1407 Blount Ave.
Guntersville, AL 35976
833-582-2324

20 South Main St.
Arab, AL 35016
833-586-2324

68278 Main St.
Blountsville, AL 35031
833-429-2324

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, Same-Day, and Next-Day Appointments:
Both scheduled appointments and same-day or next-day appointments are offered for the convenience of our patients. Same-day or next-day appointments are suitable for quicker visits where the patient has one simple problem, such as a sore throat or a cold, etc. Scheduled appointments are best when the visit is likely to take longer due to the complexity of the medical issue or if the patient simply prefers to have 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 check-in to avoid a wait at check-out. If you have a deductible, the full deductible is due unless a determination can be made otherwise. The patient/guarantor will be responsible for any amount of the visit not paid for 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 upfront. 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.

In order 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 the use of an automatic dialing device, as applicable.

Prescription Refills Over The Phone
Please make your provider aware on the day of your visit if you need any prescriptions refilled. To ensure that practice personnel understand your current medical condition, the practice generally will need to see a patient back in the office before 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 during 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 received 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 given a copy to read when convenient for you. The notice is yours to keep.

Consent for Treatment

I request and authorize healthcare 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, as well as medication administration.

I understand that, excluding an emergency or extraordinary situation, 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 the benefits and risks of a particular 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 Our Office

We are grateful that you have chosen us to provide your healthcare needs. Please carefully read the following office policies, initial each item, sign, and date. We will provide you with a copy for your records. Thank you!

_____ No foul or abusive language toward the office staff will be tolerated.

_____ Our office will not prescribe Mepergan, Methadone, or Soma for any reason. Please note that no narcotics are kept on the premises.

_____ We make every effort to minimize your wait time. We accommodate both scheduled, same-day, or next-day appointments. If you are 15 minutes late for your appointment, we may need to reschedule it for a later date.

_____ Payment, including any outstanding balances, is due before seeing the provider.

_____ Please refrain from driving or operating heavy machinery while taking any narcotic medication prescribed by our office.

_____ When you provide a check as payment, you authorize us to make a one-time electronic fund transfer from your account or process the payment as a check transfer. You also agree to a $30.00 fee for returned payments through electronic fund transfer from your account.

_____ ANY & ALL non-covered charges will be the patient's financial responsibility. If the patient is a minor, the parent or legal guardian will be responsible for payment. This includes office visits, labs, x-rays, or other ancillary services.

_____ We cannot prescribe your current medications without the medication bottles, a medication list from your pharmacy, or a medication list from the patient detailing the medication name, dosage, and frequency. This information is essential for us to provide the appropriate care.

_____ Please be aware that the provider has discretion when prescribing medications.

_____ Patients seeking care for pain management or other conditions requiring chronic use of controlled medications may be required to undergo a drug screen during the initial visit. The cost, if not covered by insurance, is $50 and MUST be paid at the time of the visit.

I have read and agree to the above guidelines. I understand that non-compliance is grounds for dismissal.

Patient's Signature: _____ Date: _____

No-Show Policy Fee

At Premier Family Care, we value your time and our commitment to providing quality healthcare services. To ensure efficient scheduling and the availability of appointments to all our patients, we have implemented a No-Show Policy Fee for missed appointments.

Policy Details:
Appointment Cancellation: We understand that unforeseen circumstances may arise, requiring you to cancel or reschedule your appointment. We kindly request that you notify us at least 24 hours in advance if you need to cancel or reschedule. Failure to do so may result in a No-Show Policy Fee. In addition, if you schedule a Same-Day Appointment and do not show for that appointment, you will be charged a No-Show Policy Fee.

No-Show Policy Fee: If you miss your scheduled appointment without prior notice or cancel with less than 24 hours' notice, a No-Show Policy Fee of $30.00 will be charged to your account. This fee is not covered by insurance and must be paid before scheduling any future appointments.

Exemptions: We recognize that emergencies and unavoidable situations can occur. Patients who can provide valid documentation of such circumstances may be exempt from the No-Show Policy Fee at the discretion of our practice.

Payment Options:
The No-Show Policy Fee can be paid at your next scheduled appointment.

Questions or Concerns:
If you have any questions or concerns about our No-Show Policy, please feel free to contact our office.

By signing below, you acknowledge that you have read and understand Premier Family Care's No-Show Policy.

Patient's Signature: _____ 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.

Patient's Signature: _____ Date: _____

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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	Physician's name: _____
Are you on a special diet?	○ Yes ○ No	If yes, please explain: _____
Do you use tobacco?	○ Yes ○ No	If yes, How much, How often: _____
Do you used controlled substances?	○ Yes ○ No	If yes, How much, How often: _____
Do you still have a menstrual period?	○ Yes ○ No	Date: _____
Do you use alcohol?	○ Yes ○ No	If yes, How much, How often: _____

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 _____

Family History:

Please specify any family members that are associated with any of the following medical conditions in your family's history.

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

Premier Family Care

1407 Blount Ave.
Guntersville, AL 35976
833.582.2324
Fax 256.582.2321

20 South Main St.
Arab, AL 35016
833.586.2324
Fax 256.202.1010 or 256.202.1096

68278 Main St.
Blountsville, AL 35031
833.429.2324
Fax 256.202.1222 or 256.202.1574

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 have received 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____