MEDICAL HISTORY

PLEASE LIST ALL PAST AND PRESENT MEDICAL PROBLEMS

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SURGERY HISTORY

PLEASE LIST ALL PAST SURGERIES

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FAMILY HISTORY

LIST ALL PAST FAMILY MEDICAL HISTORY

MOTHER ____

FATHER ____

SIBLING(S) ____

GRANDPARENT(S) ____

OTHER ____

MEDICATIONS

LIST MEDICATIONS YOU ARE TAKING AND HOW OFTEN YOU TAKE THEM

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ALLERGIES

LIST ANY MEDICATIONS YOU ARE ALLERGIC TO

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PHARMACY

NAME AND LOCATION

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FINANCIAL POLICY

We are committed to providing you with the best possible medical care; if you have special needs, we are here to work with you. The following information is provided to avoid any misunderstanding or disagreement concerning your payment for professional services.

- Our office participates with a variety of insurance plans. It is your responsibility to:
  - Bring your insurance card to every visit
  - Be prepared to pay your copay or deductible at each visit

For medical care not covered under your insurance, ***payment in full is due at the time of the service.***

- If you have insurance that we do not participate in, our office is happy to file a claim upon your request; however, ***payment in full is expected at the time of service***.
- If you are unable to pay for necessary medical care, you may be eligible for financial assistance. It is your responsibility to inform us prior to the visit.
- Referrals: It is your responsibility to bring any required referrals for treatment, ***at, or prior to the visit***. If you do not have the referral, your visit may be rescheduled, or you may be financially responsible.
- If the patient is a minor (18 years or younger), the parent or guardian must sign below. The parent or guardian or unaccompanied minor is responsible for any payment due at the time of service, bringing the necessary referral(s) and insurance card(s).
- If you have any questions about your insurance, we are happy to help you. Specific coverage issues; however, should be directed to your insurance company member services department (the number is usually on the back of the insurance card)

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communications. Questions about financial arrangements should be directed to the physician's office.

Please sign that you have read and agree to the financial policy.

______________________________________ ______________

Signature of Patient or Responsible Party Date

______________________________________ ______________

Signature of Co-Responsible Party Date

NOTICE OF PRIVACY PRACTICES

Effective Date of this Notice: April 1, 2003

As required by the Privacy Regulations created because of the Health Insurance Portability and Accountability Act of 1996 (HIPPA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOU INDIVIDULALY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS CAREFULLY.

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In treating you, we will create medical records about you, and will comply with all laws regarding confidentiality of those records. Every member of our staff is trained and informed on confidentiality and will follow this notice, including physicians, nursing staff, and office personnel. We will take all precautions to restrict access to confidential records by unauthorized persons.

Ways we may use your IIHI:

Treatment: Information is needed to properly evaluate, diagnose and treat you. It is required in order to prescribe medications, order laboratory tests, refer you for further treatments, evaluations and discuss findings with you, your other physicians and caretakers, etc., and family, if you desire. We will remind you of your appointments.

Payment: If we fire insurance for you, we will provide information to your insurer(s), or to other 3rd parties who may be paying on your behalf, so that we may obtain payment for our services. Statements of any possible outstanding bills will be sent to you, and may contain medical information.

Health Care Operations: Our practice may use and disclose you IIHI to operate our business, such as to evaluate quality of care given to you.

Other Reasons: Include disclosures required by federal, state or local law; certain special circumstances such as public health risks, health oversight activities, lawsuits, etc. This can include disclosures to medical examiners or coroners, military authorities, police investigations, and the likes.

YOUR RIGHTS REGARDING YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI)

Confidential Communications: You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

Requesting Restrictions: You have the right to request a restriction in our use or disclosure of you IIHI for treatment, payment or health care operations, and to only certain individuals. **We are required to agree to your request.** Your request must be in writing in a clear and concise manner to our privacy officer given below.

Inspection and Copies: You have the right to inspect and obtain copies of you IIHI that may be used to make decisions about you by submitting your request in writing to the privacy officer. We may charge fees for the costs involved, and in certain limited circumstances deny requests. You may request a review of our denial.

Amendment: You may request, in writing, an amendment of your health information if you believe it is incorrect or incomplete, for as long as the information is by or for our practice. A request MUST provide a reason that supports your request. We will not amend something that, in our opinion, is accurate and complete.

Accounting of Disclosures: You have the right to request an "accounting of disclosures", a list of certain *non-routine* disclosures our practice might have made of you IIHI for non-treatment or operation purposes. These requests must be in writing and must state a time period, which may not be longer than six years from the date of disclosure and may not include dates before April 14, 2003. Multiple request within a 12-month time period will be charged a fee.

Right to a Paper Copy of This Notice: You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, please contact the Privacy Officer listed below.

Right to File a Complaint: If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, please contact the Privacy Officer listed below. You will not be penalized for filing a complaint.

Right to Provide an Authorized for Other Uses and Disclosures: Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authtorization you provide to us regarding the use and disclosure of you IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose you IIHI for the reasons described in the authorization. Please note we are required to retain records of your care.

CHANGES TO THIS NOTICE: We reserve the right to make any changes to this notice, but a current copy will always be posted and available.

Any complaints or requests are to be directed to our ***Privacy Officer***:

Blane E. Bateman, D.O.
901 Leighton Avenue, Suite 506
Anniston, Alabama 36207

I acknowledge, by signing below, that I have received the Notice of Privacy Practices and Individual Rights

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Patient or Patient's Guardian/Representative Date