WELCOME TO Pelham Internal Medicine

PATIENT INFORMATION

Date:_____/_____/_____

Patient Name:_____ Date of Birth:_____/_____/_____

Address: _____

Street City State Zip Code

Home Phone#: ( )_____ Cell#: ( )_____

Social Security Number:_____ Sex: ❑Female ❑Male

Email Address: _____

Employer:_____Work Phone#: ( ) _____

Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed

If married, spouse's name:_____

Spouse's employer: _____

Do you have a Living Will? ❑Yes ❑No Do you have a Power of Attorney? ❑Yes ❑No

If yes, who? _____

Emergency Contact:_____ Relationship:_____

Home# :( )_____Cell# :( )_____Work# :( )_____

Emergency Contact:_____ Relationship:_____

Home# :( )_____Cell# :( )_____Work# :( )_____

Emergency Contact:_____ Relationship:_____

Home# :( )_____Cell# :( )_____Work# :( )_____

Notice of Privacy Practices (NPP) Acknowledgement

A Notice of Privacy Practices (NPP) is provided to all patients and explains: (1) how your Protected Health Information (PHI) may be used or shared; (2) your rights to access or amend your PHI, request information on disclosure of your PHI, and request additional restrictions on our uses and disclosures of PHI; (3) your rights to complain if you believe your privacy rights have been violated; and (4) our responsibilities for maintaining the privacy of your PHI.

Patient Communication Consent

We may need to contact YOU regarding our medical care. This is to acknowledge that you authorize Pelham Internal Medicine to check all that apply.

- ☐ Leave a detailed message on voice mail/machine
- ☐ Call my workplace phone number and leave a message
- ☐ Call my workplace phone number and speak only to me
- ☐ Transmit and Receive messages through Patient Portal
- ☐ None of the above

I further authorize the disclosure of my PHI to the following Individuals or Family Members

Name: ___________________________________ Relationship to Patient:____________________________

Phone: ___________________________________

Types of Information: ☐ All ☐Appointment Reminders ☐ Results (lab test,X-ray, etc) ☐ Financial

Okay to contact via: ☐ Telephone ☐ Leave a Voice Mail ☐ Patient Portal ☐ Other _______________

Name: ___________________________________ Relationship to Patient:____________________________

Phone: ___________________________________

Types of Information: ☐ All ☐Appointment Reminders ☐ Results (lab test,X-ray, etc) ☐ Financial

Okay to contact via: ☐ Telephone ☐ Leave a Voice Mail ☐ Patient Portal ☐ Other _______________

Name: ___________________________________ Relationship to Patient:____________________________

Phone: ___________________________________

Types of Information: ☐ All ☐Appointment Reminders ☐ Results (lab test,X-ray, etc) ☐ Financial

Okay to contact via: ☐ Telephone ☐ Leave a Voice Mail ☐ Patient Portal ☐ Other _______________

Name of Patient : ____________________________________

Signature of Patient: _______________________________ Date:____________________________

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AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Demographics		
Name:	**Preferred Name**	**SSN:**
Home Address	**City, State, Zip Code**	
Email for Patient Portal	**Date of Birth**	**Treatment Dates** **MM/DD/YYYY**
		From: to

This Release is for the following information:

☐ ALL Information in my chart can be released to the physician listed below. I understand this means all records in my chart related to my health and may include the following: Psychiatric notes, HIV, drug use, AIDS/HIV information and I express consent to release all information

☐ Only Information for the treatment dates listed above.

I consent for my records to go from:	I consent for my records to go to:
	Pelham Internal Medicine Dr. Bela Patel, D.O. 2156 Highway 52 East Suite 100 Pelham, AL 35216 (P) 205-747-2273 (F) 205-749-2329

I understand that my records are protected by Federal regulation and cannot be disclosed without consent unless otherwise provided for in the regulations. I understand that this authorization is revocable as to future requests upon written revocation. Written revocations are to be sent to the Privacy Officer of the above provider releasing the records. I understand that a revocation is not effective to the extent that the provider has already relied on this authorization for the use of the disclosure of information. Authorization will expire in 60 days from the date below.

Authorizing Party Date Witness Date

Authorizing Party (other than patient) Date

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CONSENT FOR TREATMENT & PAYMENT

Consent for Treatment: I consent to necessary medical examination, testing, and/or treatment as determined by my physician.

Assignment of Benefits and Guarantee of Account: I hereby authorize payment directly to Pelham Internal Medicine of benefits otherwise payable to me, including major medical insurance and payment of surgical or medical benefits. I understand that I am financially responsible to Pelham Internal Medicine for charges not covered by this assignment. For services furnished by Pelham Internal Medicine, I hereby guarantee the payment of all accounts for services rendered. For payment of said accounts for services, I hereby agree to pay all costs of collections, including attorney's fees.

I have received a copy of the Patient Bill of Rights and Responsibilities and Privacy Practice.

Signature _____ Date _____

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NO SHOW/CANCELLATION POLICY

ACKNOWLEDGEMENT FORM

I acknowledge the following:

- It is important to my health that I show up on time for my doctor's appointment.
- If I am late (15 minutes or more after the scheduled time) I understand that I will be placed into a work-in slot, if available. If one is not available, I will be asked to reschedule.
- I understand that arriving after my scheduled appointment time should be an exception and a rare occurrence.
- If I do not show up for a scheduled appointment, it may affect my health and it creates an unused appointment slot that could have been used for another patient.
- It is important that I notify this office at least 24 hours in advance when I need to cancel my appointment.
- If notice is not given, there will be a $50 fee accessed to my account due before my next appointment.
- My doctor may choose to terminate me from this practice if I have more than 3 no-show occurrences or excessive late arrivals at any given time.

Signature _____ Date _____

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Financial Policy

Patients are expected to provide identification and if un-insured, a current insurance card(s) at the time of service. Patients are financially responsible for all services provided and are expected to pay for services at time of service, including any past due balance from a prior date of service. Returned checks will be subject to fees.

Medicare: The office will bill the Medicare intermediary. Patients are responsible for the following: annual Medicare deductible, all applicable co-pays of the allowed charge, any non-covered services, and any covered service ordered by the physician which does not meet Medicare's medical necessity and for which the beneficiary signed an Advanced Beneficiary Notice.

Medicare Supplemental and Secondary Insurance: The practice will bill both Medicare and secondary insurances.

Medicaid: Patients must provide the practice with a current Medicaid card at each visit. Medicaid patients are responsible for applicable co-pays and for all non-covered services. Medicaid patients are responsible for securing necessary referrals from their primary care physicians.

Commercial, HMO, and PPO Insurance Plans: Patients are responsible for payment of the co-pay, co-insurance and/or deductible or non-covered amounts at the time of service as well as for any charges for which the patient failed to secure prior authorization, if authorization is necessary. Insurance is filed as a courtesy and benefits are authorized to be paid directly to the practice. Patients are responsible for the balance in full if not paid by the insurance within 30 days. If the patient is not prepared to pay the co-pay or deductible, a member of the clinical staff will determine if it is medically necessary for the patient to see the physician. If the patient's condition allows, the appointment will be rescheduled.

Self-Pay: Patients are responsible for payment in full at the time of service for all services rendered.

Worker's Compensation: We will not accept any worker's compensation claims.

Personal Injury/Motor Vehicle Accidents and Other Third-Party Liability: The patient is responsible for the balance in full at time of service. Any settlement you receive from your insurance company or other third party will be handled by you, your insurance company, and/or your attorney.

Out of State Insurance: If the patient presents with an out of state HMO/PPO insurance card, we will need to verify the patient's benefits for out of state or out of network benefits. The patient may be required to make payment in full or pay any co-pay, co-insurance, or deductible.

Preventive Care Services: Please be aware that if an additional problem is addressed at the time of our visit, a co-pay, deductible or office visit fee may be charged. If services are denied for payment by your insurance or your have failed to provide us with your correct insurance information, you will be responsible to pay for these services.

Laboratory Draws and Bills: It is the patient's responsibility to instruct the lab tech of the laboratory that your insurance requires you to use. Any laboratory procedures that are ordered during today's visit will be billed to your directly by the laboratory. Please contact the laboratory directly for any questions regarding your lab bill.

Paperwork: There is a charge for filling out any forms (FMLA, VA Forms, and any letters) by Dr. Patel and/or staff when needed.

Authorization and Consent

Assignment and Release: I hereby assign my insurance or other third party carrier benefits to be paid directly to the Physician Practice, realizing I am responsible for any resulting balance. I also authorize the Physician to release any information required to process this claim to my insurance carrier and/or to my employer or prospective employer. I acknowledge that I am financially responsible for services rendered, and failure to pay any outstanding balances may result in collection procedures being taken. Further, I agree that if this account results in a credit balance, the credit amount will be applied to any outstanding accounts of mine, or to a family member whose account I am guarantor for. **Electronic Check Conversion:** When you provide a check as payment, you authorize us either to use information from your check to make an one-time electronic funds transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account the same day.

Consent for treatment: I hereby authorize the physicians, midlevel providers, nurses, medical assistants, and other practice staff to conduct such examinations, and to administer treatment and medications as they deem necessary and advisable.

No Show Policy: I understand if I fail to come for a scheduled appointment or cancel less than 24 hours prior to the appointment, I will be considered a "no show". A no show fee per occurrence may be charged. Ongoing occurrences of no shows may result in dismissal from the Practice.

I understand the Financial and No Show Policy, Authorization and Consent for Treatment, and hereby agree to them:

Signature _____ Date _____

SSN _____

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Please mark the box next to each question.)

	Not at all	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	❑	❑	❑	❑
2. Feeling down, depressed, or hopeless	❑	❑	❑	❑
3. Trouble falling or staying asleep, or sleeping too much	❑	❑	❑	❑
4. Feeling tired or having little energy	❑	❑	❑	❑
5. Poor appetite or overeating	❑	❑	❑	❑
6. Feeling bad about yourself or that you are a failure, or have let yourself or your family down	❑	❑	❑	❑
7. Trouble concentrating on things, such as reading the newspaper or watching television	❑	❑	❑	❑
8. Moving or speaking so slowly that other people could have noticed; or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	❑	❑	❑	❑
9. Thoughts that you would be better off dead or of hurting yourself in some way	❑	❑	❑	❑

NEW PATIENT MEDICAL HISTORY

Patient:_____ Date of Birth: _____

Medical History:

Check box if you have ever been diagnosed with any of the following:

- ❑ Asthma
- ❑ Anemia
- ❑ Anxiety
- ❑ Arthritis
- ❑ Cancer-Type _____
- ❑ Chronic Bronchitis
- ❑ Chronic Pain
- ❑ Cirrhosis
- ❑ Clotting Disorder
- ❑ COPD
- ❑ Depression
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy/Seizures
- ❑ Fibromyalgia
- ❑ GERD
- ❑ Heart Attack
- ❑ Heart Disease
- ❑ Heart Murmur
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ HIV positive/AIDS
- ❑ Insomnia
- ❑ Kidney Disease
- ❑ Kidney Stones
- ❑ Migraines
- ❑ Stroke
- ❑ Thrombophlebitis
- ❑ Thyroid Disease
- ❑ Tuberculosis
- ❑ Other – Please List Below

  _____

Family History:

If any blood relative has ever had any of the following, please check box and indicate relationship.

- ❑ Bleeding Tendency _____
- ❑ Cancer
  Type _____
- ❑ Diabetes _____
- ❑ Heart Attack _____
- ❑ Heart Disease _____
- ❑ High Blood Pressure _____
- ❑ Kidney Disease _____
- ❑ Liver Disease _____
- ❑ Migraine Headaches _____
- ❑ Stroke _____
- ❑ Tuberculosis _____
- ❑ Other _____

Surgeries and/or Hospitalizations: List below with approximate date:

Reason	Date	Reason	Date

Previous Primary Care Physician:_____

Other Physicians involved in your care: _____

Medications Prescription & over the counter medications that you are currently taking (use additional sheet, if necessary).

Medication Name	Dose (mg)	How many times a day?

Allergies to Food/Medications:_____

_____

Pharmacy Name:_____ Phone Number ( )_____

Pharmacy Address:_____

Review of Systems

Check box if you have any of the following symptoms: **IN THE PAST TWO WEEKS**

Respiratory
- ❑ shortness of breath
- ❑ congestion
- ❑ cough
- ❑ wheezing

Endocrine
- ❑ cold intolerance
- ❑ heat intolerance
- ❑ increased thirst

Gastroenterology
- ❑ nausea
- ❑ heartburn
- ❑ constipation
- ❑ diarrhea
- ❑ difficulty swallowing
- ❑ indigestion
- ❑ abdominal pain

Urology
- ❑ frequent urination
- ❑ difficult or painful urination
- ❑ blood in urine

Dermatology
- ❑ rash
- ❑ flushing
- ❑ wound
- ❑ dry skin

Cardiology
- ❑ chest pain
- ❑ palpitations
- ❑ varicose veins
- ❑ sweating
- ❑ swelling
- ❑ fluttering sensation

Female Reproductive
- ❑ pregnant
- ❑ menopause

Male Reproductive
- ❑ difficulty with erection

Hematology
- ❑ easy bruising
- ❑ bleeding

Psychology
- ❑ depression
- ❑ anxiety
- ❑ stress

General
- ❑ weight gain
- ❑ weight loss
- ❑ loss of appetite
- ❑ fevers
- ❑ weakness
- ❑ fatigue

Ophthalmology
- ❑ diminished vision
- ❑ blurring of vision
- ❑ loss of vision
- ❑ vision floaters

Neurology
- ❑ headaches
- ❑ tingling
- ❑ fainting
- ❑ dizziness
- ❑ difficulty walking
- ❑ memory loss

Musculoskeletal
- ❑ joint pain
- ❑ leg cramps
- ❑ back pain
- ❑ arm pain
- ❑ neck pain
- ❑ leg pain
- ❑ muscle pain

Habits

❑ Smoking Packs Daily? _____
How Long? _____

❑ Vaping Puffs Daily? _____
How Long? _____

❑ Dipping Dips Daily? _____
How Long? _____

Interested in stopping? ❑Y ❑N

If you quit, when did you quit?

_____

How long did you smoke?

_____

❑ Alcohol: Type _____
Frequency _____
Amount _____

Have you ever used illegal drugs? ❑Y ❑N If so, what drugs?

_____

Sexual Activity

Currently sexually active? ❑Y❑N Sexual partner(s) is/are/have been: ❑Male ❑Female

Birth control method? ❑None needed ❑ Other (please describe): _____

Females Only

Mammogram When?_____ Where?_____

DEXA (Bone Density) When?_____ Where?_____

PAP smear When?_____ Where?_____

Males Only

PSA/Prostate exam When?_____ Where?_____

Males and Females

Colonoscopy/Cologuard When?_____ Where?_____

Eye Exam When?_____ Where?_____

Influenza Vaccination (flu shot) When?_____ Where?_____

Pneumonia Vaccination When?_____ Where?_____

Td/Tdap vaccination (tetanus shot) When?_____ Where?_____

Other vaccinations (please list) When?_____ Where?_____