Tuscaloosa Integrative Family Medicine

Patient Information:

Name:______________________________

DOB:____________ SS#:____________

Address: ____________________________

City: ____________ State: ____ Zip: ________

Home#: ____________ Cell#: ____________

E-mail: ____________________ Sex: M / F

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Due to federal government requirements, please circle the following for patient being seen:

☐ Prefer not to answer

Race:	☐ Caucasian	☐ African American	
	☐ Pacific Islander	☐ Native American	
	☐ Alaskan	☐ Asian	☐ Other

Preferred Language: ☐English ☐Spanish ☐Other

Best Form of Contact:

☐ Home ☐ Cell

☐ Work ☐ Other:____________

Best time to call: ____________________

Ok to leave detailed message? Y / N

Preferred Pharmacy: This is pharmacy we will call your medications into unless you specify otherwise.

Pharmacy Name: ____________________

Pharmacy Phone #: ____________________

Guarantor Information:

(Person financially responsible for patient.)

☐Check here if same as above patient; if not please fill out.

Name: ______________________________

DOB: ____________ SS#: ____________

Address: ____________________________

City: ____________ State: ____ Zip: ________

Home#: ____________ Cell#: ____________

E-mail: ____________________ Sex: M / F

Relationship to patient: ☐Spouse ☐Child ☐Other

Insurance Information:

Primary: ____________________________

Contract#: ____________________________

Group#: ______________________________

Subscriber Name: ______________________

Subscriber DOB: _______________________

Relationship to patient: ☐Spouse ☐Child ☐Self ☐Other

Secondary: __________________________

Contract#: ____________________________

Group#: ______________________________

Subscriber Name: ______________________

Subscriber DOB: _______________________

Relationship to patient: ☐Spouse ☐Child ☐Self ☐Other

Patient Employment:

Employer Name: ________________________

Work #: ________________ Ext: ________

Emergency Contact:

Name: ______________________________

Phone#: _____________________________

Relationship: _________________________

How did you hear about us? (Mark all that apply)

☐Newspaper ☐TV ☐Phone Book ☐Internet

☐Spa ☐Friend/Relative ☐Doctor ☐Other:

____

Authorization for Release of Medical Records:

By providing this authorization I understand that the authorization is voluntary and is being done at the request of the patient. I understand that I may refuse to sign this authorization and my treatment and/or payment obligations will not be affected. I understand that the health information to be obtained and released may be subject to re-disclosure by the recipient of the health information and no longer protected by the Federal Privacy Rules. I understand that I may revoke this authorization at any time by notifying Tuscaloosa Integrative Family Medicine in writing, but if I do, it will not have any effect on uses or disclosures prior to the receipt of the revocation. I understand that this authorization is for 6 years until otherwise specified.

I hereby authorize Tuscaloosa Integrative Family Medicine to use, disclose my health information as follows:

Name:________________ Relationship:________

Name:________________ Relationship:________

Name:________________ Relationship:________

Name:________________ Relationship:________

Assignment of Benefits & Guarantee of Account:

I acknowledge full financial responsibility for any charges incurred on my behalf as a patient, my family member who is a patient, or on behalf of the patient whom I have agreed to as responsible party. I understand that it is my responsibility as the patient to verify my contracted benefits with my insurance carrier in reference to any services provided by Tuscaloosa Integrative Family Medicine. I understand that all copays are due at the time of service. The portion which insurance does not cover is my financial responsibility. Tuscaloosa Integrative Family Medicine charges a fee of $30 for returned checks. In the event of a returned check, cash will be the only method of payment accepted for your account. In the event my account is turned over to a collection agency, I agree to pay all costs, including, but not limited to, collection fees and/or attorney's fees and all court costs, if any. I further agree to pay that outside agency an additional 30% on the outstanding portion of my account, hereby waive all rights of exemption under the Constitution and laws of the State of Alabama.

Signature: ____________________________

<Patient signature if patient over age 13>

Signature: ____________________________

<Guarantor if patient under age 13>

Today's Date: _________________________

Caroline Day, M.D. 5710 Watermelon Road Suite 600 Northport, AL 35473 P: 205-345-6272 F: 205-758-1493

Tuscaloosa Integrative Family Medicine

Health History Form

Name: ______________________________________
DOB: ________/________/________

Why are you seeing the doctor today?

____
____
____
____
____

When did you first notice the symptoms?

____
____

Medical Problems:
Please list all medical problems/illnesses for which you are currently being treated:

____
____
____
____
____

Past Medical History:
Please indicate if you have had any of the following:

☐ Mammogram ☐ Colonoscopy ☐ DEXA scan ☐ Pneumonia Vaccine

Surgeries/Hospitalization	Year	Complications

Social History: Please check
☐ Employed (occupation) ____________________
☐ Unemployed ☐ Disabled
☐ Work in home ☐ Student ☐ Retired
Children: ☐ Yes ☐ No Ages: ______________
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Exercise:
☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never
What type of exercise: ________________________
Are you on a special diet?
☐ Yes ☐ No Describe: ____________________
History of substance abuse?
☐ Yes ☐ No Describe: ____________________
Currently Smoke?
☐ Yes ☐ No Packs per day_____ for_____ years.
Previously a smoker?
☐ Yes ☐ No Quit for _____ years.
Drink Alcohol?
☐ Yes ☐ No Frequency:_______ Type: ________

Medication Example:		
Lexapro -- once daily	10 mg	2 years

Allergies: ☐ No Known Drug Allergies
Food/Environment: ____________________
Medications: ____________________

____
____
____
____

Family History:
Has anyone in your immediate family been diagnosed with the following disease? If yes, please indicate which family member.

Cancer	☐ Yes	☐ No	________
Heart Disease	☐ Yes	☐ No	________
High Blood Pressure	☐ Yes	☐ No	________
Diabetes	☐ Yes	☐ No	________
Bleeding Disorders	☐ Yes	☐ No	________

Review of Systems:
Are you currently having or have you had problems with:
If yes, please describe.

Allergic/Immunologic	☐ Yes	☐ No	________
Cardiovascular (Heart)	☐ Yes	☐ No	________
Diabetes	☐ Yes	☐ No	________
Ears, Nose, Throat	☐ Yes	☐ No	________
Endocrine (Thyroid)	☐ Yes	☐ No	________
Eyes	☐ Yes	☐ No	________
Gastrointestinal	☐ Yes	☐ No	________
Hematologic (Bleeding)	☐ Yes	☐ No	________
High Blood Pressure	☐ Yes	☐ No	________
Integumentary (Skin)	☐ Yes	☐ No	________
Musculoskeletal	☐ Yes	☐ No	________
Neurological	☐ Yes	☐ No	________
Numbness/Tingling	☐ Yes	☐ No	________
Psychiatric	☐ Yes	☐ No	________
Psychological	☐ Yes	☐ No	________
Respiratory (Lung)	☐ Yes	☐ No	________
Urologic (Bladder)	☐ Yes	☐ No	________

Patient Signature:

____

Date: ________/________/________

Tuscaloosa Integrative Family Medicine

HIPAA 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 describes how we may use and disclose your protected health information (from this point referred to as your PHI) to carry out treatment, payment or health care operations and for other purposes. It also describes your rights to access and control your PHI. "Protected health information" is information about you, including demographic information, that may identify you & that relates to your past, present or future physical or mental health or condition & related health care services.

Uses and Disclosures of Protected Health Information: Your PHI may be used & disclosed by your physician, our office staff & others outside of our office that are involved in your care & treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, & any other use required by law.

Treatment: We will use & disclose your PHI to provide, coordinate, or manage your health care & any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. Also, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or to treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the healthcare plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, & conducting or arranging for other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name & indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

We may use or disclose your PHI in the following situations without your authorization: As required by law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food & Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, & Organ Donation, Research, Criminal Activity, Military Activity & National Security, Worker's Compensation, Inmates, Required Uses & Disclosures. Under the law, we must make disclosures to you & when required by the Secretary of the Department of Health & Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted & Required Uses & Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physicians practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to inspect & copy your PHI. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, & PHI that is subject to law that prohibits access to PHI.

You have the right to request a restriction of your PHI. This means you may ask use not to use or disclose any part of your PHI for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested & to whom you want the restrictions to apply. Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use & disclosure of your PHI, your PHI will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us & we may prepare a rebuttal to your statement & will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

We reserve the right to change the terms of this notice & will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or the Secretary of Health & Human Services if you believe your privacy rights have been violated by us. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, & provide individuals with, this notice of our legal duties & privacy practices with respect to PHI. Signature below is an acknowledgement that you have received this notice of our Privacy Practices.

Signature: ______________________________ Date: ____________________

Caroline Day, M.D. 5710 Watermelon Road, Suite 600 Northport, AL 35473 P: 205-345-6272 F: 205-758-1493

Tuscaloosa Integrative Family Medicine

Policies Acknowledgement Form

Please initial each line to verify you have read, understand, and agree to the following:

- ______ Appointments: Please plan to arrive a few minutes prior to your appointment time to complete and/or update any outstanding paperwork. It is our goal to have each patient in and out as quickly as possible without compromising the level of care each patient receives. We appreciate at least a 24-hour notice for all reschedules or cancellations. In the event of excessive no-shows for your scheduled appointments, your account will be charged a $35no-show fee for each occurrence.
- ______ Co-pay Policy: We are *required by law* to collect co-pays at the time of visit, for each visit. The Health Care Financing Administration (HCFA) is the federal government agency responsible for setting policy and overseeing the Medicare and Medicaid programs. HCFA has mandated that providers of health care MUST collect co-pays and deductibles. This is enforced by the Office of the Inspector General (OIG). Providers that do not collect are subject to prosecution for fraudulent billing under federal law! Routine co-pay waiving constitutes ordinary financial fraud. Penalties include fines up to $25,000.00, five years in jail, or both! Private insurance companies can also prosecute providers who fail to collect co-pays and/or deductibles.
- ______ Refills: We try and match your refills to your scheduled appointments as much as possible; this is why it is so important to keep your scheduled follow-up appointments. We do not call in refills routinely and we do not prescribe antibiotics over the phone.
- ______ Scheduled Drugs: Dr. Day monitors and screens ALL patients using/prescribed scheduled drugs with the Alabama Prescription Drug Monitoring Program. We do not routinely prescribe/refill requests for opioid (codeine, hydrocodone, Tramadol) or benzodiazepines (Xanax, Klonopin, Ativan). We do not carry narcotic shots in our office and encourage patients with chronic pain issues to seek treatment with specialized pain management clinics.
- ______ Test Results: Dr. Day also likes to discuss your lab work and/or test results with you personally at your follow-up visits. If there are any urgent and/or critical results, you will be notified promptly by Dr. Day or a member of her staff. You are welcome to and encouraged to receive copies of any lab work results and/or test results in order to keep a personalized health file at home. To receive records from our office, you will need to fill out a medical release form and pick records up from the office. Picture ID is required in order for records to be released to you or any authorized person listed on your release.
- ______ In-Patient Care: Dr. Day does not admit or manage in-patient care while in the hospital; we have a number of excellent hospitalist services and hospitals in the Tuscaloosa/Birmingham area to choose from whom are available 24-hours. Her focus is on prevention and keeping her patients healthy and out of the hospital. However, should you need to be admitted or have an emergency after hours, please inform the ER / admitting physician that Dr. Day is your primary care doctor so she can follow up and coordinate your care once you are discharged from the hospital.
- ______ Consent for Treatment: I consent to necessary treatment including lab tests, x-rays, procedures, administration of medication and/or other studies that may be needed to diagnose or treat any illness that I present with.
- ______ Guarantee of Account: I hereby guarantee the payment of my account and/or any account I have signed as the guarantor for and waive all claims of exemption under the State of Alabama and agree to pay, if necessary, all costs of collection, including attorney's fees.

Print Name: ______________________ Signature: ______________________

Today's Date: ______________________

Tuscaloosa Integrative Family Medicine

Refill Policy

As of 12/01/2014

As of December 1, 2014, we have a new prescription refill policy. We understand that this is a change for both you and us. We hope to work together to ensure safe, efficient and high-quality medical care. Thank you for being our valued patient!

It is typically Dr. Day's practice to give prescriptions with refills to coincide with your follow-up appointments for monitoring. It is very important to request your prescriptions during your routine office visits. In order to ensure that you do not run out of your medications, please make sure to schedule a follow-up appointment at the end of each visit. If office visits are scheduled and kept on a regular basis, prescriptions are refilled at these visits and pharmacies follow instructions on prescriptions given, then requests for refills outside of your routine office visits should rarely occur.

As of December 1, 2014, requests made for prescription refills made outside of an office visit will be subject to a fee:

1. $20.00 will be charged for routine prescription refills that are not requested during an office visit.
2. $30.00 will be charged for other medication requests – if approved by Dr. Day.

To request a refill, please leave a detailed message on our refill request voicemail. *Please allow 2 business days for the refill request to be completed.*

Ways to reduce unnecessary refill requests and medication errors:

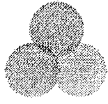
1. We require office visits on a regular basis for all of our patients taking prescription medication. The interval for follow-up visits will vary depending on the type of medication you are prescribed. Please be sure you have enough medication to last until your next scheduled visit.
2. Before you come to your regular appointment, you should look over your medications, diabetic supplies, inhalers, etc. to determine if you need to request any new prescriptions at your appointment.
3. Please bring all of your prescription bottles with you to your appointment. This is important to make sure that you're taking the correct medications in the correct dosages. We will take the time to carefully review your medications and write refills at your office visit.
4. It is your responsibility to schedule a follow-up appointment *before* you run out of your medication. We recommend you schedule your next visit before you leave our office.
5. If you are changing pharmacies, you can usually have your new pharmacy request prescriptions to be transferred from your old pharmacy.

"Auto-Renewal", "Auto-Fax", "Readyfill", etc.

Most of the requests for refills that we receive are generated automatically from the pharmacy without the patient's knowledge. "Auto-Renewal" or "Auto-Fax" programs with most pharmacies are at fault for most of these requests. **As of December 1, 2014, we will no longer respond to refill requests that are faxed from the pharmacy. If you are in need of a refill we expect you to contact us directly and leave a detailed message on our Refill Request Voicemail. Prior authorization requests faxed from your pharmacy will still be accepted.**

Patient Name: ______________________________ Date of Birth: ______________

Signature: ______________________________ Date: ______________



Tuscaloosa Integrative Family Medicine

Administrative Fees:

- Sports Physical Forms $50 per form
- Disability Forms $50 per form
- Medical Insurance Forms $50 per form
- FMLA Forms $50.00 per form
- PEEHIP Wellness Forms $25.00 per form
- Medical Records: $1.00 per page up to 25; each additional .50 per page
- No Show Fees: $35.00 per visit
- Medication Refills: $20 Routine Medications/$30 all other Medications

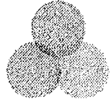
Policy Changes: effective August 1,2019

- **Past Due Accounts**: You must pay 25% of the account balance + Copay at scheduled office visit.
- **Rx Refills**: No medication refills for accounts with a past due balance over $100
- **Medical Records**: No Medical Records, Referrals, etc. will be sent until accounts are current.
- **Payment Plans**: Accounts that are past due and have shown "Good Faith" n paying monthly will be seen at scheduled office visit.
- **Collections**: Accounts over a year old with a balance of $100 will be sent to collections.
- **Statements**: An email address is obtained to send your statement or you may inquire through the Patient Portal.

I have read the updates to the Patient Policies and I am aware of the policies stated.

______________________________ ______________________

Patient Signature Date



Tuscaloosa Integrative Family Medicine

Authorization and Consent to transmit Appointment Reminders via Unsecured Internet and Text Messaging:

I expressly request, authorize, direct, permit and unequivocally consent to Tuscaloosa Integrative Family Medicine (TIFM) transmitting my Appointment Reminders, to include the date, time and location to me. I expressly and unequivocally waive any claims or rights with respect to transmission of ePHI or PHI via the unsecured Internet. I knowingly, intentionally and voluntarily waive all rights, claims and damages relating to negligence, breach of confidentiality or other tort and all other legal claims that could be asserted against TIFM or any of its employees, agents, members, or otherwise as a result of any third person improperly accessing, using or disclosing my Appointment Information as a result of transmission via the unsecured internet or Text Messaging. I intend to legally bound hereby.

Email address: ______________________________

Cell Phone #: ____________________ Carrier: ______________

☐ I wish to "Opt Out" of having any Appointment Reminders. _______ _________

Initials Date

______________________________ ______________

Signature of Patient or Personal Representative Date

______________________________ ______________

Print Name of Personal Representative Relationship to patient (not SELF)