Primary Care Internists of Montgomery, P.C.
1722 Pine Street, Suite 309
Montgomery, AL 36106-1178
Phone 334-262-0342 / Fax 334-262-0390

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Attention

The attached paperwork MUST be fully completed before you will be taken back to see the physician for your physical. We understand that most of this information has not changed since the last time you were in, but requirements by the insurance companies such as Blue Cross of Alabama, Viva, United Healthcare, Aetna, and Cigna as well as Medicare require that we capture this information from you annually at your visit.

Thank you in advance for your cooperation.

Primary Care Internists of Montgomery, P.C.

PATIENT REGISTRATION

Welcome to our office. In order to serve you properly, we will need the following information. **(Please Print) Doctor:** ----------
All information will be strictly confidential.

Patient's Name (As it appears on insurance cards)	Sex M F	Birth Date ____/____/_____ Age_____	Marital Status Single [ ] Married [ ] Widowed [ ] Divorced [ ]
Residence address City State Zip		Home Phone:	Patient's Social Security #
Person financially responsible for this account if not the patient: **(Signature must be at bottom of page)**	Self Spouse Parent	Patient Email Address:	Responsible Party's SS#
Responsible Party Drivers License # State:	**Patient's E-mail address:**		How Long at current Employer?
Address of Responsible Party if different from patient:		Retired? YES [ ] NO [ ]	Other phone (cell)
Name of employer Address		Business Phone	Occupation

Name of Spouse/Parent	Birth date	Social security #	Business phone
Preferred Pharmacy and phone number:	Referred by: (include address and phone)		
Person to contact in case of emergency(listed on HIPAA form):	Relationship to patient	Phone	

Medicare Yes [ ] No [ ]	Please Provide Copy of Card	BCBS Yes [ ] No [ ]	Please Provide Copy of Card	Effective Date
Medicare Secondary insurance name Please Provide Copy of Card				

Workers' Compensation? Yes No **If Yes-put W/C or MVA carrier below** Motor Vehicle? Yes No	Date of Accident	Treatment authorized by	Claim #	W/C or MVA Insurance Phone #
If not Medicare of BCBS – Primary Insurance Company Please Provide Copy of Card				Is insurance through your employer? YES NO
Subscriber Name	**Subscriber birth date**			
Patient's Race:	Patient's Ethinicity: Hispanic OR Non-Hispanic		Preferred Language:	

Medicare Lifetime Signature on File:

I request that payment of authorized Medicare benefits be made on my behalf to Primary Care Internists of Montgomery Center, PC for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits payable for related services

_____ _____

Patient Signature Date

Private Insurance Authorization for Assignment of Benefits/Information Release:

I, the undersigned authorize payment of medical benefits to PCI for any services furnished me by the physician. I understand that **I am financially responsible for any amount not covered by my contract**. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits. **AGREEMENT TO PAY:** The undersigned accepts the fees charges as a lawful debt and promises to pay said fee including the cost of collection, attorney fees, and court costs if such be necessary, waiving now and forever the right to claim exemption under the constitution and laws of the State of Alabama, or any other state.

_____ _____

Patient or Resposible PartySignature (if child is under 18 years old) Date

Dear Patient,

Welcome to your Preventive Medicine Visit today, sometimes referred to as your *annual wellness exam or your annual physical.* The focus and scope of today's visit is on preventive care and includes an age and gender appropriate history and examination, counseling and risk factor reduction intervention.

CPT coding guidelines state *"If an abnormality is encountered or a pre-existing problem is addressed in the process of performing this preventive medicine service.....then the appropriate office outpatient code should also be reported."*

In other words, if a problem is addressed during the Preventive Visit, then we must bill for the Problem Visit in addition to the Preventive Services. While your preventive care may be covered at 100%, your problem or "sick" visits are subject to co-pays and/or deductibles.

In regards to annual lab screenings, be advised that a "screening" is designed for a person who has not yet been diagnosed with a particular disease. For example; your insurance carrier may allow for lipid screenings on an annual basis to determine if you have high cholesterol. Once it is determined that you do in fact have hyperlipidemia and are being treated for it, you may not be "screened" for it any longer. Your provider will order periodic tests to monitor your condition to check the efficacy of your medication, diet and exercise program, but once you have the disease, you are no longer eligible for free screenings.

If you have questions about this and would like to speak with one of our staff in the billing department, please let our receptionist or lab staff know. Our entire staff will be glad to assist you in any way possible during your visit today.

Sincerely,

Primary Care Internists of Montgomery, PC

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My signature below indicates I have read and understand this document.

_____ _____ _____

Patient Signature Birthdate Date

Primary Care Internists of Montgomery, P.C.
1722 Pine Street Suite 309 Montgomery, AL 36106--1178

Annual Intake Questionnaire

Date _____ Name _____ Date of Birth ____/____/____ Age _____

Marital Status _____

Current Illness- Please list the main items you want to discuss with the doctor:

_____
_____
_____
_____

Record the medications and supplements that you take (or supply the nurse with a list or the medications you have brought):

○ **None**

_____
_____
_____
_____
_____

_____
_____
_____
_____
_____
_____

Record any other medications that you have taken in the past 6 months:

○ **None**

_____
_____
_____
_____

What are you allergic to (medications and/or other agents):

○ **None**

_____
_____
_____
_____

Past Medical History

Record the approximate date of all of your previous surgeries or medical procedures that you did not disclose in previous visits:

○ **None**

_____
_____
_____
_____

Record the approximate date and location of any hospitalizations, which did not require surgery, since your last visit:

○ **None**

_____
_____
_____
_____

Please list any medical providers that you see outside this practice on a regular basis:

○ **None**

Gynecologist _____
Cardiologist _____
Dermatologist _____
Ophthalmologist _____
Orthopedic _____

Other:
1) _____
2) _____
3) _____
4) _____

List approximate year of the following immunizations:

Tetanus _____ Pneumonia _____ Shingles _____ Flu _____ Other _____

Estimate the date of your last colonoscopy and the doctor who performed the test:
Date: ____/____/____ Doctor: _____

Systems Review (mark [**X**] for all that apply)

General
- o Tired
- o Feeling poorly, worse in the morning
- o Recent weight gain
- o Recent weight loss
- o Sleep disturbances
- o Excessive daytime sleepiness
- o Snoring

Cardiac
- o Chest pain or discomfort
- o Palpitations or irregular heart beat
- o Reported history of heart murmur
- o Shortness of breath
- o Difficulty breathing while in bed
- o Swelling of the feet
- o Pain in legs when walking
- o Night time leg cramps
- o Varicose veins

Pulmonary
- o Cough
- o Coughing up sputum
- o Night sweats
- o Wheezing

Gastrointestinal
- o Difficulty swallowing
- o Decreased appetite
- o Heartburn more than 3x a week
- o Nausea
- o Vomiting
- o Vomiting blood
- o Abdominal pain
- o Diarrhea
- o Constipation
- o Blood in stool
- o Black stool
- o Recent change in bowel habits
- o Diverticulosis
- o Diverticulitis
- o History of colon polyps
- o Hemorrhoids
- o Liver problems
- o Gallbladder disease

Skin
- o Rash
- o Skin lesions
- o Changes in skin spots or moles

Endocrine
- o Enlarged neck (goiter)
- o Hot Flashes
- o Intolerance to cold

ENT
- o Eye problems
- o Glaucoma
- o Temporary loss of vision
- o Hearing loss
- o Ringing in ears
- o Sinus pain
- o Nosebleed
- o Chronic hoarseness
- o Sore throat

Genitourinary
- o Slow urine stream
- o Blood in urine
- o Urinary frequency more than twice during the night
- o Urinary frequency increased
- o Painful urination
- o Kidney stones
- o Bladder control problems
- o Risk of sexually transmitted disease
- o Problems with sexual function

Musculoskeletal
- o Back pain
- o Neck pain
- o Joint pain
- o Joint swelling

Neurological
- o Headaches
- o Fainting (syncope)
- o Seizures
- o Dizziness
- o Burning sensation in hand or feet
- o Memory lapses or loss

Psychiatric
- o Feeling depressed
- o Anxiety
- o Feel lonely
- o Decreased concentration
- o Highly irritable
- o Loss of pleasure

Are you being treated for any of the following (make [**X**] for all that apply):

- O Anemia
- O Anxiety
- O Asthma
- O Attention deficit disorder
- O Bladder or urinary problems
- O Blood disorder
- O Chronic allergies
- O Chronic back pain
- O Chronic headaches
- O Chronic pain
- O Congestive heart failure
- O COPD
- O Coronary heart disease or heart attack
- O Depression
- O Diabetes
- O Eye disorders
- O Fibromyalgia
- O Gastric reflux
- O Hearing loss
- O Hyperlipidemia (high cholesterol)
- O Hypertension (high blood pressure)
- O Kidney disease
- O Liver disease
- O Osteoporosis
- O Other arthritis
- O Rheumatoid Arthritis
- O Seizures
- O Skin disorders
- O Stroke or TIA
- O Thyroid disorders
- O Cancer
  - a) Lung
  - b) Thyroid
  - c) Breast
  - d) Ovarian
  - e) Prostate
  - f) Colon
  - g) Skin
  - Other _____

Family History

Please record any medical illnesses that have appeared in your parents, siblings, or children (blood) that you did not record in previous visits and relationship of that relative.

_____
_____
_____
_____
_____
_____

Social History

How much education do you have? _____

Retired? __ Yes __ No

If not retired, what is your job? _____

Where & with whom do you live? _____

List the amount of caffeinated beverages you drink in a day _____

Tobacco use __ Yes __ No ___ Past User If a past user, when did you quit? _____

What kind? _____ How much per day? _____ How long? _____

List how many alcohol beverages, on average, you drink in a day _____

Do you consider yourself an alcoholic, even if you are not currently drinking? _____

Do you or have you ever used illegal drugs? __ Yes __ No

Indicate religious affiliation, if any _____

Do you have a living will, health care directive, or advanced directive? __ Yes __ No

If you do not, would you like to discuss this with the doctor? __ Yes __ No

How often do you exercise? And what type? _____

Women Only

Please estimate the last date of the following:

Bone Density Test _____

Mammogram _____

Pelvic Exam/Pap Smear _____

Mark [**X**] if any of the following symptoms apply to you:

- O Problems with menses (periods)
- O Abnormal vaginal bleeding
- O Menopause symptoms
- O Vaginal discharge or itching
- O Lump in breast
- O Vaginal bleeding problems

PRIMARY CARE INTERNISTS OF MONTGOMERY, P.C.
Consent and Conditions for Treatment
PAYMENT IS DUE AT THE TIME OF SERVICE

PRINT NAME: _____ DOB: _____

In order to reduce confusion and misunderstanding between our patients and the practice we have adopted the following financial and office policies. If you have any questions about the policy, discuss them with our Practice Manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibility as an essential element of your care and treatment.

PAYMENTS ACCEPTED – For your convenience we accept Debit Cards, Visa, MasterCard, Discover, American Express, checks or cash as method of payment. Unless you have health insurance that can be verified prior to your visit, or other arrangements have been made in advance full payment is due at the time of service. For all services rendered to minor patients we will look to the adult (parent or guardian) accompanying the patient for payment.

HEALTH INSURANCE: PRIMARY INSURANCE - Insurance companies where we have a Participating Provider agreement, we will accept assignment of benefits. We will require, as does your insurance contract in most cases, to pay your co-payments or deductibles prior to your visit. Primary insurance plans where we do not participate will be billed, as a courtesy, by our office and we will require assignment, so that the payment will be made directly to us. We will attempt to verify your insurance coverage and benefits prior to you being seen by the provider and collect the amount that is deemed correct by them for the services that we provide. If we are unable to verify your coverage you will be responsible for payment in full. If this causes a credit balance, we will refund this balance with 90 days of notification from your insurance company that you have met your deductible obligation.

SECONDARY OR SUPPLEMENTAL INSURANCE – We will file your secondary or supplemental insurance for you one time as a courtesy to the patient. It will be the patient's responsibility to make sure that we receive payment.

We have no way of knowing in advance the total amount of your visit today. Your office visit charge (time the Provider spent with you, only) will run between $50.00 - $300.00 depending on whether you are a new patient or already an established patient with us. Lab work and all other procedures performed here in the office will have separate billable charges that will be added to your final office bill. If your insurance company refuses to pay today's charges for any reason, you will be held responsible. **Payment is due at the time of service with our office.**

OTHER OFFICE POLICIES -

Missed Appointments – In order to provide the best possible service and availability to all of our patients, it is our policy that we may charge $25.00 for a missed office visit. (Note: we cannot bill your insurance company for this charge).

Late Arrivals – To respect the needs of all of our patients, if you are more than 15 minutes late for your appointment you may be asked to reschedule your appointment.

Returned checks – Our fee for returned checks is $30.00. This fee is to be paid in the form of a money order or cash in order for you to pick up the returned check.

Forms that need to be filled out – If you need a form filled out and signed by your provider and do not wish to have an appointment there will be a $25 fee for filling out that form for you. This payment will be required before the completed form is release back to you.

Consent for Treatment – I present myself for treatment and in doing so I hereby consent to the rendering of such care, which may include routine diagnostic procedures, and or other medical and surgical procedures, by the providers of Primary Care Internists, as may in their professional judgment be deemed necessary or beneficial. I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks. I acknowledge that no guarantees have been made to me as to the result of any examination or treatment. I further understand that I have the right, in collaboration with my physician, to make decisions involving my health care to accept or refuse treatment to the extent permitted by law and to be informed of the medical consequences of such refusal.

ASSIGNMENT OF BENEFITS/INFORMATION RELEASE: I, the undersigned authorize payment of medical benefits to Primary Care Internists of Montgomery for any services furnished me by the provider. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

AGREEMENT TO PAY: For Primary Care Internists of Montgomery, I the undersigned accept the fees charged as a lawful debt and promise to pay said fees including the collection agency fees (33.33%), attorney fees, and court costs if such be necessary, waiving now and forever the right to claim exemption under the constitution and laws of the State of Alabama, or any other state.

EXPRESS PRIOR CONSENT TO CONTACT CONSUMER BY CELL PHONE: You agree, in order for us to service your account or to collect monies you may owe, Primary Care Internists and/or agents may contact you by telephone at any number associated with your account, including wireless numbers, which may result in charges to you. We may also contact you by sending text message or emails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice message and/or use of automatic dialing devices, as applicable.

I have read this disclosure and agree that Primary Care Internists, its employees and/or agents my contact me as described above, and I understand the financial policy of the practice and I agree to be bound by its terms.

_____ _____

Signature of the Patient or Responsible Party Date

*Because the patient is an authorized minor, or physically or mentally incapacitated, this consent is given on behalf of the patient.

By: _____ as: _____

PRIMARY CARE INTERNISTS OF MONTGOMERY, P.C.

HIPAA- Medical Information Release

Due to **federal privacy guidelines under HIPAA (required April 2001)** we are required to have a medical release of information on file for each patient. This authorizes our office to release medical information to your designated family members, caregivers, and friends, as well as, pharmacists, hospitals, emergency medical personnel, and referral specialists about you or your minor (under 14 yrs of age) children's PROTECTED HEALTH INFORMATION (PHI). Included would be all health and identifiable information. This authorizes us to share your health information, after proper identification, by verbal or written communication, telephone, cell phones, answering machine, fax, mail or e-mail as needed for your care to only those you have identified below. Power of Attorney's would be listed separately. By your signature below you also acknowledge that you have read the Notice Of Privacy Practices.

In order for us to do this please list names, relationship to you and phone numbers of the authorized individuals below. Do not list anyone who has not agreed to provide us with their date of birth for identification purposes.

****PLEASE PRINT****

I _____(patient name or child's name) DOB: _____ give my authorization to the following individual(s) listed below to discuss my medical care with you and or your staff on my behalf.

Names	**Relationship**	**Phone #**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any health information you do not wish to be given out please list below.

_____ _____
_____ _____
_____ _____

The above information is private and confidential and will be placed in your medical record. This authorization will expire 12 months from the date signed.

Signature _____(Relationship)_____Date_____

DISCLAIMER (Complete only if you want ***no one*** else to have any access to information, including family members.)

____I do not want you to discuss my medical care with anyone other than myself.

Revised 09/10/2013

Patient Name: _____ DOB: _____

Medicare Wellness Exam

Today you are offered a Medicare Wellness Exam. This exam is covered at no additional expense to you. It is paid for by Medicare so your doctor and his staff can have the time to review items that Medicare has found important to your health. This <u>does not</u> substitute your "yearly physical" which is designed to review your current and treat possible health problems. There will be a separate charge for that, subject to the usual co-pay and/or deductible.

Please answer the following questions as part of the exam:

1. Have you had a Medicare Wellness Exam outside of this office in the past year? Yes No
2. Do you have an advanced directive or living will? Yes No
3. Would you like to discuss an advance directive or living will? Yes No
4. Do you or your family and friends feel that you have a problem with thinking or memory? Yes No

The following questions are required as a part of your <u>first</u> Medicare Wellness Exam. Otherwise, they are optional.

5. Do you have little interest or pleasure in doing things? Yes No
6. Do you feel down, depressed or hopeless? Yes No
7. Is help needed with the phone, transportation, shopping, preparing meals, housework, laundry, medications or managing money? Yes No
8. Have you had any falls or accidents in the past year? Yes No
9. Do you have trouble hearing? Yes No