**Hoover Family Medicine**
**Patient Registration**

**PATIENT INFORMATION (PLEASE PRINT)** **CHART NUMBER:**

SSN: Sex: ☐ Female ☐ Male Preferred Name:

Last Name: First Name: Middle Initial: Suffix:

Street Address: Apt:

City: State: ZIP: Birth Date:

Home Phone: Work Phone: Cell Phone: Other:

Cell carrier: ☐ Text Message Authorization for Appointment Reminders (subject to carrier data/messaging rates)

Email Address: ☐ Email Authorization for Appointment Reminders

Marital Status: Responsible Party: ☐Self ☐Parent ☐Guardian ☐Other:

Race: Primary Language: Ethnicity:

Preferred Contact Method: ☐ Phone Call ☐ Text Message ☐ Email ☐ Other:

Employment Status: ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Student ☐ Other:

**EMERGENCY CONTACT:**

Name: Phone: Relationship:

**RESPONSIBLE PARTY (IF NOT SELF):**

Last Name: First Name: Middle Initial: Suffix:

Street Address: Apt:

City: State: ZIP: Birth Date:

Home Phone: Work Phone: Cell Phone: Other:

**INSURANCE INFORMATION (FILL OUT ONLY IF YOU DO NOT HAVE THEM WITH YOU. IF YOU DO: LEAVE BLANK):**

**PRIMARY INSURANCE COVERAGE**
(ATTACH COPY HERE – FRONT & BACK)

Insurance Carrier:

ID/Policy Number:

Group Number:

Subscriber Name:

Subscriber DOB:

Relationship: □ Self □ Spouse □ Child □ Other:

**SECONDARY INSURANCE COVERAGE**
(ATTACH COPY HERE – FRONT & BACK)

Insurance Carrier:

ID/Policy Number:

Group Number:

Subscriber Name:

Subscriber DOB:

Relationship: □ Self □ Spouse □ Child □ Other:

**A. Consent to Treatment**

I authorize the physician at Hoover Family Medicine and other healthcare providers under the direction of the physician to provide reasonable and proper medical care by today's standards. I understand that no guarantee has or will be made to me regarding any possible result or cure based on my examination and/or treatment.

_____ Initials

**B. Assignment of Benefits**

I hereby assign all insurance benefits provided by my insurance company directly to Hoover Family Medicine.

_____ Initials

**C. Payment Policy**

I understand that I am fully responsible for all charges incurred during care and treatment, regardless of any insurance benefits I may have. I also understand that insurance claims filed by this office for services rendered are being filed strictly as a courtesy to me, and in no way releases me of my financial obligation to this office. If my insurance company does not pay the claim within 60 days, I will be fully responsible for the payment. I will provide all necessary assistance to the office to have my claim paid by my insurance company. I understand that if my account balance remains unpaid for a period of 90 days that Hoover Family Medicine retains the right to institute whatever methods necessary to collect the unpaid balance. As the patient and/or guarantor, I will be responsible for any collection fees, attorney fees, court costs and other expenses incurred in the collection of the unpaid balance. Furthermore, I waive all rights of exemption under the laws of the State of Alabama and any other state.

_____ Initials

**D. Notice of Privacy Practices**

I acknowledge receipt of the current version of the "Notice of Privacy Practices" of Hoover Family Medicine, which describes how my Private Health Information (PHI) may be used.

_____ Initials

**E. Authorization for Disclosure of PHI**

I specifically authorize the following persons to receive my protected health information:

| ☐ Spouse (enter their information below) | ☐ Child (enter their information below) | ☐ Other Relation: _____ (enter their information below) |
|---|---|---|
| Name: _____ | Name: _____ | Name: _____ |
| SSN: _____ | SSN: _____ | SSN: _____ |

**PATIENT DRIVERS LICENSE/IDENTIFICATION (FILL OUT ONLY IF YOU DO NOT HAVE IT WITH YOU. IF YOU DO: LEAVE BLANK):**

**PATIENT DRIVER LICENSE/IDENTIFICATION**
(ATTACH COPY HERE)

State/Country: _____
DL Number: _____
Passport ID: _____
Expiration Date: _____

_____ _____
Patient Signature Date

**OR (IF PATIENT IS A MINOR):**

_____ _____
Responsible Party Signature Date

_____ _____
Printed Name of Responsible Party Date

## MEDICAL HISTORY AND SCREENING FORM

Name: _____ Birth Date: _____ Date: _____

May I send a copy of your consultation to your other physicians or primary health care provider and consult with them as necessary?

□ Yes □ No Physician Name: _____ Phone: _____ Patient Initials: _____

Marital Status: _____ Sex: □ Female □ Male Occupation: _____

### Present Medical History

Comments: _____

Date: Last Colonoscopy: _____ □ Normal

Date: Last Eye Exam: _____ □ Normal

Date: Last Physical Exam: _____ □ Normal

Date: Chest X-ray: _____ □ Normal

Date: Last Dental Visit: _____ □ Normal

Date: Last (EKG or ECG): _____ □ Normal

Date: Last Pap Smear: _____ □ Normal

Date: Last Mammogram: _____ □ Normal

**List any Prescription Medications & dietary supplements or vitamins you are currently taking:**

1. Medication: _____ Dose: _____ Times/day: ___ Prescribing Doctor: _____
2. Medication: _____ Dose: _____ Times/day: ___ Prescribing Doctor: _____
3. Medication: _____ Dose: _____ Times/day: ___ Prescribing Doctor: _____
4. Medication: _____ Dose: _____ Times/day: ___ Prescribing Doctor: _____
5. Medication: _____ Dose: _____ Times/day: ___ Prescribing Doctor: _____
6. Medication: _____ Dose: _____ Times/day: ___ Prescribing Doctor: _____
7. Medication: _____ Dose: _____ Times/day: ___ Prescribing Doctor: _____
8. Medication: _____ Dose: _____ Times/day: ___ Prescribing Doctor: _____
9. Medication: _____ Dose: _____ Times/day: ___ Prescribing Doctor: _____
10. Medication: _____ Dose: _____ Times/day: ___ Prescribing Doctor: _____

**List any drug allergies:**

Medication: _____ Reaction: _____ Medication: _____ Reaction: _____

Medication: _____ Reaction: _____ Medication: _____ Reaction: _____

Medication: _____ Reaction: _____ Medication: _____ Reaction: _____

**List Hospitalizations or Surgeries:**

_____

_____

_____

**Dates and reasons for Hospitalization or Surgeries:**

_____

_____

_____

**Immunization History:**

Hepatitis B Vaccine: □ Yes Date: _____ □ No

Pneumococcal Vaccine: □ Yes Date: _____ □ No

Influenza B Vaccine: □ Yes Date: _____ □ No

Tetanus Booster: □ Yes Date: _____ □ No

Zoster Vaccine: □ Yes Date: _____ □ No

Tuberculosis Vaccine: □ Yes Date: _____ □ No

**Sexual History:**
Sexually Active: □ Yes □ No Children: □ Yes, how many: ____ □ No
What kind of protection/method do you or your partner use? (Condoms, Oral Birth Control, Injection, IUD, None): _____

**Social History:** Organ donor? □ Yes □ No Religious Beliefs: _____ Alcohol Use: □ Yes □ No □ Occasional
Smoke: □ Yes □ No How many cig/day: _____ Starting Age _____ Quit Smoking: □ Yes When: _____

**Women's Pregnancy History:**
Total # of Pregnancies: _____ Number of Abortions: _____ Number of Tubal Pregnancies: _____
Number of Miscarriages: _____ Premature Births: _____ How many living children: _____

**Women's Health:** First day of your last Menstrual Period _____ History of Abnormal Pap Smear: □ Yes □ No

**Men's Health:** Date: Last Prostate-Specific Antigen levels _____ Date: Last Rectal Exam-Prostate _____

## Past Medical History

Check those of which you have been diagnosed with previously (leave others blank).

□ Anemia
□ Arthritis: Where? _____ What type? _____
□ Asthma
□ Cancer: What Type? _____
□ Cardiovascular Disease
□ Cataracts
□ COPD
□ Diabetes: □ Type I □ Type II Last HgA1C: _____
□ Epilepsy or seizures
□ Glaucoma
□ Heart attack: When? _____
□ Heart murmur
□ Hepatitis C
□ HIV
□ Hyperlipidemia
□ Hypertension
□ Inflammatory Bowel Disease (IBD)
□ Irritable Bowel Syndrome (IBS)
□ Kidney Disease: What type? _____
□ Lupus
□ Migraines
□ Organ Transplant: What type? _____
□ Pneumonia
□ Psoriasis
□ Scoliosis
□ Sickle cell
□ STD What type? _____
□ Stroke
□ Substance Abuse What substance? _____
□ Thyroid Disease What type? _____
□ Ulcer What type? _____
□ Mental Health Conditions (circle below):
□ Schizophrenia □ Bipolar □ PTSD □ Anxiety
□ Depression □ ADD □ Autism □ _____
□ Other: _____
□ Other: _____

## Family Medical History

**Father:** □ Alive - Current Age: ____ □ Deceased - Age at death: _____ Medical Problems: _____

**Mother:** □ Alive - Current Age: ____ □ Deceased - Age at death: _____ Medical Problems: _____

Check the box if any of your **blood relatives** (including grandparents, aunts and uncles) have had any of the following. Indicate who and on which side of the family (exclude cousins, relatives by marriage and half-relatives):

□ Alcoholism _____
□ Anemia _____
□ Asthma _____
□ Autoimmune disease _____
□ Cancer _____
□ COPD _____
□ Elevated Cholesterol _____
□ Glaucoma _____
□ Heart attack _____
□ Heart disease _____
□ High blood pressure _____
□ HIV _____
□ Kidney Disease _____
□ Mental Health _____
□ Sickle cell _____
□ Stroke _____
□ Other: _____
□ Other: _____

# Hoover Family Medicine (HFM)

**Initial below each policy and sign/date the last page.**

**Patient Name:** _____

## General Medication Refills Policy

Hoover Family Medicine requires at least five business days notice for general medications to be refilled. Many of the medications given to you must be closely monitored for effectiveness and side effects. Depending on your condition, if you have not been seen by your practitioner within a specified time period, medications may be declined, or only be prescribed for 30 days to allow you time to schedule an appointment with your physician/practitioner. Please try not to run out of medication prior to requesting a refill. Ensuring that your medication refills are up-to-date at every clinic visit is the safest, most efficient way to ensure you do not run out of essential medications.

Medication may NOT be refilled after office hours or on the weekends. Prescriptions for medications that we have not previously prescribed for you will NOT be filled.

X _____ Initial (Signifying the understanding of HFM's General Medication Refills Policy)

## Paperwork Request Policy

Please allow 7-10 business days for completion of any paperwork. In certain situations, an additional office visit may be required for certain types of paperwork to be completed.

X _____ Initial (Signifying the understanding of HFM's Paperwork Request Policy)

## Referral Policy

Hoover Family Medicine often utilizes the use of specialty clinics. If you know of a specialty clinic you would like to be set up with please inform our staff before you leave the office. If you do not know of a specialty clinic you would like to go to, it is your responsibility to contact your insurance company and find an appropriate specialist. It is then your responsibility to contact us with the information so we can then send your referral. If you need to reschedule the appointment time we set up for you it is up to you to contact the specialty clinic to do so. Many insurance companies require the addition of specified tests and/or procedures before a referral can be made. An additional office visit may be required to ensure all requirements are met for individual policies. An employee may also contact you to gather additional information if required. Please allow 7-10 business days for a referral to be sent. Please keep in mind a referral may take additional time if further information is required.

X _____ Initial (Signifying the understanding of HFM's Referral Policy)

## Narcotics Policy

Our doctors and practitioners are committed to evaluating and treating pain at every visit. There are a multitude of options for treating pain including oral medications, physical therapy, exercise, relaxation techniques, use of heat and or cold, and acupuncture that we may prescribe or refer patients for. In most cases, treatment of the underlying medical condition will result in alleviation of pain. We offer conservative, narcotic-free treatment of chronic pain that is associated with numerous conditions. Our clinic is not set up for the management of chronic pain with narcotics or opioids. In accordance with recommendations by the *Federation of State Medical Boards*, we will direct those patients in need of the use of controlled substances to pain specialists and experts for further evaluation, treatment, and monitoring.

On some occasions, the use of narcotic medications may be an essential tool in the care of a patient. In accordance with the oversight of the *Alabama Medical Board* which governs safe and effective medical practices, our practices policies are as follows:

1. On a first new patient visit, no narcotics or other controlled substances will be prescribed in the absence of a clear, acute injury.
2. In the interest of safety, patients requiring chronic pain medications must agree to obtain medications from only one physician and one pharmacy.
3. Prescriptions will not be filled outside of normal business hours, and will be subject to our customary medication refill policies.
4. New prescriptions will not be written for lost or stolen prescriptions.
5. If all of the prescribed medication is taken prior to the refill date, then the refill request will be denied.
6. Chronic pain or pain beyond that which is normally expected for a specific condition that continues to require narcotic medication will be referred to a pain management clinic.

X _____ Initial (Signifying the understanding of HFM's Narcotics Policy)

**Signature:** _____ **Date:** _____

## Hoover Family Medicine

# NOTICE OF PRIVACY PRACTICES

## 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.

This Notice of Privacy Practices is being provided to you as a requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how Hoover Family Medicine (HFM) may use and disclose medical information about you to carry out treatment, payment for our health care services and for other health care operations or purposes that are permitted or required by law. It also describes your rights to access and control medical information about you. As a patient of HFM, one of the responsibilities you have entrusted to us is the protection of your personal medical information. **Our physicians and staff take this responsibility very seriously.**

The uses and disclosures listed below may be limited by Alabama Requirements described under Regulatory Requirements.

### Uses and Disclosures of Protected Health Information (PHI) for Treatment, Payment and Health Care Operations

The following describes the different ways that we (HFM) may use and disclose your PHI for treatment, payment and health care operations.

**For Treatment** – We may use PHI about you to provide you with medical treatment or services. For example, we may disclose your PHI to doctors, nurses, technicians, training doctors, or other health care professionals who are involved in taking care of you.
**For Payment** – We may use and disclose PHI about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may disclose your PHI to your insurance company so that they will pay for our services rendered to you.
**For Healthcare Operations** – We may use and disclose your PHI for health care operations. Some of these operations include the use or disclosure of your PHI for quality improvement, doctor/employee review activities, compliance, and the training of medical residents and other health care professionals, which includes preceptorships for health care affiliates. For example, we may compare the treatment you received to other similar episodes of care to ensure that HFM continues to provide the highest quality services.

### Business Associates

We may disclose PHI to "business associates", who perform services on behalf of our practice. Some examples of our business associates are transcription services, collection agency, and call answering service. Whenever an arrangement between our Practice and a business associate involves the use or disclosure of your PHI, we will have a written contract with that business associate that will protect your privacy.

### Uses and Disclosure of Protected Health Information (PHI) Based upon Your Written Authorization

Other uses and disclosures of PHI not covered by this notice or the laws that apply to our Practice (described below) will be made only with your written permission. If you provide us permission to use or disclose your PHI, you may revoke that permission, in writing, at any time. If you revoke your permission, thereafter we will no longer use or disclose PHI about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission.

### Uses and Disclosures That May Be Made With Your Agreement or Opportunity to Object

Unless you object, we may disclose some of your PHI to a family member, other relative, friend, or other persons you identify. We may also notify these people about your location and condition. When you are unable to agree or object, we may still disclose your PHI for these purposes in certain circumstances.

### Other Permitted and Required Uses and Disclosure That May Be Made Without Your Authorization

In addition to using and disclosing your PHI for treatment, payment and health care operations, we may use or disclose your PHI without your written authorization in the following situations:

- As required by law: We may use or disclose your PHI when required to do so by applicable law. For example, in certain circumstances, we may also disclose PHI to report about an individual that we reasonably believe to be a victim of abuse, neglect, or domestic violence.
- For public health purposes.
- For health oversight activities authorized by law: We may disclose your PHI to the government for oversight activities, such as audits, investigations, inspections, licensure and disciplinary actions, and other activities necessary for monitoring the health care system.
- For Workers' Compensation claims. (These programs provide benefits for work-related injuries or illnesses.)
- To a coroner, medical examiner or funeral director for the purpose of identifying a decedent, determining a cause of death, or as necessary to enable such parties to carry out their duties.
- For cadaveric organ, eye or tissue donations.
- For medical research purposes.
- To prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- For specialized government functions: In certain circumstances, we may use and disclose your PHI if you are a veteran or in the military. We may also disclose your PHI to authorized federal officials for intelligence and other national security activities, for the protection of the President or others, and for special investigations. If you are an inmate of a correctional institution or under custody of a law enforcement officer, we may disclose your PHI to the correctional facility or official in certain circumstances.

**Continued on Page 2**

**Communication**

We may use and disclose your PHI to contact you (by telephone or mail) and remind you of an appointment, or to inform you of treatment alternatives or other health-related benefits and services that may be of interest to you. We may be required to leave a message on your answering machine, when contacting you by telephone to remind you about an appointment, provide instructions prior to a diagnostic test or procedure, or to discuss payment. We may also use and disclose your PHI to encourage you to purchase or use a product or service through face-to-face communication or by giving you a promotional gift of nominal value.

**Your Rights Regarding Medical Information About You Right to Inspect and Copy**

You have the right to inspect and copy PHI that may be used to make decisions about your care. To inspect and copy PHI, you must submit your request in writing to our Privacy Officer. You will be notified when you record is ready to inspect or copies are completed. If you request a copy of the information, we will charge you a reasonable fee for the cost of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain circumstances.

**Right to Amend**

If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have a right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing to our Privacy Officer, and it must explain why you are requesting an amendment to your PHI. We may deny your request in certain circumstances. If this request is denied, HFM will send you a written letter supporting reason for denial.

**Right to an Accounting of Disclosures**

You have the right to request an "accounting of disclosure." This is a list of certain disclosures we have made of your PHI. You must submit your request in writing to our Privacy Officer. Your request must state a time period that may not be longer than six years and not include dates before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the cost but we will notify you of this charge before it is incurred to you.

**Right to Request Restrictions**

You have the right to request a restriction or limitation on the PHI we use or disclose. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to our Privacy Officer. In your request, you must tell us: 1) what information you want to limit; 2) whether you want to limit our use, disclosure or both; and, 3) to whom you want the limits to apply. **Any previous restrictions given verbally or written to a HFM employee are no longer valid and must be requested in the above manner.**

**Right to Request Confidential Communications**

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. To request confidential communications, you must make your request in writing to our Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. **Any previous requests given verbally or written to a HFM employee are no longer valid and must be requested in the above manner.**

**Right to a Paper Copy of This Notice**

Even if you agreed to receive this notice electronically, you have a right to request a paper copy by writing our Privacy Officer or asking for a copy at the reception/check-in desk at our HFM facility.

**Regulatory Requirements**

We are required by law to maintain the privacy of your medical information, and we must abide by the terms of this notice. (That is, the version that is currently in effect). We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for the medical information we already have about you, as well as any information we receive in the future. We will post a copy of the current notice, with the effective date listed in the bottom right hand corner of the last page. In addition to the privacy protections provided under federal law (which are described in this notice), Alabama law (referred to in this notice as the Alabama Requirements) requires us in certain situations to get your written consent (or, under some statutes or rules, written consent from your attorney, guardian, or upon court order) before we can use or disclose your information.
The Alabama Requirements may apply:

- If you qualify as a patient that suffers from a sexually transmitted disease;
- If you qualify as a patient that receives benefits from the State of Alabama for certain developmental disabilities or mental retardation;
- If you qualify as a patient that the Alabama Medicaid program has asked us to serve as a Case Management Service Provider for;
- If you qualify as a patient that receives rehabilitative services through the Alabama Medicaid program;
- If you qualify as a patient that receives certain benefits under the Alabama Medicaid's Preventive Health Education program.

**Complaints**

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services (or his or her designee). To file a complaint with HFM, contact our Privacy Officer at the address below. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

**If you have any questions about HFM's Notice of Privacy Practices, please contact the Privacy Officer listed below.**

**Privacy Officer**
**1575 Montgomery Highway** 3081 Lorna Road, Suite 101
**Birmingham, AL 35216**
**Facsimile: (205) 979-3726**
**Effective date: April 14, 2003**

**Hoover Family Medicine**
**Allergy Assessment**

Date of visit: _____

Name: _____ DOB: _____ Insurance: _____

Do you think you suffer from allergies? _____ Yes _____ No

Have you experienced the following symptoms in the past 60 days? (Circle all that apply)

| | | |
|---|---|---|
| Itching | Rash | Dry Skin |
| Nasal Congestion | Itchy Nose | Sensitivity to clothing or touch |
| Post Nasal Drip | Red/Itchy Eyes | Headaches |
| Runny Nose | Loss of taste/smell | Bad breath |
| Sneezing | Watery Eyes | Snoring |
| Coughing | Sinus Infections | Nosebleeds |
| Fatigue | Shortness of Breath | Discolored drainage |
| Wheezing | Symptoms with Exercise | Swelling |

Do you feel that you have increased sensitivity to the following? (Circle all that apply)

| | | |
|---|---|---|
| Dust | Cut grass/Raked leaves | Time of day: AM / PM |
| Fall pollen | Mold/Mildew | Home |
| Spring pollen | Mustiness/Dampness | Workplace |
| Dog | Indoors | Food: _____ |
| Cat | Outdoors | Rain |
| Feathers | Weather changes | Strong Odors |
| Smoke | Temperature changes | Other animals: _____ |
| Exercise | Heartburn | Sinus Infections |

My symptoms occur: (Circle one or both) Year-Round / Seasonally

| | | |
|---|---|---|
| Have you had a sinus x-ray or CT scan? | Yes | No |
| Are you currently taking any medications for allergy symptoms? | Yes | No |
| Have you ever been treated with allergy shots? | Yes | No |
| Do you suffer from asthma? | Yes | No |
| Do you have a history of anaphylaxis? | Yes | No |
| Are you currently taking any beta blockers? | Yes | No |
| Do you have cancer? | Yes | No |
| Are you pregnant? | Yes | No |