Professional Medical Associates, P.C.

PLEASE PRINT

Full Name: _____
Preferred Name: _____ **Maiden Name**: _____
DOB: _____ **Age**: _____ **SSN**: _____
Race: _____ **Ethnicity**: _____ **Preferred Language**: _____
Marital Status: _____ **Driver's License #**: _____
Address: _____
City: _____ **State**: _____ **ZIP**: _____
Home Phone #: _____ **Work Phone #**: _____ **Cell Phone #**: _____
Employer: _____ **Occupation**: _____
Preferred Method of Contact (please circle): **Home Phone** **Cell Phone** **Text** **Email**
Pharmacy Name and Location: _____ **Email Address**: _____

Responsible Party Information

Name: _____ **DOB**: _____
SSN: _____ **Employer**: _____ **Relationship**: _____

Emergency Contact: _____ **Phone #**: _____
Emergency Contact: _____ **Phone #**: _____

Primary Insurance Co.: _____
Policy ID#: _____ **Group#**: _____
Policy Holder: _____ **Policy Holder DOB**: _____
Relationship: _____ **Policy Holder SSN**: _____
Policy Holder Employer: _____

Secondary Insurance Co.: _____
Policy ID#: _____ **Group#**: _____
Policy Holder: _____ **Policy Holder DOB**: _____
Relationship: _____ **Policy Holder SSN**: _____
Policy Holder Employer: _____

***********IMPORTANT INFORMATION – PLEASE READ BEFORE SIGNING***********

CONSENT FOR TREATMENT: I have completed this form full and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I consent to treatment necessary for the care of the patient. RELEASE OF INFORMATION: I authorize release of my medical and financial records to individuals as delineated in Professional Medical Associates (PMA) Privacy Practices. I, the undersigned, give prior express consent to Professional Medical Associates, P.C. (PMA), its employees and/or agents, to contact me at any/all phone numbers, including cell numbers or text messaging, which could result in charges to me, or any email provided by me for the purpose of treatment, payment or healthcare operations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing devices, as applicable. I further acknowledge that a copy of the Notice of Privacy Practices from PMA has been made available to me.

AGREEMENT TO PAY: On any unpaid balance, I assign benefits due from any insurance company or third party to PMA. I understand that payment is due on the date service is rendered. 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. A copy of the financial policy for PMA has been made available to me.

Signature: _____**Date:** _____

PMA
Professional Medical Associates
101 E. Brunson Street, Suite 200
Enterprise, AL 36330
Phone (334) 393-3686 / Fax (334)347-4906

MEDICAL INFORMATION RELEASE

Due to federal privacy guidelines under the Health Insurance Portability and Accountability Act (HIPPA), we are required to have a medical release of information on file for each patient. This authorizes our office to release medical information to family members, caregivers, and friends you have designated, about your PROTECTED HEALTH INFORMATION. Included would be all health and identifiable information. This authorizes us to share your health information, after proper identification, by verbal or written communication, phone, fax, or mail as needed for your care to only those identified below. Powers of Attorney would be separate from this authorization.

I understand that my medical information may contain information regarding HIV testing and/or treatment, drug or alcohol testing and/or treatment, psychiatric treatment and I authorize their release.

I give my authorization to the following individual(s) to discuss my medical care with my physician and/or staff on my behalf. PLEASE PRINT.

NAMES AND RELATIONSHIP	DATE OF BIRTH	PHONE NUMBER
_____	_____	_____
_____	_____	_____

Please list below any health information that you do not want to be given out:

_____

_____: I DO NOT release my medical information to ANYONE other than myself.

I hereby release Professional Medical Associates, P.C. or any of their agents from legal responsibility or reliability for disclosure of above information to the extent indicated and authorized.

The above information is private and confidential and will be placed in your medical records. This authorization will EXPIRE IN TWELVE (12) MONTHS for the date signed or we receive written notification from you to revoke it.

PATIENT SIGNATURE_____ DATE ____/____/_____

WITNESS SIGNATURE_____

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E-PRESCRIBING PBM CONSENT FORM

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care.

Benefits data are maintained per health insurance providers by organizations known as Pharmacy Benefits Manager (PBM). PBMs are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan. The Medicare Modernization Act (MMA) 2003 listed standards that must be included in an e-Prescribe program. These include:

- **Formulary and benefit – transactions – Gives the prescriber information about which drugs are covered 'by the drug benefit plan'.**
- **Medication history transactions – Provides the physician with information about medications the patient is already taking prescribed by any provider, to minimize the number of adverse drug events.**

By signing this consent form you are agreeing that Professional Medical Associates, P.C., can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Patient Name (Printed)_____DOB: ___/___/_____

Signature of patient (or Representative): _____Date: ___/___/____

Relationship, if other than patient: _____

Consent Denied:_____ Date: _____

Professional Medical Associates, P.C.

Office Policies

We appreciate your selection of our practice to serve the medical needs of your family. Everyone in our office is dedicated to providing quality patient care. We look forward to working with you to optimize your health.

Please initial the following items indicating that you have read and understand each listed:

_____**Business Office Hours:** 7:30 am to 5:00 pm, Monday through Friday. Closed major holidays.

_____**Appointments: If you fail to come in for your appointment and do not cancel within 24 hours or fail to come in for a same day appointment, you could be charged a $25 no-show/cancellation fee. 3 missed appointments can result in being dismissed from the practice. New patients who arrive late or fail to show for their appointment may not be allowed to reschedule/establish with our office.** We will try to accommodate you on the dates and times you request. We understand your time is valuable. In order to minimize your wait-time, you must arrive on time and cancel with appropriate notice. **We ask that all cell phones be turned off during your visit.** <u>You must obtain prior approval before presenting to appointments relating to auto accidents or worker's compensation cases.</u> All providers usually have daily work-in/same-day appointments available. In order to continue to be an active patient of the practice, I understand that I need to be seen at least annually.

_____**Telephone calls:** Phones are answered from 7 am until 4:30 pm, Monday thru Friday. The fastest way to get a response from our office is thru your patient portal, not telephones. If you have not signed up for the portal, please ask the Front Desk staff to sign you up. Due to the number of calls handled per day, all messages are prioritized by the designated provider's medical staff. Some calls may have to be returned the next working day. Please allow ample time for medical staff to return your call. **We ask that you do not leave multiple messages.** Your questions and concerns are important to us. **For EMERGENCIES after hours, call 334-393-3686 and press 8 to be transferred to our answering service. Messages will be forwarded to the on-call provider as needed.**

_____**Communication:** PMA may contact you at any phone numbers, email or physical addresses you provide for the purpose of treatment, payment, or healthcare operations. This includes courtesy appointment reminders. PMA may utilize pre-recorded/artificial voice messages and/or use of automatic dialing devices. Any charges by you phone carrier related to text messaging, email cellular data or minutes, etc. are your financial responsibility.

_____**Primary Care:** We are a Primary Care office. In order to provide quality comprehensive care, we must work with any specialist involved in your care. You must notify us in a timely manner of any and all physician/medications that you are currently using. Failure to do so places you at risk and is cause for termination from the practice. Every patient will need an annual wellness visit to discuss preventive and wellness measures.

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Office Policies

_____**Lab & Test Results:** We provide full lab, x-ray and ultrasound services. All test results will be discussed at a follow up appointment or may be communicated via patient portal. **It is your responsibility to follow up on all test results.** You may be required to come in for a follow up to discuss the results.

_____**Medical Records:** Copies of your medical records are provided to mutual physicians at no charge to the patient. If you request a personal copy of your medical records, there is a charge for copying records. We have 30 days to comply with your records requests. You can download medical information via the patient portal.

_____**Prescription Refills:** We encourage refills to be done at the time of the visit. For your safety and convenience, our office is now using an electronic prescription system. Please call your pharmacy directly to process your medication refill requests. In the event that you may need to contact us for refills during normal business hours, we have a voicemail set up for you to leave a message or you can send us a portal message. Please **allow 48 hours** for your refill to get to your pharmacy. **Please note that the on call physician does not routinely refill medications (routine maintenance or pain). Those requests should be handled during normal business hours.** Our providers require regular routine visits for refills. There may be a charge related to refills outside of an office visit and this service is not covered by your insurance.

_____**Virtual Visits/Patient Portal:** If you are unable to come to the office for an appointment, we offer virtual visits. Most insurance carriers cover virtual visits at our office, this also applies to detailed services provided via the Patient Portal in lieu of an office visit. Patients are responsible for all non-covered costs. Virtual visits can be scheduled by calling our office.

_____**Forms:** Our doctors may require an office visit and/or fee to complete forms. We request 7 business days for form completion. An expedition fee may apply if form is required less than 7 business days.

_____**Behavior:** Patient and employee safety is a priority of PMA. Disrespectful (including sexually inappropriate) language and/or behaviors towards staff and/or other patients (in person and/or online) will be cause for immediate termination from the practice.

_____**Nursing Home Patients:** Our doctors admit to Enterprise Health & Rehab. **Any problems or concerns of a nursing home patient should be directed to the nursing home staff.** Our physicians and/or NPs/PAs are in constant contact with them. In the event your concerns are not taken care of by the facility, please contact the Practice Manager at our office to assist.

_____**Chronic Care Management (CCM):** Our office provides chronic care management services to qualified patients. This program is voluntary. If you choose to participate, your insurance will be filed and you will owe for any deductibles and/or copays.

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_____**Payment Policy: All patients are responsible for payment of any monies due (co-pays, deductibles and/or coinsurance) AT THE TIME SERVICES ARE RENDERED.** If your insurance processes your claim and states that you owe more money than was collected at the time of service, prompt payment is expected. Accounts over 90 days old could be placed with an outside collection agency and charged a 33.33% collection fee. If your account is placed in collections, you will be required to pay the collection amount in full prior to scheduling another appointment or being seen. If you make payment with a check and it is returned, will also incur a return check fee of $30 per check. The return check fee can be paid with cash, money order or credit card, but not with another check. Additional fees will be charged accordingly and legal action could be pursued thru the District Attorney's office.

I have completed this fully and certify that I am the patient or duly authorized agent of the patient. I further acknowledge that a copy of this form has been made available to me.

Signature: _____Date: _____

Witness: _____Date: _____

NEW PATIENT MEDICAL HISTORY FORM

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Full Name: _____ Date: _____

Birth Date: _____ Age: _____

ALLERGIES ❑ NO ALLERGIES

ALLERGY	ALLERGIC REACTION

MEDICATIONS

MEDICATIONS *(Please list ALL)*	DOSE *(Mg., pill, etc.)*	TIMES PER DAY

If you need more room to list medications, please write them on a blank sheet of paper with the required information

HEALTH MAINTENANCE SCREENING TEST HISTORY

CHOLESTEROL	Date:	Facility/Provider:	Abnormal Result? Y N
COLONOSCOPY/SIGMOID	Date:	Facility/Provider:	Abnormal Result? Y N
MAMMOGRAM	Date:	Facility/Provider:	Abnormal Result? Y N
PAP SMEAR	Date:	Facility/Provider:	Abnormal Result? Y N
BONE DENSITY	Date:	Facility/Provider:	Abnormal Result? Y N

VACCINATION HISTORY

Last Tetanus Booster or TdaP:	Last Pnuemovax *(Pneumonia)*:
Last Flu Vaccine:	Last Prevnar:
Last Zoster Vaccine *(Shingles)*:	

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PERSONAL MEDICAL HISTORY

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Alcoholism/Drug Abuse			
Asthma			
Cancer *(type:_____)*			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes *(type:_____)*			
Emphysema *(COPD)*			
Heart Disease			
High Blood Pressure *(hypertension)*			
High Cholesterol			
Hypothyroidism/Thyroid Disease			
Renal *(kidney)* Disease			
Migraine Headaches			
Stroke			
Other:			
Other:			

SURGERIES

TYPE *(specify left/right)*	DATE	LOCATION / FACILITY

Patient Name: _____ DOB: _____

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WOMEN'S HEALTH HISTORY

Date of Last Menstrual Cycle:	Age of First Menstruation: _____ Age of Menopause: _____
Total Number of Pregnancies:	Number of Live Births:
Pregnancy Complications:	

FAMILYMEDICAL HISTORY ❑ NO SIGNIFICANT FAMILY HISTORY IS KNOWN

✔ CHECK ALL THAT APPLY	Alcohol/Drug Abuse	Asthma	Cancer (type:_____)	Emphysema (COPD)	Depression/Anxiety	Bipolar/Suicidal	Diabetes	Early Death	Heart Disease	High Cholesterol	High Blood Pressure	Kidney Disease	Stroke	Thyroid Disease	Migraines	Other:_____	Other:_____	Other:_____
Parent																		
Sibling																		
Child																		
Other:_____																		

SOCIAL HISTORY

Occupation *(or prior occupation)*:	❑ Retired ❑ Unemployed ❑ LOA ❑ Disabled
Employer:	Years of Education or Highest Degree:
If employed, do you work the night shift? Y N N/A	
Marital Status *(check one)*: ❑ Single ❑ Partner ❑ Married ❑ Divorced ❑ Widowed ❑ Other:_____	
Do you have children? Y N	If yes, how many?

OTHER HEALTH ISSUES

TOBACCO USE	Smoke Cigarettes? Y N *(If you never smoked, please move to Alcohol /Drug Use)*		
Current: Packs/day _____ # of Years _____	***Past:*** Quit Date: _____ Packs/day _____ # of Years _____		
Other Tobacco *(check one)*: ❑ Pipe ❑ Cigar ❑ Snuff ❑ Chew			
ALCOHOL/DRUG USE	Do you drink alcohol? Y N	❑ Beer ❑ Wine ❑ Liquor	# of Drinks/week:
Do you use marijuana or recreational drugs? Y N		Have you ever used needles to inject drugs? Y N	
Have you ever taken someone else's drugs? Y N			

Patient Name: _____ DOB: _____

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OTHER HEALTH ISSUES continued...

SEXUAL ACTIVITY	Sexually involved currently? Y N *(If no sexual history, please continue to Exercise)*	
Sexual partner(s) is/are/have been: ❑ Male ❑ Female ❑ Both		
Birth control method: ❑ None ❑ Condom ❑ Pill/Ring/Patch/Inj/IUD ❑ Vasectomy		
EXERCISE	Do you exercise regularly? Y N *(If you answered no, please move to Sleep)*	
What kind of exercise? _____	***Duration:*** How long (min.): _____ How often: _____	
SLEEP	How many hours, on average, do you sleep at night *(or during the day, if working night shift)*?	
DIET	How would you rate your diet? ❑ Good ❑ Fair ❑ Poor	Would you like advice on your diet? Y N
SAFETY	Do you use a bike helmet? Y N	Do you use seat belts consistently? Y N
Working smoke detector in home? Y N		If you have guns at home, are they locked up? Y N
Is violence at home a concern for you? Y N		Have you completed an Advance Directive for Health Care (ADHC), Living Will, or Physical Orders for Life Sustaining Therapy (POLST)? Y N

OTHER PROVIDERS/SPECIALISTS

SPECIALIST	NAME	LAST VISIT
Cardiology		
Gastroenterologist (GI)		
OB/GYN		
Neurology		
Pulmonary		
Other:_____		
Other:_____		

ADDITIONAL INFORMATION

Have you traveled outside of the country in the last 30 days? Y N	If yes, where?
Have you served in the military? Y N	If yes, how long and what branch?
Were you deployed? Y N	If yes, where?

Patient Name: _____ DOB: _____

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REVIEW OF SYSTEMS ✔ CHECK ALL THAT APPLY

CONSTITUTION	CARDIOVASCULAR	SKIN
Activity change	Chest pain	Color change
Appetite change	Leg swelling	Pallor
Chills	Palpitations	Rash
Diaphoresis	**GASTROINTESTINAL**	Wound
Fatigue	Abdominal distention	**ALLERGY/IMMUNO**
Fever	Abdominal pain	Environmental allergies
Unexpected weight change	Anal bleeding	Food allergies
HEAD, EAR, NOSE & THROAT	Blood in stool	Immunocompromised
Congestion	Constipation	**NEUROLOGICAL**
Dental problem	Diarrhea	Dizziness
Drooling	Nausea	Facial asymmetry
Ear discharge	Rectal pain	Headaches
Ear pain	Vomiting	Light-headedness
Facial swelling	**ENDOCRINE**	Numbness
Hearing loss	Cold intolerance	Seizures
Mouth sores	Heat intolerance	Speech difficulty
Nosebleeds	Polydipsia	Syncope
Postnasal drip	Polyphagia	Tremors
Rhinorrhea	Polyuria	Weakness
Sinus pressure	**GENITOURINARY**	**HEMATOLOGIC**
Sneezing	Difficulty urinating	Adenopathy
Sore throat	Dysuria	Bruises/bleeds easily
Tinnitus	Enuresis	**PSYCHIATRIC**
Trouble swallowing	Flank pain	Agitation
Voice change	Frequency	Behavior problem
EYES	Genital sore	Confusion
Eye discharge	Hematuria	Decreased concentration
Eye itching	Penile discharge	Dysphoric mood
Eye pain	Penile pain	Hallucinations
Eye redness	Penile swelling	Hyperactive
Photophobia	Scrotal swelling	Nervous/anxious
Visual disturbance	Testicular pain	Self-injury
RESPIRATORY	Urgency	Sleep disturbance
Apnea	Urine decreased	Suicidal ideas
Chest tightness	**MUSCULAR**	
Choking	Arthralgias	
Cough	Back pain	
Shortness of breath	Gait problems	
Stridor	Joint swelling	
Wheezing	Myalgias	
	Neck pain	
	Neck stiffness	

Patient Name: _____ DOB: _____