a copy of the Facility's Notice of Privacy Practices that provides information about how the Facility may use and disclose my protected health information.

The undersigned certifies that he/she has read the foregoing, understands it, accepts its terms, has received a copy of it and is the patient or is duly authorized by the patient as their agent to execute the above.		
Patient's Signature or Legal Representative	Date	
Relationship to Patient	Interpreter, if utilized	
Witness Signature	If Telephone Consent, Second Witness Signature	
Conditions of Treatment and Consent to Medical Treatment ADM-1701GSR -- (10/06)		ADDRESSOGRAPH / PATIENT LABEL