Advanced Medicine + Pediatrics, LLC

705 South 3rd Street
Gadsden, AL 35901
Phone: (256) 546-1445 Fax: (256) 485-4765

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

To: _____

_____

I, _____ hereby authorize Advanced Medicine + Pediatrics to receive the following protected health information requested.

Date of Birth: _____

Social Security #: _____

Signature: _____

Date: _____

Witness: _____

Reports requested: _____

_____

Date Mailed/Faxed: _____

Advanced Medicine + Pediatrics, LLC

Patient Information:

Name: _____ DOB: _____ Age: _____ Sex: Male/Female

Home Phone: _____ Alternate Phone: _____ SS #: _____

Address: _____ City: _____ State/Zip: _____

Driver's License #: _____ Marital Status: _____ Spouses Name: _____

Employment Status (Circle one): Full Time/Part Time/Retired/Student/Disabled

Employer's Name: _____ Work Phone: _____

Responsible Party Information:

Name: _____ Relationship to Patient: _____

Date of Birth: _____ SS #: _____

Street Address: _____ Home Phone: _____

City/State/Zip: _____ Driver's License #: _____

Employee: _____

Insurance Information:

Primary Insurance Name: _____ Policy #: _____ Group #: _____

Policyholder's Name: _____ DOB: _____ SS #; _____

Relationship to Patient: _____ Place of Employment: _____

Effective Date: _____ Copay: $ _____

Secondary Insurance Name: _____ Policy #: _____ Group #: _____

Relationship to Patient: _____ Place of Employment: _____

Advanced Medicine + Pediatrics, LLC

Could you possibly be pregnant? ____

Date of Last Menstrual period (female) _____

May we leave messages on your answering machine regarding your medical care with our office? _____

Current Medications (including any over the counter Medicines dose, how frequently taken):

_____
_____
_____
_____
_____
_____

All your/ or your child's current Medical Diagnosis:

_____
_____
_____
_____

Your Family/your child's Family Medical History: _____
_____
_____
_____

Your / or your child's Surgical History (include dates if possible): _____
_____
_____
_____

Drug/food/insect allergies (yours or your child's) List: _____
_____

Pharmacy: _____

In Case of Emergency whom can we notify?

Person to contact: _____ Relationship: _____ Phone #: _____
Person to contact: _____ Relationship: _____ Phone #: _____
Person to contact: _____ Relationship _____ Phone #: _____

Patient/Responsible Party Signature _____ Date: _____

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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 Advanced Medicine + Pediatrics 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.

_____

Pharmacy Name

_____

Pharmacy Location

_____

Preferred Lab

_____

Patient Signature/Date

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HIPPA INFORMATION RELEASE FORM

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability Act of 1996("HIPPA"), I have certain right to privacy regarding my protected health information. I understand that this information can and will be used to:

-Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

-Obtain payment from third-party payers

-Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time. I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions but if you do agree that you are bound to abide by such restrictions.

You, (Advanced Medicine + Pediatric, LLC) may release my medical information to:

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Patient Signature: _____ Date: _____

ADVANCED MEDICINE PLUS PEDIATRICS. LLC

TERRY PERRY, M.D., Family Medicine
MARIA LEE, M.D., Pediatrics
705 South 3rd Street Gadsden, AL 35901
(256) 546-1445 fax: (256) 485-4546

Financial Policy:

As a courtesy to our patients we will file your insurance. It is the responsibility of the patient to be aware of their benefits and any required preauthorization. We require any co-payments and deductible to be paid at the time of service and these amounts are only an **estimate** on our part. If your insurance company pays less than expected, you will be billed the difference. The balance is your responsibility whether your insurance company pays or not. If your insurance company has not paid your account in 60 days, the balance will be due and becomes your responsibility. The parent or guardian of a minor patient is responsible for payment of service. If for any reason payment is not made in full, I understand that I am liable for any collection fees and/court costs. I, the undersigned, do here by agree to pay all amounts and charges for services rendered. In the event that the doctor agrees to file insurance claims, I authorize the release of any medical information necessary to process that claim and request that payments of benefits be made to the Advanced Medicine + Pediatrics, LLC/ the doctor. I understand that I am fully responsible for any portion of these services that are not covered by my insurance benefits. If payment by check is returned, I understand that I will be liable for any fees associated with the returned check, and the bank fees associated with it. I, the undersigned, also agree that it is my responsibility to keep this office updated on any changes. These changes may include changes in address, phone number, insurance, medical or surgical history, and medication changes, etc. I understand that it is my responsibility to notify this office immediately following any changes in my personal information.

Patient/Responsible Party Signature: _____ Date: _____

ADVANCED MEDICINE PLUS PEDIATRICS. LLC

TERRY PERRY, M.D., Family Medicine
MARIA LEE, M.D., Pediatrics
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No Show Policy:

Please be aware that our office enforces a no-show policy. If you do not call and cancel or reschedule your appointment within 24 hours, you will be charged a $ 20.00 no show fee. We strongly urge that if you are unable to make your appointment, please call l and let us know to avoid being charged this fee.

Patient Name: _____ Date: _____

Signature: _____

Advanced Medicine + Pediatrics, LLC

Office Policies & Patient Responsibilities:

Office Hours: Closed for lunch 12:30 p.m. -1:30 p.m.
Monday – Thursdays: 8:00 a.m. – 5:00 p.m.
Friday: 8:00 a.m. – 12:00 p.m. sick visits only, no routine visits

Your Appointments: Our office sees patients by **appointments only**. If you are unable to keep your appointments, please notify us as early as possible, so that we are able to offer the time to another patient. **Do Not** arrive earlier than 30 minutes since you will be seen at your scheduled appointment time regardless of how early you arrive. In order for us to take care of the patients in a timely manner. If you are more than 15 minutes late for your scheduled appointment, you may have to wait longer to be seen, or we may have to reschedule the appointment. This is so that we do not cause an inconvenience to the patients who arrive on time for their appointment.

Pay your Copay and Balances: We are legally required to collect copays. Patients without co-pays will be rescheduled. Please let our staff know if you have a financial situation that limits your income and under certain circumstances. We will work out payment options or arrangements. Please bring a current copay of your insurance card to every visit. As a courtesy, we will bill your insurance for you. In the event that your insurance does not pay for your visit, you are responsible for the entire balance due.

Prescriptions: **You must bring all medications with you to every appointment**. Please check before your appointment to make sure you do not need any refills. If you need a refill on a prescription before your next scheduled appointment, please call our office at least **two days advance.** This will allow us time to call in your prescription to your pharmacy. All prescriptions will be called to the pharmacy within **48 hours** of the time they were phoned to the office.

Smoking is strictly prohibited on the office grounds!
Please no food/drink/cell phone or pagers in the office.

It is your responsibility as the patient to keep us updated on all of your information. This includes address, phone number, insurance, and any medication changes.
Failure to comply with all responsibilities will result in your dismissal from the clinic.

I, _____ have read and understand the office policies & patient responsibilities of Advanced Medicine + Pediatrics, LLC.

Patient's Signature _____ Date: _____

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Authorization for Treatment of Minors

Date: _____

I, _____, hereby authorize the following person(s) to bring _____ to Advanced Medicine + Pediatrics, LLC to Dr. Maria Lee/ Dr. Terry Perry for treatment. I understand the authorized person(s) must bring proof of patient's insurance and be prepared to pay any copay required by the patient's insurance at the time of service. If services requested are not covered by an insurance policy, the authorized person(s) must be prepared to pay for any charges incurred at the time of the visit.

Authorized Person(s)	Relationship to the patient
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

Parent or guardian Date

_____ _____

Witness Date