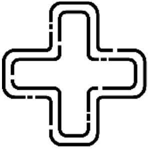


MRN: ___________________________

Patient Information

Today's Date: ____________________

Patient Legal Name (First, Middle, Last) ____

Nickname ________________________

Mailing Address _________________________________ **City** ________________ **State**________ **Zip Code** __________

Home phone______________________ **Work phone** ____________________ **Cell phone** _______________________

Social Security Number _________________ **Date of Birth**_______________ **Driver's License Number** _____________

Birth Sex (circle one) Male Female **Marital Status** (circle one) **S M D W** **Race**______________

Ethnicity (circle one) Hispanic/Latino Not Hispanic/ Latino **Language preference** ____________________

Contact Preference (circle one) Home phone Work phone Cell phone Email Text

Are you a Veteran? Yes No **Is it okay to leave a voicemail?** Yes No

Is today's visit due to an injury? **Yes** **No**

If so, where were you injured? HOME AUTO WORK OTHER ILLNESS **DATE OF ACCIDENT / INJURY:** ___________

Primary Physician (First and last name) _________________________________ **Phone number**___________________

Name of Insured (person listed on insurance card) ________________________ **Date of Birth** ____________________

Patient's relation to insured party: ____

Name of patient's employer ___________________________________ **Full time/ Part time** _____________________

School (if attend) _____________________________________ **Full time/ Part time** ___________________________

Emergency Contact:

Name_______________________________ **Relation**____________________ **Phone number** ___________________

Patient's Email Address: ____

Would you like to be invited to the patient portal? Yes No

Parent/ Guardian Information, if patient is a minor:

Name _________________________________ **Address** ____

Phone Number________________________ **SSN** ________________________ **DOB** __________________________

Clinic Location (please circle one): Family Care Main Family Care South Urology Gynecology Surgical Arts Spine Urgent Care Orthopedic & Sports Med

Patient's Signature: ____

CULLMAN REGIONAL

Medical Group

Patient Name: ___________________________________ **DOB**: ____________________ **MRN**: ______________

Authorization to Release Limited Health Information to Specified Individuals

Cullman Regional is dedicated to protecting patient privacy. It is your right to receive quality care without concern that your personal health information will be shared or disclosed to others without your authorization. Your medical information is protected by law and will **ONLY** be used in treatment, payment and healthcare operation services.

This is to authorize Cullman Regional and staff to release limited medical information to your designated family members, significant others or friends **regarding your presence, room/location and medical condition, if known, during your stay**. I understand this authorization is not valid after discharge and does not allow release of my medical records.

Please list authorized family members, significant others or friends we can call or release information to regarding your stay.

Name: ________________________________ **Phone #:** ________________________ **Relationship:** _______________

Name: ________________________________ **Phone #:** ________________________ **Relationship:** _______________

Name: ________________________________ **Phone #:** ________________________ **Relationship:** ________________

This is to authorize Cullman Regional to release information to your designated family members or significant others **regarding your bill**.

Please list authorized family members, significant others or friends we can call or release information to regarding your bill:

Name: ________________________________ **Phone #:** ________________________ **Relationship:** _______________

Name: ________________________________ **Phone #:** ________________________ **Relationship:** _______________

Name: ________________________________ **Phone #:** ________________________ **Relationship:** _______________

If there is no one listed, we can ONLY talk to you regarding your bill.

Patient Signature: ____ Date: ______________

Witness Signature: ____ Date: ______________

Patient name: ________________________________Date:_______________
DOB: _________________ MR#/Patient ID:____________________________

CONDITIONS OF ADMISSION, PRIVACY NOTICE, PHOTO ID AND FINANCIAL RESPONSIBILITY

CONSENT FOR HOSPITAL SERVICES: Consent is given to Cullman Regional, Cullman Regional Anesthesiology Consultants, Birmingham Radiology Group, Alteon Health Emergency Group, Perseus Hospitalist Group, Cunningham Pathology Associates and Cullman Regional EMS, its contractor and its employees to provide hospital services and administer physician orders. Certain procedures may require separate consents. Physicians are responsible for explaining medical or surgical procedures. The undersigned authorizes observers to be present during treatment/surgery for purposes of medical training and education. Physicians are responsible for explaining medical or surgical procedures and patients may be called following their procedure for quality and continuum of care.

PERSONAL VALUABLES: Cullman Regional is not responsible for money, jewelry, dentures, hearing aids, eye glasses, watches, credit cards and such other items which are not deposited in the hospital safe.

AUTHORIZATION TO RELEASE INFORMATION: The undersigned authorized Cullman Regional and any physician rendering service, for example, Cullman Regional Anesthesiology Consultants, Birmingham Radiology Group, Alteon Health Emergency Group, Perseus Hospitalist Group, Cunningham Pathology Associates and Cullman Regional EMS to release medical or other information about the patient which may be necessary for the completion of insurance claims, review of services, or receipt of benefits. Such information may include medical records. The information may be released to third-party payers, including the third-party payer's agent and/or representative, or anyone responsible for payment of hospital and/or physician charges.

ASSIGNMENT OF BENEFITS: The undersigned assigns to and authorizes direct payment of benefits (including insurance benefits, otherwise payable with respect to patient) to Cullman Regional, Cullman Regional Anesthesiology Consultants, Birmingham Radiology Group, Alteon Health Emergency Group, Perseus Hospitalist Group, Cunningham Pathology Associates and Cullman Regional EMS. The undersigned agrees to assist in process claims for benefits.

MEDICARE AUTHORIZATION: I certify the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request the payment of authorized benefits be made on my behalf to Cullman Regional, Cullman Regional Anesthesiology Consultants, Birmingham Radiology Group, Alteon Health Emergency Group, Perseus Hospitalist Group, Cunningham Pathology Associates and Cullman Regional EMS or any physician rendering service during my treatment.
.
PHYSICIANS: Physician, including without limitation, Cullman Regional Anesthesiology Consultants, Birmingham Radiology Group, Alteon Health Emergency Group, Perseus Hospitalist Group, Cunningham Pathology Associates, rendering services in our facilities. They are not employees or agents of Cullman Regional.

FINANCIAL RESPONSIBILITY: The undersigned agrees to pay for hospital services; accommodations and physicians services rendered to the patient and are hereby obligated to pay the account of the hospital. It is understood that in the event of obstetrics care the undersigned is obligated to pay the hospital account for mother and infant(s). It is understood and agreed that Cullman Regional charges not paid may be placed with an attorney or collection agency. It is understood and agreed that reasonable cost of collection including attorney fees, collection agency fees, and/or open account interest charges assessed are payable by the undersigned. To the extent not expressly prohibited by applicable law, the undersigned agrees to pay all hospital charges not paid in full to the hospital by the third-party payer. Cullman Regional accepts cash, MasterCard, Visa, Discover Card, and American Express as forms of payment.

The undersigned is aware that in some cases the patient's hospital bill may not be covered in full by the insurance company. The undersigned is aware of the fact the patient/guarantor is responsible for any balance insurance does not pay. This balance due may include provision set by your insurance company such as co-payments, deductibles and "usual and customary" allowances. Co-payments and deductibles are due upon admission and be paid prior to discharge. If no insurance is provided, the undersigned acknowledges that the hospital may utilize a third party vendor(s) whose duty is to identify insurance or government sources that may pay for the services rendered. If you have insurance and do not want us to submit a claim to your insurance, you must notify us within 3 days of service.

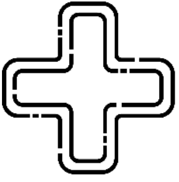
EXPRESS PERMISSION TO CONTACT PATIENT OR UNDERSIGNED RESPONSIBLE PARTY BY CELL PHONE AND/OR EMAIL:
The undersigned agrees, in order for Cullman Regional to service the account of the undersigned or to collect monies owed by the undersigned, Cullman Regional and/or its agents may contact the following number,_______________, which could result in charges to me. Cullman Regional may also contact the undersigned by sending text messages to such number or emails to the following email address, ______________________________. Methods of contact may include pre-recorded/artificial voice messages and /or use of automatic dialing devices, as applicable. The undersigned has read this disclosure and agrees that Cullman Regional, its employees, and/or agents may contact the undersigned as described for the purposes set forth herein.

IDENTIFICATION AUTHORIZATION: It is now required to have photo identification, in the event you do not have a proper photo ID, we will be taking a photograph for our records. I do hereby authorize Cullman Regional to photograph me or my relative for whom I am responsible. I understand that the photographs are used to assure quality of patient care for internal purposes only. It will be kept in my Medical Record File and/or Electronic Medical Record at Cullman Regional responsible, should my photo be inadvertently released.
Please understand that Cullman Regional may need to disclose certain information about you to federal or local officials for tracking purposes. We are required to report certain diseases or conditions to organizations such as the Alabama Department of Public Health or the Center for Disease Control and Prevention. This list includes, but is not limited to: HIV, Tuberculosis, Viral Meningitis, and Hepatitis A, B and C.

I ACKNOWLEDGE THAT I HAVE READ THIS FORM AND UNDERSTAND ITS PURPOSE AND CONTENT.
I HAVE RECEIVED THE PRIVACY NOTICE.

____ _____________________
Guarantor (Agreement to pay) Date

____ _____________________
Witness Signature Date



Cancellation and No-Show Agreement

Cancellation

In the event a patient needs to reschedule or cancel his or her appointment, the patient must do so in an adequate amount of time. Cullman Regional Medical Group defines an adequate amount of time as 24 hours in advance. If a patient does not reschedule or cancel his or her appointment within 24 hours three consecutive times or more, the patient risks being discharged from the practice.

No-Show

In the event a patient does not show for his or her assigned appointment, the patient will be considered a no-show. The front desk registration staff will mark the patient as a no-show and may place a $25.00 no-show fee to the patient's account. After three no-show events, Cullman Regional Medical Group holds the right to discharge the patient from the practice.

I ACKNOWLEDGE THAT I HAVE READ THIS FORM AND UNDERSTAND ITS PURPOSE AND CONTENT.

Patient Signature: _______________________________________ Date: _____________

CONSENT FORM FOR ePRESCRIBE PROGRAM

ePrescribe Program

ePrescribing is a way for doctors to send electronically an accurate, error free and understandable prescription from the doctor's office to the pharmacy. The ePrescribe Program also includes:

- **Fill status notification –** Allows the health care provider to receive an electronic notice from the pharmacy telling them if your prescription has been picked up, not picked up, or partially filled.
- **Medication history transaction –** Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy.

The medication history information would include medications prescribed by your health care provider at Cullman Regional Medical Group as well as other health care providers involved in your care and may include sensitive information including, but not limited to, medications related to mental health conditions, venereal diseases/sexually transmitted diseases, abortion(s), rape/sexual assault, substance (drug and alcohol) abuse, genetic diseases, and HIV/AIDS. ***As part of this Consent Form, you specifically consent to the release of this and other sensitive health information.***

Consent

By signing this consent form you are agreeing that your provider at Cullman Regional Medical Group may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or deny consent may not be the basis for denial of health services. You also have a right to receive a copy of this form after you have signed it.

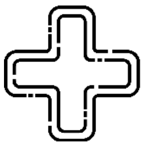
This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing, but if you do, it will not have any effect on any actions taken prior to receiving the revocation.

Understanding all of the above, I hereby provide informed consent to Cullman Regional Medical Group to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

___________________________________Print Patient Name _________________Patient DOB

___________________________________Signature of Patient/Guardian _________________Today's Date

___________________________________Relationship to Patient



1938 Alabama Hwy 157, Ste 101
Cullman, AL 35058
Phone (256) 735-5505
Fax 1 (256) 964-9954
CullmanRegional.com

Patient Name: ___________________________________ **DOB:** __________ **Chart #** _________

Allergies: □ **NO KNOWN ALLERGIES**
List any known allergies and reactions: ____

Medications	Dose (mg)	Frequency (how often)	Reason for taking meds
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

Please circle ALL that apply:

Work Status: Full Time / Part Time / Unemployed / Retired / Disabled / Student (If Student fill out below)

Name of School:__________________________________**Sports Activities:** ____________________________

Type of Work: Primarily Seated / Light Duty / Manual Labor

Marital Status: Married / Single / Divorced / Widowed / Separated

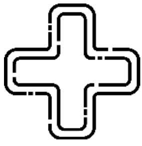
Living Situation: / Alone / With Spouse / With Parents /Nursing Home / With Children/ Other: _____________

Referring Physician or Clinic:_________________________________**Family Doctor:** ______________________

Shoe Size (If treating foot or ankle): ____________________

Please check below all that apply:

Family History:	**Personal Behavior History:**
☐ Diabetes Mellitus	☐ Alcohol Use
☐ Cancer	☐ Tobacco Use
☐ Heart Disease	☐ Smoker ___Previous_____Current
☐ Hypertension	☐ Snuff ___Previous_____Current
☐ Arthritis	☐ Never Smoked



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PAST MEDICAL HISTORY FORM

Have you ever been diagnosed BY A DOCTOR with any of the following?

HEENT:
- ☐ Cataract
- ☐ Migraine Headaches

Cardiovascular:
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Peripheral Vascular Disease
- ☐ HTN (High Blood Pressure)
- ☐ CHF (Congestive Heart Failure)

Endocrine:
- ☐ Diabetes
- ☐ Thyroid Disorders

GU:
- ☐ Kidney Infections
- ☐ Kidney Failure

GI:
- ☐ Gastric Ulcer
- ☐ Acid Reflux
- ☐ Hiatal Hernia

Hematologic:
- ☐ Anemia
- ☐ Blood Transfusions
- ☐ DVT (Blood Clot)
- ☐ Hepatitis
- ☐ HIV

Neuro:
- ☐ Seizures
- ☐ CVA (stroke) yr________
- ☐ Peripheral Neuropathy

Neoplasm:
- ☐ Cancer

Musculoskeletal:
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Osteoporosis
- ☐ Fractured Bones

List Here ________________________

Pulmonary:
- ☐ Chronic Obstructive Pulmonary Dz (COPD)
- ☐ Asthma
- ☐ Pneumonia

OTHER ___________________________

ALL Previous Surgeries: ☐ **NONE**

☐Tonsils ☐Appendix ☐Gallbladder ☐Stent ☐Heart Bypass ☐Right Total Hip ☐Left Total Hip
☐Right Total Shoulder ☐Left Total Shoulder ☐Right Total Knee ☐Left Total Knee

Other Surgeries Not Listed: ____

REVIEW OF SYMPTOMS: Are you CURRENTLY having any of the following symptoms:

Systemic:
- ☐ Fever
- ☐ Weight loss
- ☐ Weight gain
- ☐ Fatigue

HEENT:
- ☐ Headache

Cardiac:
- ☐ Chest Pain
- ☐ Irregular Heartbeat
- ☐ Cold Hands or Feet

Endocrine:
- ☐ Temperature Intolerance
- ☐ Excessive Thirst

GI:
- ☐ Abdominal Pain
- ☐ Heartburn
- ☐ Trouble Swallowing

GU:
- ☐ Urinary Loss of Control
- ☐ Pain with Urination
- ☐ Frequent Urination

Hematologic:
- ☐ Bleeding Problems
- ☐ Easy Bruising Tendency

Musculoskeletal:
- ☐ Night Cramps

Neuro:
- ☐ Difficulty Keeping Balance
- ☐ Memory Lapse or Loss
- ☐ Numbness
- ☐ Tingling

Pulmonary:
- ☐ Shortness of Breath

Psych:
- ☐ Feeling Depressed
- ☐ Anxiety

Skin:
- ☐ Skin Rash
- ☐ Skin Redness

I UNDERSTAND THIS INFORMATION WILL BECOME A PART OF MY PERMANENT RECORD.

Patient Signature: ____ Date: _______________________________