Moundville Medical Associates

PLEASE COMPLETE ALL INFORMATION BELOW:
Present your insurance cards and photo ID.

REASON FOR TODAY'S VISIT?_____
If the reason for today's visit is due to an accident, please list type of accident and date of occurrence:

_____

******Are you a HOSPICE patient? Yes or No If yes, Hospice Name**_____

Patient's Name: _____ Male or Female

Date of Birth: _____ Age: _____ Social Security Number:_____

Mailing Address:_____City:_____State:_____Zip:_____

Home Phone:_____ Cell Phone:_____Email:_____

Marital Status: () Married () Single () Divorced () Widowed **Race:** () Black () White () Other_____

Language: () English () Spanish () Other_____ **Ethnicity:** ()Non-Hispanic () Hispanic

Please Circle YES or NO: **Agriculture Worker:** YES or NO **Homeless:** YES or NO
School-based health center patient: YES or NO **Veteran:** YES or NO **Public Housing patient:** YES or NO

Employer: _____ Employer Phone: _____

Employer Address: _____

If Retired, Date of Retirement: _____ Are you disabled? () Yes () No Date:_____

Pharmacy of Choice? 0 Boone's 0 CVS-Greensboro 0 KC Drugs 0 Other_____

EMERGENCY CONTACT INFORMATION:

Name:_____ Relationship to Patient:_____ Phone Number:_____

PATIENT GUARANTOR:

Name:_____ Relationship to Patient:_____ Phone Number:_____

Cell Phone: _____ Date of Birth: _____ Social Security Number: _____

Address:_____

Patient Portal Authorized Representative:_____Email:_____

PRIMARY INSURANCE COVERAGE: (Examples: Medicare, Medicaid, HUMANA, Blue Cross & Blue Shield, Tricare, etc.)

Insurance Company_____ Contract #:_____ Group#_____

Policyholder Name_____ Date of Birth:_____ Effective Date:_____

Relationship of Patient to Policyholder_____

SECONDARY INSURANCE COVERAGE: (Examples: Medicare, Medicaid, HUMANA, Blue Cross & Blue Shield, Tricare, etc.)

Insurance Company_____ Contract #:_____ Group#_____

Policyholder Name_____ Date of Birth:_____ Effective Date:_____

Relationship of Patient to Policyholder_____

RELEASE OF RESPONSIBILITY FOR LEAVING AGAINST MEDICAL ADVICE/PRIOR TO TRIAGE/PRIOR TO MD VISIT:
I know that if I choose to leave the clinic without being evaluated, I may have undiagnosed diseases, illnesses, injuries, or life threatening condition which could worsen or even result in my death. Should I leave without being evaluated, I understand that I am doing so against medical advice and I accept full responsibility for my decision to leave the clinic and release Hale County Hospital Clinic and the Hale County Hospital Healthcare Authority, their employees, agents, and medical staff from any and all harm and damages which may arise as a result of my leaving.

PLEASE SIGN BELOW:

x_____ _____
Patient Or Authorized Representative & Relationship **Date**

INTERNAL MEDICINE HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Preferred Provider: ___ Dr. Rachel Rackard ___ Jamie Haney, CRNP ___Rachel Crawford, CRNP
___ Dr. Angela Smelley ___ First Available
Psychiatry ONLY: ____ Dr. Donna Davis ___ Dr. John Dorsey

Main reason for today's visit:_____
Other concerns:_____

ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

ALLERGY	REACTION
1._____	_____
2._____	_____
3._____	_____

MEDICATIONS

Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

DRUG NAME	STRENGTH	FREQUENCY TAKEN
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____
5._____	_____	_____
6._____	_____	_____

IMMUNIZATION HISTORY

Immunizations and most recent date:

( ) Chickenpox	Date:_____	( ) Meningococcus	Date:_____
( ) Flu Shot	Date:_____	( ) MMR *(Measles, Mumps, Rubella)*	Date:_____
( ) Gardasil/HPV	Date:_____	( ) Pneumonia	Date:_____
( ) Hepatitis A	Date:_____	( ) Tdap *(Tetanus and pertussis)*	Date:_____
( ) Hepatitis B	Date:_____	( ) Tetanus	Date:_____
( ) Covid Vaccine	Date:_____	( ) Shingrix *(Shingles)*	Date:_____
( ) _____	Date:_____		

PAST MEDICAL HISTORY

Please check all that apply:

( ) Anxiety Disorder
( ) Arthritis
( ) Asthma
( ) Bleeding Disorder
( ) Blood Clots (or DVT)
( ) Cancer
( ) Coronary Artery Disease
( ) COPD
( ) Diabetes - Insulin
( ) Diabetes - Non-Insulin
( ) Dialysis
( ) Diverticulitis
( ) Fibromyalgia
( ) Gout
( ) Has Pacemaker
( ) Heart Attack
( ) Heart Murmur
( ) Hiatal Hernia or Reflux Disease
( ) HIV or AIDS
( ) High Cholesterol
( ) High Blood Pressure
( ) Hypothyroidism
( ) Overactive Thyroid
( ) Kidney Disease
( ) Kidney Stones
( ) Leg/Foot Ulcers
( ) Liver Disease
( ) Osteoporosis
( ) Polio
( ) Pulmonary Embolism
( ) Reflux or Ulcers
( ) Stroke
( ) Tuberculosis
( ) Other _____

PAST SURGICAL HISTORY

SURGERY	REASON	YEAR	HOSPITAL
1. _____	_____	_____	_____
1. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

(WOMEN ONLY) OBSETRIC AND GYNECOLOGICAL HISTORY

Last PAP Smear Date _____ ( ) Abnormal
Last Mammogram Date _____ ( ) Abnormal
Age of first menstrual period: _____
Date of last menstrual period or age of menopause: _____
Number of pregnancies: _____ births: _____
miscarriages: _____ abortions: _____
( ) Cesarean sections If yes, then number: _____
( ) Sexually active
Current sexual partner is ( ) Female ( ) Male
Do you use condoms ( ) Yes ( ) No
Other Birth control method used: _____
( ) Interested in being screened for STD's

( ) Bleeding between periods
( ) Heavy periods
( ) Extreme menstrual pain
( ) Vaginal itching, burning, or discharge
( ) Wake in the night to go to the bathroom
( ) Hot flashes
( ) Breast lump or nipple discharge
( ) Painful intercourse

FAMILY HEALTH HISTORY

RELATION	ALIVE	AGE	SIGNIFICANT HEALTH PROBLEMS
Grandmother (maternal)	Y/N	____	□Alcoholism □Arthritis □Genetic Disease □Hypertension □Stroke □Depression □Diabetes □Heart Disease □Osteoporosis □Cancer
Grandfather (maternal)	Y/N	____	□Alcoholism □Arthritis □Genetic Disease □Hypertension □Stroke □Depression □Diabetes □Heart Disease □Osteoporosis □Cancer
Grandmother (paternal)	Y/N	____	□Alcoholism □Arthritis □Genetic Disease □Hypertension □Stroke □Depression □Diabetes □Heart Disease □Osteoporosis □Cancer
Grandfather (paternal)	Y/N	____	□Alcoholism □Arthritis □Genetic Disease □Hypertension □Stroke □Depression □Diabetes □Heart Disease □Osteoporosis □Cancer
Father	Y/N	____	□Alcoholism □Arthritis □Genetic Disease □Hypertension □Stroke □Depression □Diabetes □Heart Disease □Osteoporosis □Cancer
Mother	Y/N	____	□Alcoholism □Arthritis □Genetic Disease □Hypertension □Stroke □Depression □Diabetes □Heart Disease □Osteoporosis □Cancer
Brother/Sister	Y/N	____	□Alcoholism □Arthritis □Genetic Disease □Hypertension □Stroke □Depression □Diabetes □Heart Disease □Osteoporosis □Cancer
Brother/Sister	Y/N	____	□Alcoholism □Arthritis □Genetic Disease □Hypertension □Stroke □Depression □Diabetes □Heart Disease □Osteoporosis □Cancer
Other	Y/N	____	□Alcoholism □Arthritis □Genetic Disease □Hypertension □Stroke □Depression □Diabetes □Heart Disease □Osteoporosis □Cancer

SOCIAL HISTORY

Education

□ Less than 8th grade □ High School □ 2 year college □ 4 year college □ Post graduate

Caffeine

□ None □ Occasional □ Moderate □ Heavy

Marital Status

□ Married □ Single □ Divorced □ Separated □ Widowed

□ Domestic partner

Alcohol

Do you drink alcohol? □ Yes □ No If so, how often? □ Occasionally □ < 3 times a week

□ > 3 times a week How many drinks per week? _____

Tobacco

Do you use tobacco? □ Yes □ No □ # of years_____ □ Cigarettes-____pks/day

□ Chew-____/day □ Cigars_____/day □ Or year quit_____

If not currently, did you ever use tobacco? □ Yes □ No

Drugs

Do you currently use recreational or street drugs? □ Yes □ No

If yes, list:_____

REVIEW OF SYSTEMS

Please check all that apply:

Allergic/Immunologic

□ Frequent Sneezing
□ Hives
□ Itching
□ Runny Nose
□ Sinus Pressure

Constitutional

□ Exercise Intolerance
□ Fatigue
□ Fever
□ Weight Gain (_____lbs)
□ Weight Loss (_____lbs)

Ears/Nose/Mouth/Throat

□ Bleeding gums
□ Difficulty Hearing
□ Dizziness
□ Dry Mouth
□ Ear Pain
□ Frequent Infections
□ Frequent Nosebleeds
□ Hoarseness
□ Mouth Breathing
□ Mouth Ulcers
□ Nose/Sinus Problems
□ Ringing in Ears

Hematologic/Lymphatic

□ Easy Bruising/Bleeding
□ Swollen Glands

Genitourinary

□ Blood in Urine
□ Difficulty Urinating
□ Incomplete Emptying
□ Increased Urinary Frequency
□ Urinary Loss of Control

Cardiovascular

□ Arm Pain on Exertion
□ Chest Pain on Exertion
□ Chest Heaviness/Pressure on Exertion
□ Irregular Heart Beats (Palpitations)
□ Known Heart Murmur
□ Light-headed on Standiing
□ Shortness of Breath when Lying Down
□ Shortness of Breath when Walking
□ Swelling (edema)

Eyes

□ Dry Eyes
□ Irritation
□ Vision Change
Date of last Exam:_____

Endocrine

□ Fatigue
□ Increased Thirst/Hunger/Urination

Gastrointestinal

□ Abdominal Pain
□ Black or Tarry Stool
□ Blood in Stool
□ Change in Appetite
□ Frequent Indigestion
□ Hemorrhoids
□ Trouble Swallowing
□ Vomiting
□ Vomiting Blood

Integumentary (Skin)

□ Changes in Moles
□ Dry Skin
□ Eczema
□ Growth/Lesions
□ Itching
□ Jaundice (Yellow Skin/Eyes)
□ Rash

Musculoskeletal

□ Back Pain
□ Joint Pain
□ Muscle Aches
□ Muscle Weakness

Neurological

□ Dizziness
□ Fainting
□ Headaches
□ Memory Loss
□ Migraines
□ Numbness
□ Restless Legs
□ Seizures
□ Weakness

Respiratory

□ Cough
□ Coughing up Blood
□ Shortness of Breath
□ Sleep Apnea
□ Snoring
□ Wheezing

Psychiatric

□ Alcohol Overuse
□ Anxiety/Stress
□ Depression
□ Do Not Feel Safe in Relationship
□ Mania
□ Sleep Problems
□ Difficulty concentrating
□ Changes in socializing
□ Substance Abuse
□ Mood changes
□ Suicidal thoughts
□ Forgetfulness
□ Nervousness

Previous use of psychotropic Medications?

□ No □ Yes

If yes, please list and why stopped.

_____
_____
_____
_____

Please add any other information about your health that you would like your provider to know here:

_____
_____
_____

_____ _____ _____

Patient, Parent, Guardian or Caregiver Signature Date

Consent for Purposes of Treatment, Payment and Healthcare Operations:

1. Consent to Treat:

This is the authorization and consent for care and treatment. It is understood that while a patient is in this clinic, the patient will be under general care of a physician and does hereby authorize and consent to all care and treatment administered by Moundville Medical Associates and its authorized representatives and to any further examination, care, and treatment which may be deemed advisable and/ or appropriate by your physician or other physicians or by authorized representatives of Moundville Medical Associates.

2. Privacy Practices:

By my signature below I acknowledge that I have been given the opportunity to review Moundville Medical Associates of Privacy Practices.

I consent to the use or disclosure of my protected health information by Moundville Medical Associates and/or its affiliates for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health operations Moundville Medical Associates and/or its affiliates. I understand that diagnosis or treatment of me by this clinic/or affiliates may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or health care operations Moundville Medical Associates/or affiliates. The clinic and/or its affiliates are not required to agree to the restrictions that I may request. However, if it agrees to a restriction that I request, the restriction is binding Moundville Medical Associates and/or its affiliates.

I have the right to revoke this consent, in writing, at any time, except to the extent that Moundville Medical Associates and/or its affiliates has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or healthcare clearinghouse. The protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have right to review Moundville Medical Associates and/or its affiliates "Notice of Privacy Practices" prior to signing this document. Moundville Medical Associates' Notice of Privacy Practices has been provided to me. The notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Moundville Medical Associates and/or its affiliates. The Notice of Privacy Practices for Moundville Medical Associates and/or affiliates is posted in the Hospital admissions office, Clinic registration desk, and Home Health Office. This notice of Privacy Practices also describes my rights and the Clinics duties with respect to my protected health information.

Moundville Medical Associates and/or its affiliates reserve the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the Hospital, Clinic or Home Health Office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

3. Statement to Permit Payment of Medicare/Medicaid Benefits to Provider:

The undersigned and/or patient certify that the information given by him/her in applying for payment under the Title XVII and or XIX of the Social Security Act is correct. The undersigned and/or patient requests that payment of authorized benefits are made to the patient or on his/her behalf to Moundville Medical Associates, including physician or supplier services for any services furnished to him/her. The undersigned and/or patient authorizes any holder of medical or other information about the patient to release to the Centers for Medicare and Medicaid Services, State of Alabama, or their intermediates, carriers, or agents any information needed to

determine these benefits for related services. It is understood that the undersigned and/or patient are responsible to Moundville Medical Associates for any health insurance deductibles and co-insurance.

4. Medicaid Non-Covered Services:

Only certain outpatient procedures are covered by Medicaid. The patient is responsible for payment of any services that Medicaid does not cover. My Physician/Medical Provider has notified me that Medicaid may deny payment for the procedure because Medicaid may not cover it. If Medicaid denies payment, I agree to be personally responsible for payment.

5. Financial Agreement and Assignment of Insurance:

The undersigned agree(s), whether signing as agent or as patient, that in consideration of services to be rendered to patient, the undersigned is obligated to pay for same in accordance with the regular rates and terms of the hospital clinic; and that should the account be referred by the clinic to an attorney for collection, the undersigned shall pay reasonable attorney fees, interest and all costs of collection. Further, the undersigned waives as to this debt all rights of exemption under the constitution and laws of AL or any other states as to personal property. In the event the undersigned and/or patient is entitled to hospital benefits to any type whatsoever, arising out of any insurance or any other party liable to the patient, then the undersigned assigns such benefits to Moundville Medical Associates. The undersigned hereby authorizes and directs that all insurance benefits assigned shall be paid directly to the clinic and or physician for the respective services rendered. The undersigned and/or patient agrees and understands that acceptance of insurance coverage is conditional until insurance pays and all charges not paid by insurance are the responsibility of the undersigned and/or patient. The undersigned and/or patient are responsible for compliance with any precertification, referrals, and/or other requirements of any insurance company or third-party payer. The undersigned and/or patient is responsible for any difference not paid by insurance whether it be for the charge structure used by the insurance company or third-party payer versus that of the hospital/medical provider. The undersigned and/or patient may have access to billing information, which may contain PHI.

This care is provided during an unprecedented national emergency due to the Novel Coronavirus (COVID-19). COVID-19 infections and transmission risks place heavy strains on healthcare resources. As this pandemic evolves, the Hospital and providers strive to respond fluidly, to remain operational, and to provide care relative to available resources and information. Outcomes are unpredictable and treatments are without well-defined guidelines. Further, the impact of COVID-19 on all aspects of emergency care, including the impact to patients seeking care for reasons other than COVID-19, is unavoidable during this national emergency.

THE UNDERSIGNED AND/OR PATIENT CERTIFIES THAT HE/SHE HAS READ THE FOREGOING AND AGREES AND ACCEPTS THE SAME.

_____ _____

Patient or Authorized Representative of Patient Signature Date

_____ _____

Patient Email Address for Patient Portal Patient Contact Phone Number

☐ ALREADY ENROLLED INPORTAL

The Interoperability and Patient Access final rule (CMS-9115-F) put patients first by giving them access to their health information when they need it most, and in a way they can best use it.

☐ Check box if you do not have email or do no wish to participate in our Patient Portal.

_____ _____

Witness Signature Date

Moundville Medical Associates

HIPAA

As required by the Health Information Portability and Accountability Act of 1996 (HIPPA) you have the right to request that communications concerning your personal health information be made through confidential channels. This medical practice will not ask you why you are making your request, and will try to accommodate all reasonable requests.

I, _____hereby request the use of the following confidential channels for the communication of the information related to my personal health, treatment or payment for the treatment. This request supersedes any prior request for confidential channel communications I may have made.

Please select all that apply:

□**Phone** I want you to contact me by telephone at: _____

□Do □Do Not Leave message on my answering machine.
□Do □Do Not Leave message with any other person.
□Do □Do Not Consent to text message.

□**Mail**
I want you to contact me at the following address: _____
□**Email**
I want you to contact me at the following e-mail address: _____
□**Fax**
I want you to contact me at the fax number: _____
Other requests for confidential communications (specify):
_____

Date:_____

Print Name:_____

Signed:_____

If not signed by the patient, please indicate relationship:

□ Parent or guardian of minor patient
□ Guardian or conservator of an incompetent patient

□ Beneficiary or person representative of deceased patient

□ HIPPA/Confidential Channel Communication Request Form completed and signed

Permission to Release Information

It is a breach of patient confidentiality for physician and/or their staff to release any information regarding you or your medical condition to anyone without your permission. This includes your medical condition, prognosis, appointment times, insurance information, billing, or demographic information. Therefore, if you anticipate the need for anyone to have access to this information, please complete the information below.

I, (we), the undersigned patient and/or responsible party hereby authorize Moundville Medical Associates, its physicians, agents, employees, or representatives to discuss or release patient information about me
including but not limited to past and current medical information, billing prescriptions, etc…to the person or persons indicated below.

□ Spouse Name_____

□ Parent(s) Name(s)_____

□ Children Name(s)_____

□ Other(s) Name(s)/Relationship(s)_____

_____

_____

I understand that this will include information related to *(initial where applicable):*

_____ Psychiatric Care

_____ Treatment for alcohol and/or drug abuse

Patient/Responsible Party Signature: _____

(All 14-year-old or older minors MUST specify in WRITING that their parents may have access to their protected health information before it is given to them.)

Date: _____

MMA Representative Initials:_____

MOUNDVILLE MEDICAL ASSOCIATES

Medication History Authority

Our Electronic Medical Records (EMR) program can automatically import your medication history from third party sources (i.e. pharmacies). In order to transfer your current and past medications to our system we must have your authority.

By signing below I hereby certify Moundville Medical Associates to transfer my medication history.

☐ YES

☐ NO

_____ _____

Patient signature Date

Moundville Medical Associates
40870 AL HWY 69 Suite A
Moundville, AL 35474
Phone number: 205-371-4444
Fax number: 205-371-8745

AUTHORIZATION FOR THE RELEASE OF INFORMATION

To:_____
_____
_____

You are hereby authorized to release information to **Moundville Medical Associates** from the records of:

Patient Name: _____ Date of Birth: _____
Address: _____
Last 4 digits of Patient's SSN: _____

Extent or nature of information to be disclosed *(initial by the subject of the types of documentation that may be released):*

_____ Complete Clinical Record
_____ Progress Notes (MD/CRNP/Therapist)
_____ Only information regarding appointment times and other information for scheduling purposes

I understand that this will include information related to *(initial if applicable):*

_____ Psychiatric care
_____ Treatment for alcohol and/or drug abuse

I understand that my records are protected under Federal Confidentiality Regulations (92 CFR Part 2) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that this disclosure may contain information concerning medical, psychological drug and/or alcohol, required immunodeficiency syndrome (AIDS) or tests for infections with human immunodeficiency virus (HIV). This authorization is good for sixty (60) days from the date of signing and limited to only that information I have requested above be sent to the facility, person or organization named herein and that it may not be further disclosed or used for any purpose other than stated in this authorization. I further understand and this can be revoked by notifying the Compliance Officer (Health Information Manager) in writing, at any time except to the extent that disclosure made in good faith has already occurred in the reliance on this consent.
I hereby release Moundville Medical Associates from any legal responsibility or liability that may arise from the disclosure or release of information, medical records, or portions thereof, including liability for violation of the right of having this information maintained in confidentiality and privacy.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Signature of Witness Date