

Corporate Care Clinic

4960 Corporate Drive NW Suite 135H, Huntsville AL 35805

Today's Date _____ Appt. Time _____ Check-in Time _____

Name: _____ DOB: _____
LAST FIRST MIDDLE

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

EMAIL: _____ SSN: _____

Reason for Visit: _____

Any new or worsening problems? If yes, please describe: _____

Primary Insurance:

Insurance Company Name: _____ Group # _____ Policy # _____

Insured's Name: _____
Last First Middle

Relationship to Patient: Self Spouse Parent Other

Insured's Social Security # _____ - _____ - _____ Insured's DOB: _____

Secondary Insurance:

Insurance Company Name: _____ Group # _____ Policy # _____

Insured's Name: _____
Last First Middle

Relationship to Patient: Self Spouse Parent Other

Insured's Social Security # _____ - _____ - _____ Insured's DOB: _____

Corporate Care Clinic

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name _____ SS Number (Optional) _____
Date of Birth _____ Address _____
Phone Number (____) _____ Date of Service _____ Patient Number _____

I authorize the use or disclosure of the above named individual's health information as described below:

1. Huntsville Hospital is authorized to make the disclosure.
2. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

<input type="checkbox"/> Facesheet	<input type="checkbox"/> Physician Orders	<input type="checkbox"/> Laboratory Results	Records Release Format
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Outpatient Record	<input type="checkbox"/> Imaging Results	<input type="checkbox"/> e-delivery (Healthport Connect)
<input type="checkbox"/> History and Physical	<input type="checkbox"/> Emergency Dept. Record	<input type="checkbox"/> Bill / Claim Form	<input type="checkbox"/> CD
<input type="checkbox"/> Operative Note	<input type="checkbox"/> EKG Report	<input type="checkbox"/> Itemized Statement	<input type="checkbox"/> Paper
<input type="checkbox"/> Pathology Report	<input type="checkbox"/> EBC Application	<input type="checkbox"/> Other _____	
<input type="checkbox"/> Consultation Report	<input type="checkbox"/> Autopsy Report		
<input type="checkbox"/> Progress Notes			
3. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
4. This information may be disclosed to, and used by, the following individual or organization:
Name: _____
Address: _____
5. For the purpose of _____
6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Record Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
7. Unless otherwise revoked, the authorization will expire on the following date, event, or condition:

If I fail to specify an expiration date, event or condition, this authorization will expire in six months from the date of signing.
8. I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.
9. I understand that as the recipient, I am responsible for the security of these medical record copies and the health information contained therein, whether in paper format or on CD/DVD.
10. I understand that I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits.

or

I understand that if I refuse to sign this form, under specific conditions the organization can refuse:

Treatment

Enrollment in the health plan

Eligibility for benefits

SIGNATURE _____		DATE _____	TIME _____
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT _____		SIGNATURE OF WITNESS _____	DATE _____ TIME _____





HH Corporate Care Clinic Registration Update Sheet

Patient: _____ Date of Birth: _____ Fin # _____

-----AUTHORIZATION TO CALL-----

I authorize HH System Clinics to leave the following messages on my answering machine/voicemail:

_____ Reminder appointments calls

_____ Lab and/or Test results

-----HH SYSTEM CLINICS ADVANCE DIRECTIVE POLICY-----

In our practices we have decided that we will initiate resuscitative measures anytime they are needed.

-----AUTHORIZATION OF TREATMENT-----

I hereby consent and authorize my physician and/or Allied Health professional to render usual and customary medical/emergency treatment that they deem advisable and necessary. I also authorize HH System Clinics to electronically request my medication history if my pharmacy participates in electronic prescribing in order to assist the provider in prescribing necessary medication therapy.

-----ASSIGNMENT OF BENEFITS, AGREEMENT AND GUARANTY -----

I authorize HH System Clinics to release any information regarding services rendered to me to third party payers in consideration of payment for my care or to other healthcare providers involved in my care. I understand payment of all insurance benefits, basic and major medical for this period of service must be made directly to HH System Clinics. If the check must be made out to me, I understand the check must be sent to this address: PN Billing P.O. Box 2705 Huntsville, AL 35804. I understand the HH System Clinics must collect for all charges not covered by insurance payments. Payment for all collection costs, securing, or attempting to collect and secure including reasonable attorney fees or Collection Agency fees, whether suit be necessary or otherwise is the financial responsibility of the patient and guardian. Patients who are considered a legal adult are financially responsible for all services rendered.

-----HH HEALTH SYSTEM NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT-----

I acknowledge that a copy of the Notice of Privacy Practices for HH Health System has been made available to me. In connection with the Notice, I also acknowledge that I have been provided with an opportunity to ask questions regarding the Notice and its contents. I understand that the most current version of the Notice will be posted with the Health System and on www.huntsvillehospital.org.

-----EXPRESS PERMISSION TO CONTACT PATIENT BY CELL PHONE-----

I agree in order for HH System Clinic to service my account or to collect monies I owe, HH System Clinics and/or our agents may contact me by any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. HH System Clinics may also contact me by sending text messages

Patient: _____ Date of Birth: _____ Fin # _____

or emails, using any email address I provided. Methods of contact may include pre-recorded/artificial voice messages and/or use of automatic dialing devices, as applicable. I have read this disclosure and agree that HH System Clinics, its employees, and/or agents may contact me as described.

-----PHOTOGRAPHY CONSENT-----

I authorize photography for purposes of clinical treatment and staff education. I understand that any images or photographs will be used solely for these purposes and that I have the right to revoke this authorization or to

refuse to be photographed at any time. I understand that only hospital authorized or issued equipment will be used to take photographs, and that my privacy and confidentiality will be maintained in the use of these images.

Signature of Patient/Authorized Representative on behalf of patient: _____

Date: _____ Time: _____

Printed Name of Person Authorized to sign for patient: _____

Basis of Authority to sign for Patient: _____

-----**FOR USE BY HEALTH SYSTEM PERSONNEL ONLY**-----

-----**(Complete if patient Acknowledgment is not obtained)**-----

The patient was provided with a copy of the Notice of Privacy Practices and a good faith attempt was made to obtain the patient's signature acknowledging receipt of the Notice. An Acknowledgment was not obtained because

Witness/Employee Signature: _____ Employee ID: _____

Date _____ Time _____

Corporate Care Clinic

Name: _____

Date of Birth: _____

Huntsville Hospital System

Race and Ethnicity

This classification provides a minimum standard for maintaining, collecting and presenting data on race and ethnicity for all Federal reporting purposes. This is not to be used as determinants of eligibility for participation in any Federal Program.

Race: (select one or more)

_____ White (not of Hispanic origin) : All persons having origins in any of the original peoples of Europe, North Africa, or the Middle East.

_____ Black (not or Hispanic origin) : All persons having origins in any of the Black racial groups of Africa.

_____ Hispanic: All persons of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.

_____ Asian or Pacific Islander : All persons having origins in any of the original peoples of the Far East, Southeast Asia, the Indian Subcontinent, or the Pacific Islands. This area includes, for example, China, India, Japan, Korea, the Philippine Islands, and Samoa.

_____ American Indian or Alaskan Native: All persons having origins in any of the original peoples of North America, and who maintain cultural identification through tribal affiliation or community recognition.

_____ Declined

Ethnicity: (select one)

_____ Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin, regardless of race. The term "Spanish origin" can be in addition to "Hispanic or Latino."

_____ Non-Hispanic or Latino

_____ Declined

Preferred Language: _____

Signature: _____

Date: _____



Corporate Care Clinic

Name _____ DOB _____

LAST FIRST MIDDLE
PHARMACY: ☐ HUNTSVILLE HOSPITAL MEDICAL MALL PHARMACY

☐ **OTHER** _____
 NAME LOCATION

PATIENT/GUARDIAN CONSENT TO RECEIVE MEDICATION HISTORY ON PATIENT VIA ELECTRONIC PRESCRIPTION.

☐ YES ☐ NO

 SIGNATURE OF PATIENT /GUARDIAN DATE

MEDICATION ALLERGIES: _____

MEDICATIONS: ☐ REFER TO LIST ☐ REFER TO BOTTLES
 (NO NEED TO LIST BELOW, IF YOU BROUGHT A LIST OR BOTTLES)

MEDICATION DOSE HOW OFTEN

MEDICATION DOSE HOW OFTEN

SOCIAL HISTORY: ☐ NONE ☐ CHANGES SINCE LAST VISIT

(CIRCLE APPROPRIATE)

☐ CURRENT TOBACCO USE -- YEARS: _____

(CIRCLE) CIGARETTES, CIGARS, SMOKELESS

☐ FORMER TOBACCO USE QUIT _____ YEARS AGO

☐ NEVER SMOKED

☐ COUNSELED TO QUIT/CUT DOWN YES NO

☐ PASSIVE SMOKE YES NO

☐ CAFFEINE USE PER DAY _____

☐ ALCOHOL USE PER DAY _____

☐ ALCOHOL TYPE _____

☐ EXERCISE TIMES PER WEEK _____

☐ EXERCISE TYPE _____

☐ OTHER _____

REVIEW OF SYSTEMS:

ARE YOU CURRENTLY HAVING PROBLEMS? ☐ YES ☐ NO

(IF YES, CIRCLE APPROPRIATE PROBLEM BELOW)

CARDIOVASCULAR	CHEST PAIN PALPITATIONS SHORTNESS OF BREATH <i>WALKING</i> SHORTNESS OF BREATH <i>WHEN LYING DOWN</i> SWELLING OF FEET OR ANKLES LIGHTEADEDNESS
RESPIRATORY	CHRONIC OR FREQUENT COUGH COUGHING UP BLOOD WHEEZING SHORTNESS OF BREATH
GASTROINTESTINAL	LOSS OF APPETITE CHANGE IN BOWEL MOVEMENTS NAUSEA VOMITING FREQUENT DIARRHEA PAINFUL BOWEL MOVEMENTS CONSTIPATION RECTAL BLEEDING BLOOD IN STOOL DARK, TARRY STOOLS
MUSCULOSKELETAL	JOINT PAIN JOINT STIFFNESS JOINT SWELLING MUSCLE WEAKNESS MUSCLE PAIN MUSCLE CRAMPS
DERMATOLOGIC	RASH ITCHING CHANGE IN SKIN COLOR
NEUROLOGIC	FREQUENT HEADACHES ONE SIDED WEAKNESS OR NUMBNESS CONFUSION MEMORY LOSS
PSYCHIATRIC	NERVOUSNESS DEPRESSION INSOMNIA ANXIETY
ENDOCRINE	HORMONE PROBLEM EXCESSIVE THIRST HEAT INTOLERANCE COLD INTOLERANCE EXCESSIVE URINATION
HEMATOLOGICAL	EASY BRUISING PROLONGED BLEEDING
IMMUNOLOGIC	SWOLLEN GLANDS SEASONAL ALLERGIES HIVES PERSISTENT INFECTIONS



DOB _____

OTHER