Patient Registration

Last Name:	First Name:	Date of Birth:	Age:	Sex:
Address:	City:	State:	Zip:	
SSN:	Race:	Ethnicity:	Primary Language:	Marital Status:
Home Phone #:	Cell Phone #	Cell Carrier:	Email Address:	
Employer Name:	Work #:	How long employed:		
Emergency Contact:	Relationship:	Phone #:		
Primary Ins:	Policy Holder:	Relationship:	Date of Birth:	
Secondary Ins:	Policy Holder:	Relationship:	Date of Birth:	

Consent & Conditions for Treatment

1. Consent for Treatment
   a) I, or _____ as my authorized representative acting on my behalf, present myself for treatment at PIKE INTERNAL MEDICINE, PC. In so doing, I hereby consent to the rendering of such care, which may include routine diagnostic procedures and such medical and surgical procedures, by authorized members of the PIKE INTERNAL MEDICINE, PC staff of their designees, as may in their professional judgment be deemed necessary or beneficial.
   b) I understand that the practice of medicine is not an exact science and that diagnosis and treatment may involve risks. I acknowledge that no guarantees have been made to me as to the result of any examination or treatment.
   c) I further understand that I have the right, in collaboration with my physician(s), to make decisions involving my health care and to accept care or to refuse treatment to the extent permitted by law and to be informed of the medical consequences of such refusal.
2. Financial responsibility / Assignment of Insurance Benefits
   a) I agree to pay PIKE INTERNAL MEDICINE, PC for any and all charges billed services rendered. I understand that such accounts are due at the time of service, but that PIKE INTERNAL MEDICINE, PC may accept assignment of insurance benefits in lieu of such payments. I understand that if i have insurance, that any co-payment or non-insured services amounts are payable at time of service.
   b) I acknowledge that PIKE INTERNAL MEDICINE, PC will make reasonable efforts to collect my assigned insurance benefits. Should said benefits remain unpaid sixty (60) days after my discharge, payment of the full amount shall be my responsibility. I further understand that if my account remains unpaid for a period of ninety (90) days, that it may be turned over to a collection agency to expedite collection, in which case I will be liable for all collection costs including a reasonable attorney's fee.
   c) I hereby assign any third party payments due me or that may become due to my under all policies of insurance held by me or for my benefit for services rendered on this date; or any related treatment, to the PIKE INTERNAL MEDICINE, PC. Should the payment(s) received exceed the current billed charges, then I authorize the application of any excess amount to any other PIKE INTERNAL MEDICINE, PC bill owed by me or any member of my family for whose bill I would be other wise responsible for. A copy of this assignment shall be as valid as the original.
3. Medicare Assignment
   a) I hereby certify that the information provided by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me release to the Social Security Administration or its intermediaries of carries any information needed for this or any related Medicare claim. I request that payment of authorized benefits be made on my behalf. I hereby assign benefits payable for physician services to the physician or organization furnishing such services or in the alternative I authorize such physician or organization to submit a claim to Medicare for payment on my behalf.
4. Release of Patient / Medical Information
   a) I consent to the release of personal and medical information to any third party payor, governmental agency providing benefits, or other person(s) / entity liable for my treatment charges. In addition, I consent to a similar release of information, as shall be necessary, to initiate my use of community resource and / or for transfer to another health care facility.

I have had an opportunity to read this form and any questions answered to my satisfaction, and I am satisfied that I understand its content and significance.

_____ _____

Insured's Signature & Date Patient's Signature & Date

_____ _____

Witness Legal Guardian or Surrogate

PATIENT ASSESSMENT SHEET

Patient Name: _____ Date of Birth: _____ Pharmacy: _____

Allergies: _____

Current Medications: _____

_____

Do you have an advance directive? [ ] Yes [ ] No (Someone to make your medical decisions should you be unable to.)

Past Medical History: (Any major problem or disease requiring medications. Ex: Diabetes, High blood pressure, Heart or Lung disease, etc)

Past Surgical History: (Any major surgery. Ex: Cardiac Bypass, Gallbladder, Appendix, etc. Include year)

Social History: (Check and fill in the blanks)

Occupation: _____ Retired: _____ Have you been treated for addiction: [ ] Yes [ ] No

[ ] Alcohol: [ ] Occasional [ ] Daily [ ] Heavy [ ] Tobacco: Years used: _____ Packs per day: _____

Family History: (Info on your father, mother, sister or brother. Check all that applies)

	High blood pressure	Liver disease	Bleeding	Heart trouble	Kidney disease	High cholesterol	Arthritis	Cancer	Diabetes	Stroke
Father										
Mother										
Sister										
Brother										

Review of Systems: (Check all that apply)

General
[ ] Negative
[ ] weight change
[ ] fever or chills
[ ] night sweats
[ ] thyroid problem
[ ] cancer
[ ] insomnia

Ear-Eye-Nose-Throat
[ ] Negative
[ ] visual change
[ ] hearing change
[ ] ringing in ears
[ ] dentures
[ ] bleeding gums
[ ] hoarseness
[ ] glasses / contacts

Respiratory
[ ] Negative
[ ] cough/sputum
[ ] rheumatic fever
[ ] tuberculosis
[ ] pleurisy/pneumonia
[ ] shortness of breath
[ ] asthma

Psychiatric
[ ] Negative
[ ] mental problems
[ ] anxiety
[ ] depression
[ ] bipolar disorders

Cardiovascular
[ ] Negative
[ ] heart attack
[ ] high blood pressure
[ ] mitral valve prolapse
[ ] thrombophlebitis
[ ] high cholesterol
[ ] rhythm problems

Gastrointestinal
[ ] Negative
[ ] dysphagia (painful swallowing)
[ ] nausea
[ ] jaundice
[ ] hepatitis
[ ] stomach ulcers
[ ] acid reflux
[ ] constipation
[ ] diarrhea
[ ] vomiting

Genitourinary
[ ] Negative
[ ] kidney infection
[ ] incontinence
[ ] venereal disease
[ ] kidney problems
[ ] frequency
[ ] kidney failure
[ ] excessive nighttime urination

Neurologic
[ ] Negative
[ ] seizures
[ ] paralysis
[ ] weakness
[ ] dizziness
[ ] numbness
[ ] stroke

Musculoskeletal
[ ] Negative
[ ] backache
[ ] joint pain
[ ] joint swelling

Skin
[ ] Negative
[ ] rash
[ ] easy bruising
[ ] lesions
[ ] skin cancers

Blood
[ ] Negative
[ ] bleeding problem
[ ] anemia
[ ] blood clots

Endocrine
[ ] Negative
[ ] diabetes

Patient Signature & Date: _____ Provider Signature & Date: _____

Pike Internal Medicine, P.C.
1350 Hwy 231 South
Troy, Alabama 36081
334.566.1270

New Patient Consent to the Use and Disclosure of Medical Records for Treatment, Payment, or Healthcare Operations

I, _____, understand that as a part of my healthcare, Pike Internal Medicine, PC, originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future health care treatment. I understand that this information serves as:
A basis for planning my care and treatment,
A means of communication among the many health professionals who contribute to my care,
A source of information for applying my diagnosis and surgical information to my bill,
A means by which a third-party payer can verify that services billed were actually provided, and
A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Privacy Policies that provide a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:
The right to review the notice prior to signing this consent,
The right to reject the use of my health information for directory purposes, and
The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care options.

In addition to myself, I consent to the following adult individuals to have access to my medical records: (please give full name and address)

_____

_____

_____

I understand that Pike Internal Medicine, PC is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Pike Internal Medicine, PC reserves the right to change their notice and practices in accordance with Section 164.520 of the Code of Federal Regulations.

I understand that as a part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

_____ _____

Patient's Signature Date

FOR OFFICE USE ONLY
( ) Consent received by _____ on _____.
( ) Consent refused by patient, and treatment refused as permitted.
( ) Consent added to the patient's medical records on _____.