Jackson Clinic-General Surgery
PATIENT INFORMATION SHEET

First Name ____ MI ____ Last Name ____ Maiden ____

Social Security Number ____ Male ____ Female ____ Date of Birth ____ Current Age ____

Marital Status: Single Married Widowed Divorced

E-mail address ____

Street Address ____ City/State ____ Zip ____

Home Phone ____ **Work Phone** ____ **Cell Phone** ____

MAY WE LEAVE MESSAGES FOR YOU REGARDING YOUR PROTECTED HEALTH INFORMATION ON YOUR:
HOME WORK CELL ALL OF THE ABOVE

Employer ____ Occupation (Job Title) ____ Full-Time/Part-Time ____

PLEASE INDICATE EMERGENCY CONTACT NAME(S), RELATIONSHIP, & PHONE NUMBER(S)

Name ____ Relationship ____ Phone # ____

Name ____ Relationship ____ Phone # ____

INSURANCE INFORMATION:

Name of Insurance Company (Primary) ____ Name of Policy Holder ____ Policy Holder DOB ____

Name of Insurance Company (Secondary) ____ Name of Policy Holder ____ Policy Holder DOB ____

PLEASE GIVE ALL INSURANCE CARDS TO THE RECEPTIONIST
RELEASE OFF INFORMATION, BENEFIT ASSIGNMENT, PAYMENT AUTHORIZATION, FULL DISCLOSURE AND AGREEMENT TO PAY FOR PROFESSIONAL SERVICES

I hereby authorize Jackson Clinic, to release any information necessary to process any insurance claim acquired in the course of my examination or treatment to allow a photocopy of my signature to e used to process my insurance claim. I claim, direct, and authorize my insurance carrier to issue payment check(s) directly to Jackson Clinic, for any insurance benefits to which I am entitled. I understand that failure to disclose pre-certification/second opinion requirements for any and all plans to which I subscribe may cause me to incur full liability for professional charges as a result of non-payment by my carrier. Regardless of insurance benefits, if any, I understand that I am fully responsible for any and all fees incurred and I agree the above is a legal and lawful debt. If it becomes necessary to forward this account to collections, I agree to be responsible for any/all collection costs, attorney fees, and/or costs. I waive now and forever my right to exemption under the laws of the constitution of the State of Alabama and any other state. I realize that in extraordinary circumstances, some insurance companies will not pay for certain procedures (i.e. MRI's or Ultrasounds). I understand that my insurance is filed as a courtesy and I am responsible for the bill.

There is a $25 fee for all no-call/no-show appointments or cancellations not made within 24 hours of scheduled appointment.
ALL CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE

Patient/Responsible Party Signature ____ **Date** ____

Health History Questionaire

Name: ______________________ Date of birth: ______________
Reason for visit: ______________________________________
Primary care physician: ______________ Referred by: ______________

Past Medical History

Please circle all that apply:

Anxiety disorder	Diverticulitis	Kidney disease
Arthritis	Fibromyalgia	Kidney stones
Bleeding disorder	Gout	Renal failure
Blood clot (or DVT)	Heart attack	Liver disease
Cancer: ____________	Hiatal hernia	Osteoporosis
Coronary artery disease	Reflux/GERD	Pulmonary embolism
Hepatitis	HIV/AIDS	Peptic ulcer
Diabetes	High cholesterol	Stroke/TIAs
Lung disease	High blood pressure	Sleep apnea
Depression	Asthma	Heart disease

Other: ______________________________________

Medications

Please list ALL medications you are taking. Prescribed and over-the-counter.
Drug name and dosage:

1. ______________ 6. ______________
2. ______________ 7. ______________
3. ______________ 8. ______________
4. ______________ 9. ______________
5. ______________ 10. ______________

Allergies

List all medications, food, latex, etc. and how each affects you.

Allergy	Reaction
1. ______________	______________
2. ______________	______________
3. ______________	______________

Name of the pharmacy you use: ______________________
Phone number: ______________ **Address:** ______________

Past surgical history

(List ALL surgeries and approximate year)

1. ______________________ 6. ______________________
2. ______________________ 7. ______________________
3. ______________________ 8. ______________________
4. ______________________ 9. ______________________
5. ______________________ 10. ______________________

Family Health History

Mother: arthritis, cancer:__________, diabetes, heart disease, stroke, high blood pressure, heart attack, other: ______________________

Father: arthritis, cancer: __________, diabetes, heart disease, stroke, high blood pressure, heart attack, other: ______________________

Brother/Sister: arthritis, cancer: __________, diabetes, heart disease, stroke, high blood pressure, heart attack, other: ______________________

Brother/Sister: arthritis, cancer: __________, diabetes, heart disease, stroke, high blood pressure, heart attack, other: ______________________

Grandmother: (maternal) arthritis, cancer: __________, diabetes, heart disease, high blood pressure, heart attack, stroke, other: ______________

Grandfather: (maternal) arthritis, cancer: __________, diabetes, heart disease, high blood pressure, heart attack, stroke, other: ______________

Grandmother: (paternal) arthritis, cancer: __________, diabetes, heart disease, high blood pressure, heart attack, stroke, other: ______________

Grandfather: (paternal) arthritis, cancer: __________, diabetes, heart disease, high blood pressure, heart attack, stroke, other: ______________

Other: ______ : arthritis, cancer: __________, diabetes, heart disease, high blood pressure, heart attack, stroke, other: ______________

Social History

Do you use tobacco or smoke? __________ packs or cans/day ______________

If you are a former smoker, year quit: ______________

Do you drink alcohol? __________ How much? __________ How often? __________

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I hereby authorize Jackson Clinic to release any information necessary to process any insurance claim acquired in the course of my examination or treatment, to allow a photocopy of my signature to be used to process my insurance claim. I claim, direct, and authorize my carrier to issue payment check(s) directly to Jackson Clinic for any insurance benefits to which I am entitled. I understand that failure to disclose pre-certification/second opinion requirements for any and all plans to which I subscribe may cause me to incur full liability for professional charges as a result of non-payment by my carrier. 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. I waive, now and forever, my right of exemption under the laws of the constitution of the State of Alabama and any other state. I understand that my insurance is filed as a courtesy, and I am responsible for the bill. I understand that I am responsible for paying any deductible, co-insurance, co-payment, or service deemed non-covered/patient responsibility, by my insurance carrier.

Date:__________ **Signature of Patient or Guarantor:______________________________________**

EXPRESS PRIOR CONSENT TO CONTACT CONSUMER BY CELL PHONE

You agree, in order for us to service your account or to collect monies you may owe, Jackson Clinic, 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 devices, as applicable.

I/we have read this disclosure and agree that Jackson Clinic, it's employees and/or agents may contact me as described above.

Responsible Party:______________________________________ **Date:__________**

ACKNOWLEDGEMENT OF NOTICE OF HIPAA

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 described in the Notice of Privacy Practices. The Notice of Privacy Practices may be revised at any time. WE WILL PROVIDE YOU WITH A CURRENT COPY UPON YOUR REQUEST.

By signing below, you are acknowledging that you have read or received a copy of the HIPAA policy.

Patient Name:______________________________________ **Date:__________**

Signature:______________________________________ **Date:__________**

If state authorized to act on behalf of patient please sign below:

Name:______________________________ Signature:______________________________________

Practice Use Only:

I, ______________________________ attempted to obtain the acknowledgement of receipt of the HIPAA policy, but was unable to do so for the following reason: ______________________________________

Signature:______________________________________ Date:__________

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PATIENT RESPONSIBILITIES

SCHEDULED OFFICE VISITS: Patients shall notify the office at least 24 business hours prior to scheduled office visit if they are unable to keep their appointment. Failure to notify the office shall result in a $25 no show fee.

REFILL REQUESTS: Patients must allow the physician office 72 business hours to finalize all routine medication refill renewals. This window of time is necessary due to the large volume of refill requests received from patients daily. Administrative measures required for authorization from many insurance plans may require additional time.

PERSONAL INFORMATION: Patients must bring their photo ID to each office visit to ensure other individuals are not receiving health care services under another individual's identity. All insurance cards must be presented at check-in, at each visit, to ensure services are billed properly.

COPAYMENTS DUE AT TIME OF SERVICE: Patients must pay their co-payment, co-insurance, or deductible amounts at the time of service, as well as any outstanding account balances. An additional billing fee may be applied if all out of pocket responsibility is not paid at time of service.

REQUEST FOR COMPLETION OF MEDICAL FORMS: Patients may be required to schedule an office visit with a physician to have certain medical forms completed, such as disability determination, family medical leave, or any other lengthy documents that require a substantial amount of the physician's time to complete. The patient may be required to pay up to $25 for completion of forms if not willing to schedule a visit.

FAMILY AND FRIENDS IN THE LOBBY: Patients are asked to restrict the number of family and friends accompanying them to their office visit to no more than 2 adults. No children are to be left unattended in the lobby or office.

MEDICAL QUESTIONS: Patients must allow 48 business hours, for responses to any non-urgent medical questions, or messages left for the nurse and/or physician. Patients should call 911 for any life threatening or emergency medical needs.

CONSENT FOR TREATMENT AND RELEASE OF INFORMATION

I consent for this provider to render the treatment of primary care. This authorization, or photocopy of same, authorizes the release of any medical information necessary for treatment and/or to process claims for services rendered by this provider. This authorization allows the provider to discuss medical information with my doctor(s) and to perform any life-saving emergency treatment necessary to sustain life, including, but not limited to assisted respiratory support.

Please list any person that may have access to your private medical information:

(1) Name:________________________________ Relationship to Patient:____________________

(2) Name:________________________________ Relationship to Patient:____________________

PATIENT SIGNATURE: **DATE:**

____ ____________________

PATIENT PRINTED NAME:

____

If someone other than the patient has signed this form, state name and relationship to patient below:

Name:________________________________ **Relationship to Patient:**____________________