CUREWELL MEDICAL CENTER

PATIENT INFORMATION SHEET

Patient Name: _____ Chart #:_____
Mailing Address: _____ _____
DOB: ____/____/____ SEX: □M □F Social Security #: _____-_____-_____

□Home Phone_____ □Cell Phone _____□Work Phone_____
(Please check which number would be preferred number for contact)
Employer:_____

Marital Status: □Single □Married □Divorced □Widowed RACE: _____
Spouse's Name _____
DOB ____/____/____ Last 4 digits of SSN _____
Spouse's Place of Employment_____
EMERGENCY CONTACT:_____ **PHONE:** _____

INSURANCE & RESPONSIBLE PARTY INFORMATION
(This section must be filled out)

Primary:_____ **Group#:**_____ **Policy#:**_____ **Responsible Party's Name (if other than patient):**_____ **□Male □Female** **DOB: ___/___/____ Phone:**_____ **Social Security #: _____-_____-_____** **Address:**_____ _____	**Secondary:**_____ **Group#:**_____ **Policy#:**_____ **Responsible Party's Name (if other than patient):**_____ **□Male □Female** **DOB: ___/___/____ Phone:**_____ **Social Security #: _____-_____-_____** **Address:**_____ _____

How did you hear about Curewell Medical Center? ***(Circle all that apply)***
□Family/Friend □Doctor/Referral □Phone Book □Other_____

I authorize and request my insurance company to pay directly to Curewell Medical Center any health benefits resulting from care received in that facility. I understand that my insurance company may not cover all services rendered on behalf of me or my dependents and I agree to assume responsibility for any services, procedures, devices, or testing not covered. I consent to the release to my insurance company of any medical record (except psychiatric) necessary to resolve claims for services rendered. I understand that co-pays and any services not covered by an insurance company are DUE IN FULL AT THE TIME OF SERVICE.

Signature**_____DATE**_____

***Relation to Patient**_____

CUREWELL MEDICAL CENTER
PERSONALIZED HEALTH HISTORY

Date: ____/____/____
Name:_____ Date of Birth: ____/____/____
Reason for Visit & Current Problems:
_____
_____

ALLERGIES/ REACTIONS TO MEDICATIONS:

Name of Medication Allergic To	Reaction

CURRENT MEDICATIONS (Prescription, nonprescription, vitamins, home remedies, herbs, etc.):

Name of Medication	Dosage	How Many Times per Day

Pharmacy Name and Location:_____

Name of Mail Order Pharmacy:_____
Mail Order Pharmacy ID# (Usually different from your medical insurance):_____

If you have Medicare D, what is the name of your company and ID#:_____

Do you use a DME company, for diabetic testing supplies, oxygen, CPAP, walkers, etc?_____
Company and Location:_____
Name:_____ Date of Birth: ____/____/____

PAST MEDICAL HISTORY:
Have you ever had the following: *(please circle all that apply)*

Measles	Anemia	Back Trouble	Hemorrhoids
Mumps	Blood/Plasma	Arthritis	Hernia
Chickenpox	Transfusion	Gout	Ulcer
Whooping Cough	Infectious Mono	Diabetes	Irritable Bowel
Scarlet Fever	Hepatitis/Jaundice	Glaucoma	Syndrome
Diphtheria	Bleeding Tendency	Bronchitis	Frequent Bladder
Smallpox	Blood Clots	Asthma	Infections
Pneumonia	Heart Disease	Emphysema	Kidney Disease
Rheumatic Fever	Low Blood Pressure	Migraine Headaches	Liver Disease
Tuberculosis	High Blood Pressure	Cancer	Thyroid Disease
Polio	Mitral Valve Prolapse	Venereal Disease	Gallbladder Disease
Epilepsy/Seizure	Stroke/TIA	AIDS/HIV	Alcoholism
	Heart Murmur		Mental Illness
			Hives/Eczema

OTHER TREATING PHYSICIANS:

Physician Name	Speciality

IMMUNIZATIONS: Please provide the dates.
Influenza (Flu)_____ Tetanus (Td)_____ Pneumococcal_____ Shingles_____
Hepatitis A_____ Hepatitis B_____Measles (MMR)_____ Other_____

HEALTH SCREENING:
Colonoscopy Date: ____/____/____ Findings Normal? **YES/NO**
Next Due Date: ____/____/____ Performed By:_____

Bone Density Test Date: ____/____/____ Findings Normal? **YES/NO**

TB Skin Test Date: ____/____/____ Sigmoidoscopy Date: ____/____/____

Ladies: Last Pap Smear Date: ____/____/____ Findings Normal? **YES/NO**

Last Mammogram Date ____/____/____ Findings Normal? **YES/NO**

Gentlemen: Last PSA Screening Date: ____/____/____ Findings Normal? **YES/NO**

PAST SURGICAL HISTORY:

Operations	Date

PAST SERIOUS ILLNESSES:

Illness	Date

FAMILY HISTORY:
Is your mother still living? **YES / NO** If deceased, at what age?_____
Is your father still living? **YES / NO** If deceased, at what age?_____
What health problems does/did your MOTHER have?_____
What health problems does/did your FATHER have?_____
Does/did any other close blood relative have any health problems *(such as heart disease, high blood pressure, diabetes, cancer, etc.)*?
Please list and describe:_____
_____

SOCIAL HISTORY:
Relationship Status: □Single □Married □Divorced □Separated □Widowed
Caffeine (cups/day): _____ Coffee _____ Tea _____Soda _____Energy Drinks
Exercise regularly? **YES / NO** Do you follow a regular diet?**YES / NO** Recreational Drug Use?**YES / NO**

TOBACCO HISTORY:
Do you currently use tobacco? **YES / NO** □Cigarettes □Cigars □Pipe □Smokeless Tobacco
Have you ever used tobacco? **YES / NO** Did you quit? **YES / NO** When?_____
Do you wish to quit? **YES / NO** Have you ever tried to quit? **YES / NO**

ALCOHOL HISTORY:
Do you drink alcohol? **YES / NO** If so, how much do you drink per week?_____
Is your drinking a concern for you or others? **YES / NO** Explain:_____

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 health. It is my responsibility to inform my physician's office of any changes in my medical status.

Signature of Patient_____ Date_____

PERMISSION TO RELEASE INFORMATION

If you anticipate the need for anyone else to have access to Protected Health Information about you, please complete the following below:

I (we,) the undersigned patient and/or responsible party hereby authorize Curewell Medical Center physicians, agents, employees, or representatives to discuss or release any or all patient information about me including but not limited to past and current medical information, billing information, appointment scheduling, prescriptions, etcetera to the person or persons indicated below:

_____Spouse Name:_____ Phone #_____

_____Parents Name(s):_____ Phone #_____

_____Children Names(s):_____ Phone #_____

_____Other Name(s):_____ Phone #_____

Patient Signature:_____ Date:_____

Patient Name:_____

Date of Birth: _____

SS No:_____

CONSENT TO OBTAIN ELECTRONIC MEDICATION HISTORY

I understand that my medication history may be obtained utilizing an electronic information exchange and that this protected health information may provide valuable information for my healthcare provider. I hereby authorize Curewell Medical Center physicians to access my medication history without limitation or exclusion as is required and/or reasonably advisable to disclose, process, retrieve, transmit, and view for the purpose of the transmission of an electronic prescription issued by a provider authorized by law to prescribe, as necessary for my care and treatment.

Patient Signature:_____ Date:_____

Patient Name:_____

Date of Birth: _____

ACKNOWLEDGEMENT & CONSENT TO USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

You are receiving healthcare services from CUREWELL MEDICAL CENTER. You agree that all records concerning your care within CUREWELL MEDICAL CENTER. shall remain the property of CUREWELL MEDICAL CENTER. You understand and agree that such information is used for: (1) your treatment - the provision and coordination of your healthcare which may require disclosure of all or any portion of your medical record information to your attending physician, consulting physician(s) and other health care providers who have a legitimate need for such information in the care and continued treatment of the patient; (2) payment for your services - billing, claims management, medical data processing, reimbursement and for determining coverage which may necessitate disclosure of such information to any insurance company, third party payor or other entity (or their authorized representatives), including any copies or excerpts of your medical record which are necessary for payment of patient's account; (3) routine healthcare operations -including, but not limited to, quality assurance, utilization review, medical review, internal auditing, accreditation, certification, licensing or credentialing activities of CUREWELL MEDICAL CENTER; and (4) medical research and educational purposes. You acknowledge that you have been provided with CUREWELL MEDICAL CENTER Notice of Health Information Practices that provides a more complete description of the uses and disclosures of the patient's healthcare information, and that the Notice has been reviewed prior to the signing of this consent. You understand that CUREWELL MEDICAL CENTER reserves the right to change the Notice and that CUREWELL MEDICAL CENTER will provide you with a revised Notice when you come to CUREWELL MEDICAL CENTER. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Restrictions Requested:_____

□ Agree □ Not Agree □ N/A

Patient Signature:_____ Date:_____

Witness Signature:_____ Date:_____

CONSENT FOR TREATMENT: I consent to necessary treatment, including drugs, medicine, procedures, x-rays, lab tests and/or other studies that may be used by the physician, the nurse, or staff.

AUTHROIZATION FOR RELEASE OF INFORMATION: I understand that my information may be given to the insurance company with whom I have coverage, agencies which may be assisting with payment for my care, billing agencies, agencies responsible for reviewing payments and/or quality of care, and other governmental agencies. I give permission for release of this information.

ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to Curewell Medical Center of benefits otherwise payable to me including major medical insurance and payment of medical benefits, but not to exceed the charges of Cardiac Electrophysiology of Alabama for these services. I understand that I am financially responsible to Curewell Medical Center, for charges not covered by this assignment. I authorize the refund of overpaid insurance benefits where my coverages are subject to coordination of benefits.

GUARANTEE OF ACCOUNT: In consideration of medical services rendered, the undersigned accepts all fees charged as lawful debt and agrees to pay Curewell Medical Center insurance notwithstanding, for all said charges. Furthermore, undersigned agrees to pay the costs of collection including reasonable attorney's fees and court costs if such be necessary, waiving now and forever the right of exemption allowed to the constitution of laws of the State of Alabama or any other state. Undersigned further understands that Curewell Medical Center does not accept insurance assignment as a guarantee of full payment.

Health Insurance Portability and Accountability Act (HIPAA)
I consent to the use or disclosure of my protected health information (PHI) by Curewell Medical Center for the purpose of diagnosis or providing treatment to me, obtaining payment for my healthcare bills, or to conduct healthcare operations. I have received a copy of the Company's Notice of Privacy Practices. The Notice describes the types of disclosures of my PHI that will occur in my treatment, payment of my bills, or in the performance of healthcare operations of the Company.

Patient Signature:_____ Date:_____

CUREWELL MEDICAL CENTER
4108 Watermelon Road
Northport, AL 35473

Authorization for Release of Medical Records

Name of Patient_____

Patient DOB_____ Patient Social Security Number: _____

Address_____

I hereby authorize the release of any and all medical information (including all physicians notes, lab results, X-ray and diagnostic results, and any mental or substance abuse records) including diagnosis, treatment, prognosis, etc. of the injuries and/or illnesses received by the above named person on and subsequent to the date of injuries and/or illnesses to CUREWELL MEDICAL CENTER.

Signature of Patient or Legal Guardian _____Date _____

Witness _____Date_____

Consent for Communication

Curewell Medical Center communicates with our patients by phone, voicemail, e-mail and/or text. Curewell Medical Center respects your right to confidential communications about your protected health information (PHI) as well as your right to direct how those communications occur. Since e-mail and texting can be inherently insecure as a method of communication, we will only communicate with you by e-mail or text with your written consent at the e-mail address or cell phone number you provide to us below. Please be aware that if you have an e-mail account through your employer, your employer may have access to your e-mail. Oftentimes our staff use these avenues to contact patients when they cannot reach patients via phone. This allows our patients to receive communication quickly and allows us to reduce the number of phone calls that take place. It can sometimes be difficult to reach us by phone and these alternate options allow us to provide you with the best care possible.

When you consent to communicating with us by e-mail or text you are consenting to e-mail and texting communications that may or may not be encrypted. In addition, voicemail or answering machine messages may be intercepted by others. Therefore, you are agreeing to accept the risk that you're protected health information may be intercepted by persons not authorized to receive such information when you consent to communicating with us through phone, voicemail, e-mail or text. Curewell Medical Center will not be responsible for any privacy or security breaches that may occur through voicemail, e-mail or text communications that you have consented to.

You may choose to limit the type of voicemail, e-mail or text communication you have with us if you wish to limit your risk of exposing your protected health information to unauthorized persons. Please indicate below what types of correspondence you consent to receive by e-mail or text.

Check all that apply:

☐ I do **NOT** consent to any voicemail e-mail or texting communication.

OR

☐ I consent to receiving communication about the **scheduling of appointments only** by the following means (check all that you consent to):

- ☐ E-mail:_____
- ☐ Text:_____
- ☐ Voicemail:_____

OR

I consent to **all** communication, including but not limited to communication about my medical condition and advice from my healthcare providers by the following means (check all that you consent to):

- ☐ E-mail:_____
- ☐ Text:_____
- ☐ Voicemail:_____

Patient Name (Printed)_____ Date _____

Signature of Patient or Legal Guardian _____ Date _____

HIPPA RELEASE OF INFORMATION

Patient Name_______________________________________ DOB___________________

Chart Number_______________________________________

In compliance with HIPPA regulations, please list who, other than yourself, who you would like for us to share information about your healthcare.

Name______________________________________ Relationship to Patient: _______________

Type of information to be disclosed (please check all that apply):
☐Test results
☐Lab results
☐Appointment dates/times
☐Prescription (pick up only)
☐Scheduled procedures
☐Medication information (to include changes and refill requests)
☐Other (please list) ___________________________________

☐I understand that only authorized persons will be given access to any of this information and the access will be limited to the areas designated by the patient.

Name______________________________________ Relationship to Patient: _______________

Type of information to be disclosed (please check all that apply):
☐Test results
☐Lab results
☐Appointment dates/times
☐Prescription (pick up only)
☐Scheduled procedures
☐Medication information (to include changes and refill requests)
☐Other (please list) ___________________________________

☐I understand that only authorized persons will be given access to any of this information and the access will be limited to the areas designated by the patient.

Name______________________________________ Relationship to Patient: _______________

Type of information to be disclosed (please check all that apply):
☐Test results
☐Lab results
☐Appointment dates/times
☐Prescription (pick up only)
☐Scheduled procedures
☐Medication information (to include changes and refill requests)
☐Other (please list) ___________________________________

☐I understand that only authorized persons will be given access to any of this information and the access will be limited to the areas designated by the patient.

Signature of Patient or Legal Guardian ___________________________ Date _________

STEPS TO ACCESS YOUR PATIENT PORTAL

1. You will receive an e-mail from practice fusion. The body of the e-mail will look similar to below:

   > Curewell Medical Center has invited you to access your health records on Patient Fusion. Learn what's in your files including lab results, medication history, and notes from doctors.

2. Click the "ACCESS YOUR RECORDS" button.

3. You will be asked to enter the access code given to you by the nurse.

4. You will be required to confirm your account.

5. To make it easier to access, save *my.patientfusion.com* to your bookmarks, and you will be able to access your profile from there.

6. You will be able to access health records including:
   a. Lab tests and results (must be individually shared by your doctor)
   b. Diagnosis
   c. Medications
   d. Immunizations
   e. Allergies
   f. Procedures (any procedure that a doctor has performed on you in their office)
   g. Care plans (plans for your future treatment)

   You can download your records to give another provider by clicking on the **Download** button in the top right. Choose "PDF format," select the information you want downloaded, and then click Download record. This can be printed and shared at any time.

CUREWELL MEDICAL CENTER
4108 Watermelon Road
Northport, AL 35473

PRACTICE FUSION- ACCESS YOUR PATIENT PORTAL ONLINE

We offer electronic access to your medical records!

1. Provide your name, e-mail address, and cell phone number.
2. Give this document to your nurse.
3. Receive a pin number from the doctor before leaving the office.
4. You will receive an e-mail with instructions on how to access the portal.
5. Your signature below means that you have read our patient portal policy and you understand the instructions given to you, and you give our staff permission to contact you through the portal.
6. Your nurse will review the policy with you in the room, and you will receive a copy.

*You may provide the e-mail address of a spouse, family member, etc. that you trust if you do not have one.

Thank you for supporting us and our move to electronic charting.

Name_____ DOB_____

Email_____ Cell Phone_____

Signature_____ Date _____