2107 O'Brig Ave.
Guntersville, AL 35976

20 South Main St.
Arab, AL 35016

68278 Main St.
Blountsville, AL 35031

Premierfamilycarellc.com

We welcome you to our practice, and we look forward to the privilege of working with you regarding your health care needs. Please feel free to ask questions and please provide all information pertinent to your health requirements. Below are practice policies important to understand.

Schedule Appointments, Walk-in Visits, and Saturday Hours
Both scheduled appointments and walk-in services are offered for the convenience of our patients. Walk-in service is best for quicker visits where the patient has one simple problem such as sore throat, cold, etc. Scheduled appointments are best when the visit is likely to take longer due to the complexity of the medical issue or, even for simple matter the patient just prefers a fixed appointment.

Collection of Patient Amounts Due
Insurance companies require that any co-pay or co-insurance amounts be collected at the time of service. Co-pay amounts will be collected at the time of check-in to avoid a wait at check-out. If you have a deductible, full deductible is due unless determination can be made otherwise. The patient/guarantor will be responsible for any amounts not paid by your insurance company. For patients without insurance, the practice offers a low flat fee pricing for the visit with the provider, so the patient will know the costs up front. Any lab, x-ray, or other services have additional fees if needed. This flat fee pricing is available only if the fee is paid at the time of service. I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs, if such be necessary.

For us to service your account or collect monies you may owe, I, the undersigned, agree that Premier Family Care and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

Prescription Refills Over the Phone
Please make your provider aware on the day of your visit, any prescriptions that need refilling. To ensure practice personnel understand your current medical condition, the practice generally will need to see a patient back in the office prior the calling in a prescription.

Assignment of Payment
By signing below, I hereby authorize payment of medical benefits directly to Premier Family Care for their services and to release any information acquired in the course of my examination or treatment for insurance purposes. I understand that records may be transmitted electronically or by mail as required.

Acknowledgement of Receipt of Notice of Privacy Practices
This signed form acknowledges that you have been offered a copy of our practice's Notice of Privacy Practices as required by federal law. Your signature does not mean that you have read this notice yet, only that you were offered a copy to read when convenient for you. The notice is yours to keep. If you have declined the copy, please initial here. _____

Consent for Treatment

I request and authorize health care services by my provider and his/her designee(s) as my provider may deem advisable and in my best interest. This may include routine diagnostic, radiology and laboratory procedures and medication administration.

I understand that excluding an emergency or extraordinary, no substantial procedure will be performed without providing me an opportunity to give informed consent for that procedure. Informed means the medical provider must disclose information to me including benefits and risks of a procedure and/or treatment. This understanding includes that no research or experimental procedures may be done without my knowledge and consent.

Patient Name _____ DOB _____

Signature of Patient, Parent, or Legal Guardian _____ Date: _____

WELCOME TO PREMIER FAMILY CARE

PATIENT INFORMATION TODAY'S DATE _____

FIRST NAME _____ LAST NAME _____ MIDDLE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____ SOCIAL SECURITY NUMBER _____ DRIVER LIC # _____

HOME PHONE _____ CELL PHONE _____ EMAIL _____

EMPLOYER _____ WORK PHONE _____OCCUPATION _____

EMERGENCY CONTACT _____ PHONE _____

HOW DID YOU HEAR ABOUT OUR PRACTICE? _____ MARITAL STATUS _____

MALE OR FEMALE _____ AGE _____ RACE/ETHNICITY_____

RESPONSIBLE PARTY

_____ Patient is responsible party

_____ Another person is responsible for account (person must be present to sign this form and at least 19 years of age)

FIRST NAME _____ LAST NAME _____ MIDDLE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____ SSN _____ DRIVER LIC # _____

HOME PHONE _____ CELL PHONE _____ EMAIL _____

EMPLOYER _____ WORK PHONE _____OCCUPATION _____

INSURANCE INFORMATION

_____ Patient is insured

_____ Another party is insured and patient is covered on his/her plan:

Insured First Name _____ Last Name _____ Middle _____

Insured Date of Birth _____ Subscriber SSN _____

Subscriber Employer _____ Work Phone _____ Other Phone _____

Insurance Company _____ Group No. _____ Contract No _____

Mailing Address for claims _____ City _____ State _____ Zip_____

*As responsible party for this account, I understand that I am legally responsible for the payment of any and all fees for treatment rendered to the patient listed above. If the patient has insurance, claims will be filed on behalf of patient, but I am ultimately responsible for the total bill, regardless of insurance payment or nonpayment.

Signed _____ Date _____

Privacy Confidentiality Act Authorization for Contact and Messages

Patient Name _____ DOB _____

DUE TO PRIVACY CONFIDENTIALITY ACT, please list the people that you approve to have access to your information as stated below:

Medical Records Information: (test results, prescription information, appointment information, etc.)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Authorization to Leave Messages

I authorize Premier Family Care physicians and staff to leave messages regarding my medical condition, such as: lab reports, other test results and medications on my answering machine or voicemail. This authorization will be in effect until I give written notice to Premier Family Care otherwise.

Agree _____ Disagree _____

Signature _____ Date _____

Health History

Patient Name _____ **Date** _____

Reason for visit: _____

Are you under a physician's care now? ○ Yes ○ No If yes, please explain: _____

Are you on a special diet? ○ Yes ○ No If yes, please explain: _____

Do you use tobacco? ○ Yes ○ No If yes, please explain: _____

Do you used controlled substances? ○ Yes ○ No If yes, please explain: _____

Date of last menstrual period? ○ Yes ○ No If yes, please explain: _____

Do you use alcohol? ○ Yes ○ No If yes, please explain: _____

Immunizations: Are you up to date? _____ Yes _____ No

When was your last flu shot? (Month/Year) _____

When was your last tetanus shot? (Month/Year) _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	○ Yes ○ No	Diabetes	○ Yes ○ No	Hives or Rash	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Degenerative Joint Disease	○ Yes ○ No	Hypoglycemia	○ Yes ○ No
Anxiety	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No
Afib	○ Yes ○ No	Easily Winded	○ Yes ○ No	Kidney Problems	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Echo Abnormal	○ Yes ○ No	Leukemia	○ Yes ○ No
Anemia	○ Yes ○ No	Emphysema	○ Yes ○ No	Liver Disease	○ Yes ○ No
Angina	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Lung Disease	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Excessive Thirst	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Mumps or Measles	○ Yes ○ No
Asthma	○ Yes ○ No	Frequent Cough	○ Yes ○ No	Osteoporosis	○ Yes ○ No
Back Problems	○ Yes ○ No	Frequent Diarrhea	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No
Bleeding Tendency	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Psychiatric Care	○ Yes ○ No
Blood Disease	○ Yes ○ No	Genital Herpes	○ Yes ○ No	Recent weight loss	○ Yes ○ No
Blood Transfusion	○ Yes ○ No	Glaucoma	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
Breathing Problem	○ Yes ○ No	Hay Fever	○ Yes ○ No	Scarlet Fever	○ Yes ○ No
Bronchitis	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Shingles	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Cancer	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No	Spina Bifida	○ Yes ○ No
Chest Pains	○ Yes ○ No	Hemophilia	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No
Cold Sores/Fever Blisters	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Stroke	○ Yes ○ No
Congenital Heart Disorder	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Convulsions	○ Yes ○ No	Herpes	○ Yes ○ No	Tonsillitis	○ Yes ○ No
Coronary Artery Disease	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Tuberculosis	○ Yes ○ No
COPD	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Ulcers	○ Yes ○ No

Have you had any other serious illness not listed above? ○ Yes ○ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the office of any changes in medical status.

Signature of Patient, Parent, or Guardian _____ Date _____

Patient's Name: _____ DOB: _____

Family History:

Do you have a family history of any of the following? (Specifically, maternal or paternal)

Alzheimer's Disease	Yes	No	_____
Cancer	Yes	No	Type: _____
DVT/PE's (Blood clots)	Yes	No	_____
Diabetes	Yes	No	_____
Heart Disease	Yes	No	_____
Hypertension	Yes	No	_____
Mental Disorders	Yes	No	_____

Medications:

Drug Name	Dosage	Frequency

Allergies:

_____

_____

Surgeries:

_____

_____

_____

_____

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Identification of Legal Guardian is required

Please print clearly

Legal Guardian Information

Name: _____ Relationship to patient: _____

Address: _____ Home/Cell Phone #: _____

City/State/Zip: _____ Work Phone: _____

Social Security #: _____ Date of Birth: _____

Patient Information

1. Name: _____ Date of Birth: _____

2. Name: _____ Date of Birth: _____

3. Name: _____ Date of Birth: _____

Section A

I authorize Premier Family Care to take the following action requested (please initial by the appropriate action to complete the request)

_____Provide a copy to me
_____Release my medical records to (please complete information below)
_____Obtain my medical records from (please complete information below)

Name: _____
Address: _____
City/State/Zip: _____
Telephone: _____ Fax: _____

Section B (Initial beside the information you request to be released)

I give special permission to release any information regarding; _____ Substance Abuse _____HIV Information

The Premier Family Care does not release psychotherapy notes of any form to any third parties, except those require by the HIPPA Privacy Rule. The patient's legal guardian must obtain psychotherapy notes from the originating psychotherapy provider.

Section C

This authorization will automatically expire one year from the date signed. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules.

Reason for request: _____

Signed: _____ Date: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in the Notice of Privacy Practices we have provided to you. We may revise our Notice of Privacy Practices at any time. We will provide you with a current copy of the Notice of Privacy Practices upon your request.

Patient name: _____

By signing below, you are acknowledging that you was offered a copy of our Notice of Privacy Practices.

_____ Date: _____, 20____
Patient Signature

OR

If you are receiving the Notice of Privacy Practices on behalf of the patient, please do the following:

- Print your name here: _____
- Specify your authority to act on behalf of the patient:

_____

- Sign your name in the space below:

_____ Date: _____, 20____

FACILITY USE ONLY

I, _____, attempted to obtain the above-named patient's acknowledgement of receipt of the Notice of Privacy Practices, but was unable to do so. I was unable to do so because (please explain below):

_____

_____

_____

Signature: _____ Date: _____, 20____