ALLMAN
FAMILY MEDICINE

1878 Jeff Road
Suite G
Huntsville, AL 35806
Office: 256.428.0444
Fax: 256.428.0447
www.allmanfamilymedicine.com

Office Policies

1. Our Mission: Our primary policy is to provide our patients with the highest quality Health care within the scope of our specialty – Family Medicine.

2. **Controlled Substances**: Because we do not provide care for chronic pain management with controlled substances, such as narcotics, any chronic pain needs or other medical conditions requiring long-term controlled substances will be referred to providers who can offer the best care for you.

_____ Initial

3. **Appointments**: Time is valuable for all of us. We want to have time to give you and your health issues our utmost attention. Therefore, we will ask for payment of $25.00 for appointments canceled inside of 24 hours. If failing to cancel and just not coming for three appointments, we may have to ask you to find another health care provider. At this time we do not offer "walk-in" appointments. However, we do have several slots during the day for "same-day" appointments for urgent problems. We strive to see you on time.

_____ Initial

4. **Prescriptions:** We strive to have zero errors with your medications. Therefore, please bring all prescription bottles to each appointment. To provide the best care possible, we prefer to write new and refill prescriptions during office visits. If possible, we will write you enough refills to last until your next appointment. Also, we will not be able to prescribe medications after hours unless it proves to be an emergency. Prescriptions may be picked up by the patient, parent, guardian, or persons listed on the Disclosure Release. We are not able to call in any controlled substances over the phone.

_____ Initial

5. **Health Forms:** We understand that health forms are required by many agencies, and we will be happy to fill these out during your appointment free of charge if it does not delay the care of other patients. Lengthy forms may have to be completed and picked up later. Any form completion requested outside of an office visit will be subject to a $25.00 charge as well as a $1.00 mailing charge.

_____ Initial

6. **Records:** In order to insure accuracy of your medical information, all of our medical records are in digital format. Copies of your medical records are available to you with a signed medical release. We do not charge for doctor-to-doctor medical record transfers. However, to cover costs we do charge the standard $0.50 per page for personal copies of records.

_____ Initial

7. **Dismissal:** We sincerely hope that we never have to part ways with a patient. However, some extreme circumstances may make this necessary. If this occurs, you will be notified by certified mail. You will have 30 days to find another doctor. During those 30 days we will continue to offer only urgent care.

_____ Initial

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Financial Policies

We are honored that you chose Allman Family Medicine as your health care home. We hope to provide you with a comfortable, relaxing, and up-to-date medical experience. Feel free to contact us with any questions. _____ Initial

1. Insurance: Please be aware that knowing your insurance contract is your responsibility. This includes knowing which labs, hospitals, and other providers your insurance covers. Please contact your insurance company for any questions about what services are covered by your plan. _____ Initial

2. Co-payments: All co-payments are due at the time of service and we do not bill for copayments. For minors, all co-payments are to be paid by the party bringing them to the visit that day.

3. Non-covered services: On occasion a service may not be deemed necessary or reasonable by your insurance program. Please be aware that payments for these services are due at the time of service. _____ Initial

4. Proof of Insurance: Please bring your current driver's license and insurance card to each appointment for insurance verification. Delays in verification of insurance may make you responsible for any payment in full.

5. Insurance Problems: Your insurance policy is a contract between you and the insurance company. Any remaining balances are your responsibility, whether or not they are paid by your insurance. Any questions or problems with your insurance should be directed to your individual insurance company. _____ Initial

6. Non-payment: Any balances after 90 days may be referred to a collection agency and may unfortunately result in you and your immediate family being dismissed from the practice. If this occurs you will be notified by certified mail, and will have 30 days to find another provider. During that time we will provide urgent services only. _____ Initial

7. Returned checks: There is a $35.00 charge for returned checks. _____ Initial

New Patient Form

Allman Family Medicine, PC

How did you hear about us? _____ Email _____

Patient Information

Patient's Name _____

Last Name First Name Middle Name Name you go by

Street _____

City, State, Zip _____ Home Phone _____ Cell Phone _____

Sex _____ Birth Date _____ Age _____ SSN _____ Driver's Lic. # _____ Marital Status _____

mm/dd/yyyy

Patient's Employer _____ Occupation _____ Work Phone _____

Spouse's Name _____

Last Name First Name Middle Name Name goes by

Emergency Contact

Contact's Name _____ Relationship _____ Phone _____

Pharmacy Information

Pharmacy Name _____

Location _____ Phone _____ Fax _____

Insurance Information

Insurance #1 _____

Group # _____ Contract # _____ Co-pay _____

Name of Insured _____ Relationship to Patient _____

Sex _____ Birth Date _____ SSN _____

mm/dd/yyyy

Insurance #2 _____

Group # _____ Contract # _____ Co-pay _____

Name of Insured _____ Relationship to Patient _____

Sex _____ Birth Date _____ SSN _____

mm/dd/yyyy

Authorization to Release Information and Assignment of Benefits

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Signature _____ Date _____

I hereby authorize Allman Family Medicine to apply benefits on my behalf for the covered services rendered by the office, or by the office's order. I request that payment from my insurance company be made directly to Allman Family Medicine or to the party who accepts assignment. I certify that the information I have reported with regard to my insurance coverage is correct.

Signature _____ Date _____

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Receipt of Privacy Practices; Consent to Use/Disclosure of Protected Health Information (PHI)

You will find a copy of our privacy practices posted in the lobby and in each exam room. If you would like a copy for your own records, please check here. _____

I, _____, was offered a copy of Allman Family Medicine's Privacy Practices Notification. Allman Family Medicine may revise its notification at any time. I understand that a copy is always available at my request. By signing this document I acknowledge that I have read, understand and agree to the terms of this consent. Further, I hereby consent and authorize Allman Family Medicine to use or disclose my PHI in conjunction with Allman Family Medicine's treatment, payment or healthcare option in accordance with the terms of this consent.

_____ _____

Signature of Patient/Guardian **Date**

Further I hereby authorize and give my consent to Allman Family Medicine to leave messages on my answering machine/voicemail for the following (check all that apply)

Appointment reminders	____	**Prescription Refills**	____
Medical Information	____	**Test Results**	____
Insurance/Payment Issues	____	**Mail**	____

I further authorize and give consent to Allman Family Medicine to communicate any of my PHI to the following person/persons:

Name	Relationship

For Insurance Purpose:

Language:	Ethnicity:
Communication Pref:	Race:

_____ _____

Signature of Patient/Guardian **Date**

Health History

Social History

Marital Status: _____ Occupation:_____Hobbies/exercise?_____

Do you have children? (list gender and ages)_____

Are you currently in school? __public __private __home Level completed_____

Do you use tobacco? __Cigarettes __Chewing __Snuff How much/often? _____

Were you previously a smoker? __Yes __No When did you quit? _____

Do you live with a smoker? __Yes __No

Do you drink alcohol? __ Yes __No Type and Amount? _____

Do you use any recreational drugs? __ Yes __ No Type and Amount? _____

Surgical History

Please list any surgeries, hospitalizations, injuries that you have had and the dates:

_____

_____

_____

_____

Health Maintenance

Please fill in the appropriate date you had your last screening tests.

Tetanus Shot_____ Age 65 and older: Pneumonia shot_____

Sexually Transmitted Diseases Screening (such as HIV, Gonorrhea, Syphilis, etc.)_____

Age ≥35/male or ≥ 45/female : Cholesterol level _____

Age 50 or older: Colon Cancer Screening_____

Age 65-75 if ever smoked 100 or more cigarettes: Abdominal Aortic Aneurysm Screening_____

Females Only:

Age 21-65 or sexually active for 3 years : Pap test_____

Age 40 and older: Mammogram_____

Age 65 and older OR 60-64 and weigh less than 155 pounds: Bone Density_____

Health History

Patient Name: _____

Reason for today's visit: _____

Medical History

Do you have a personal medical history of (check all that apply):

__Anemia
__Cancer-please list type _____
__ Stroke
__ HIV Infection
__ Eczema
__Arthritis
__High Cholesterol
__Heart Disease
__Migraines
__Hepatitis
__Substance Abuse
__Asthma
__Diabetes Mellitus
__Hypertension
__Thyroid disorders
__Psychiatric Disorder
__ Glaucoma
__Allergic Rhinitis
__Seizure Disorder
__Kidney Disease
__Tuberculosis
__ Peptic Ulcer

Please list any allergies: _____

Please list any medications you are currently taking including: prescription, over-the-counter, supplements and vitamins.

_____
_____
_____
_____

Family History

PLEASE LIST RELATIVES AGE AT ONSET OF ILLNESS

Please list any chronic health problems: (e.g. *cancer-please list type, diabetes, high blood pressure, high cholesterol, heart disease, stroke, heart attack, thyroid disease, substance abuse, asthma, kidney disease, etc*)

Father_____
Mother_____
Brothers_____
Sisters_____
Paternal Grandfather_____
Paternal Grandmother_____
Maternal Grandfather_____
Maternal Grandmother_____
Uncles_____
Aunts_____

Review of Systems

Please check the symptoms below that you have persistent problems with or are concerned about:

General

__Feeling Tired/Poorly __Fever __ Weight loss/gain

Skin/Hair/Nails/Lymph

__Changes in skin color __Easy bruising __Dry Skin __Rash
__Itching __Skin Lesions __Swollen glands

Joints/Muscles

__Muscle aches __Muscle weakness __Joint pain, localized
__Joint swelling __Joint stiffness

Head/Ears/Eyes/Nose/Mouth/Throat

__Headaches __Dizziness __Fainting __Worsening vision
__Watery eye discharge __Double vision __Loss of hearing __Ringing in ears
__Mucous eye discharge __Discharge from ears __Earache __Nasal discharge
__Nasal stuffiness __Nosebleeds __Mouth sores __Teeth symptoms
__Soreness/pain in mouth __Hoarseness __Sore throat

Breast

__Breast lump __Breast pain __Nipple discharge

Respiratory System

__Cough __Night Sweats __Coughing up blood __Exposed to TB

Cardiovascular System

__Palpitations __Difficulty Breathing __Chest Pain __Soft Tissue Swelling

Gastrointestinal System

__Appetite __Heartburn __Constipation __Difficulty Swallowing
__Nausea __Belching __Flatulence __Abdominal pain
__Diarrhea __Vomiting __Stool changes

Genitourinary System

__Decreased urine volume __Painful urination __Blood in urine __Sexual complaints

__Changes in urinary habits __Urinary loss of control Birth control method:_____

Genitourinary System-Females Only

__Vaginal discharge __Itching/Burning __Abnormal menses duration

__Severe menstrual pain __Heavy Bleeding __Postmenopausal bleeding

Age at first period:____ Age at menopause:_____ LMP:_____

Genitourinary System-Males Only

__Testicle symptoms __Blood in semen __Penile lesion __Discharge

Nervous System

__Sense of smell __Taste disturbances __Numbness __Abnormality of walk

__Difficulty keeping balance __Tingling __Speech difficulty __Sensitive pain/touch

Psychiatric History

__Depression __Anxiety __Hallucinations __Memory Loss

Allman Family Medicine Allergy Questionnaire

Patient Name: _____ Date of Birth: _____

Contact Number: _____ Today's Date: _____

Do you experience any of the following symptoms?	Yes	No	Frequency Daily, Weekly, Monthly, Seasonally, Year around
Runny/ Stuffy Nose, Frequent Sneezing, Post Nasal Drip			
Itchy / Dry / Watery Eyes			
Itchy / Dry Mouth, Throat or Ears			
Frequent Cough or Frequent Colds			
Seasonal Allergies			
Sinus Problems			
Food Allergies			
Sinus Problems			
Restless, Poor Sleep or Snoring			
Fatigue or Irritability due to Restlessness or Poor Sleep			
Have you ever been told you have Asthma, RAD or Eczema?			
Have you ever used Albuterol?			
Have you ever been to an Allergist?			
Does your family have a history of Allergies?			

What medicines have you used to control your symptoms in the past year? (Please Circle)

1.) Over-the-Counter Medications

a. Allergy/Cold Medications

___ Claritin, Alavert, Zyrtec or Allegra
___ Benedryl or Sudafed
___ Cough, Cold or Sinus Medication

b. Over-the-Counter Nasal Sprays

___ Nasal Saline, Nasal Washes or Neti Pot

c. Over-the-Counter Nasal Decongestants

___ Afrin or Neosynephrine

2.) Prescription Medicines

d. Oral Allergy Medications

____ Claritin, Zyzol, Singular

e. Nasal Steroids / Antihistamines

____ Flonase, Nasonex, Rhinocort, Nasacort, Astelin, Veramyst, Patanase

3.) List any allergy medications you have tried:

_____

4.) Have you been previously tested for allergies?
____ Yes ____ No

Above information reviewed and discussed with the patient: _____ Yes _____ No

I will refer this patient out for In-House Allergy testing: _____ Yes _____ No

Provider: _____