Please PRINT CLEARLY

Name: _____
First Middle Initial Last

Street Address: _____

Zip Code: _____ **City:** _____ **State:** _____

Home Phone: _____ **Mobile number:** _____
(Area code) number (Area code) number

Preferred method for reminders: ☐ MyChart ☐ Home phone ☐ Mobile ☐ E-mail ☐ Mail

E-mail address: _____ @ _____

Employer Name: _____

Work Phone: _____ **May we contact you at work?** ☐ Yes ☐ No
(Area code) number

Birth date: _____ **Social Security#** _____

Ethnic: Asian ____ **Caucasian** ___ **Black** ___ **Hispanic** ___ **Other** _____

Marital Status: Married___ **Single**___ **Widowed**___ **Divorced/Sep**___ **Child** ___

**If patient is a child please complete this information for the parent.*

***Spouse's Name:** _____
First Middle Initial Last

***Spouse's Employer:** _____

***Spouse's Work Phone:** _____ **Birth date:** _____

Emergency Contact name & number: _____

Reason For Visit: _____
Please be specific

Is today's visit accident or injury related? ____ **yes** ____ **no** **Date of occurrence** _____

Work related? ____ **yes** ____ **no**

How did you hear about our office? ☐ Doctor ☐ Another patient ☐ Newspaper ☐ TV ☐ Internet

If referred by a doctor please list his/her *full name*, address and telephone number:

_____

If referred by another patient please list their name: _____

Family members treated by SAMPA & relationship: _____

People we may discuss your medical care with: _____

_____

After completing this page, please return it to the front desk before completing the remaining information

Date Completed: _____ **Patient Information Form** **Rev 8/19/14**

Name: _____ Date: _____

PERSONAL PHYSICIANS

Family Practice: _____
Telephone Number: _____
Gynecologist: _____
Telephone Number: _____
Gastroenterologist: _____
Telephone Number: _____
Orthopedist: _____
Telephone Number: _____

Cardiologist: _____
Telephone Number: _____
Pulmonologist: _____
Telephone Number: _____
Neurologist: _____
Telephone Number: _____

Telephone Number: _____

ALLERGIES

☐ None ☐ See below

_____	_____	_____	_____
_____	_____	_____	_____

Are you allergic to latex? ☐ Yes ☐ No

Are you on a C-pap machine? ☐ No ☐ Yes Prescribed by: _____

MEDICATIONS (*Prescription, Over the Counter or Herbs*) PATIENT IS CURRENTLY TAKING

Medicine Over the Counter or Prescription or Herbs	Strength	Dosage	Prescribed By
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Name: _____ Date: _____

MEDICATIONS (*Prescription, Over the Counter or Herbs*) PATIENT IS CURRENTLY TAKING

Medicine Over the Counter or Prescription or Herbs	**Strength**	**Dosage**	**Prescribed By**

If you are unable to answer any of the questions, please bring it to the doctor's attention. This form becomes part of your medical record and is held in confidence between you and your physician.

Please Print

Name: _____ **Date:** _____

Social History: Place of birth: _____ Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Military Service: ☐Yes ☐No When:_____ Where:_____ Maritime Employee: ☐Yes ☐No

International travel or lived overseas: ☐ Yes ☐ No When:_____Where:_____

Use of tobacco: ☐ Never ☐ Previously, but quit ☐ Current packs/day _____

Use of alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐Daily

Do you use illegal drugs? ☐ Never ☐ Type/Frequency _____

Family Medical History:

	Age	Diseases	If Deceased, Cause of Death
Father	____	_____	_____
Mother	____	_____	_____
Siblings	____	_____	_____
	____	_____	_____
Spouse	____	_____	_____
Children	____	_____	_____
	____	_____	_____
	____	_____	_____

Previous Surgeries and Hospitalizations:

Date	Hospital	Reason	Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Date of last EKG: _____ **Female - date of last pap smear** _____

Female- date of last mammogram _____

Date of last chest X-ray: _____ **Female- dale of last menstrual period** _____

Date of last colonoscopy: _____ **Male- date of last prostate check** _____

Do you take blood thinner? _____ **Do you take diet pills?** _____

Good general health lately ..... ☐ ☐ Joint pain ..... ☐ ☐

Physician Reviewed _____ Date: _____

PATIENT MEDICAL HISTORY

SURGICAL ASSOCIATION
of Mobile, P.A.

E-Prescribing Information and Patient Consent

What is E-prescribing and why does Surgical Association E-prescribe?

E-prescriptions, or electronic prescriptions are computer generated prescriptions created by your provider and sent directly to your pharmacy. Surgical Association participates in e-prescribing because we care about your health and well-being and E-prescribing has multiple safety benefits.

How does E-prescribing work?

Instead of writing your prescription on a piece of paper, your doctor enters it directly into the computer. Your prescription travels from your doctor's computer to your pharmacy's computer. E-prescription information is not sent over the open internet or as an E-mail. Your E-prescription arrives at your pharmacist's computer faster and may help to save you time. The E-prescription can be sent to the pharmacy you choose. If you do not want your prescription sent electronically, or your pharmacy does not accept E-prescriptions, your provider can print your prescription for you.

Privacy

The privacy of your personal health information contained in all of your prescriptions, whether written or electronic, is protected by federal law and state laws. The federal law is the Health Insurance Portability and Accountability Act (HIPAA). HIPAA requires that your personal health information be shared only for the purpose of providing you with clinical care. E-prescriptions meet this requirement.

Patient Consent for E-prescribing

I agree that Surgical Association of Mobile, P.A. may E-prescribe and may request and use my prescription medication history from other health care providers or third-party pharmacy benefit payers for treatment purposes.

_____ _____

Patient Name (print) Date

_____

Patient Signature

Gulf Coast Bariatric INSTITUTE

Surgical Association of Mobile, P.A.

Narcotic Prescription Policy

In order to comply with state and national regulations concerning the dispensing of narcotic analgesics we will adhere to the following policy:

1. Narcotic pain medicine will ONLY be prescribed for post-operative pain.
2. Post-operative prescriptions will be written only for a supply of medications required until the next follow up visit.
3. Narcotics should only be taken by the patient as directed on the bottle.
4. If the patient's pain has increased and is requiring more than the prescribed amount, a physician visit will be necessary to assess the reason for the increased need for narcotic analgesics and make appropriate testing and treatment recommendations at that time.
5. NO NARCOTIC PRESCRIPTIONS WILL BE PRESCRIBED BY PHONE OR AFTERHOURS AT ANY TIME.
6. If medication refill needs to take place afterhours or on a weekend, the patient should present to the emergency room for physician evaluation to receive enough medication to cover their pain until an appointment can be made with your surgeon.
7. Medications not related to the patient's surgery should be directed to the primary care or prescribing physician.
8. It is the responsibility of the patient to keep track of the pills being consumed daily and call several days in advance for an appointment if a refill may be needed.
9. Lost, damaged or stolen prescriptions will not be replaced.
10. If you are receiving narcotics from another physician, you are expected to disclose this information at your first visit.
11. Our practice is not designed to provide chronic narcotic medications to patients. Should this be necessary, you will be referred to a pain specialist.

_____ _____

(printed name) (date)

_____

(signature)

3 Mobile Infirmary Circle, Suite 212
Mobile, AL 36607
(251) 433-2609

cc: patient

6/28/19

SURGICAL ASSOCIATION
of Mobile, P.A.

NOTICE OF PRIVACY PRACTICES

8/13/13

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. We must obtain your authorization before the use and disclosure of any psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosure that constitute a sale of PHI. Uses and disclosures not described in this Notice of Privacy Practices will be made only with authorization from the individual.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the Practice may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the Practice or the hospital. For example, we may disclose medical information about you to people outside the Practice who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.

For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the Practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other Practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts. WHO WILL FOLLOW THIS NOTICE. This notice describes our Practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other Practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the Practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the Practice, whether made by Practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny *your* request to inspect and copy in certain very limited circumstances.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the Practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.

Right to Request Removal from Fundraising Communications. You have the right to opt out of receiving fundraising communications from the Practice. Right to Restrict Disclosures to Health Plan. You have the right to restrict disclosures of PHI to a health plan if the disclosure is for payment of health care operations and pertains to a health care item or service for which the individual has paid out of pocket in full.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the Practice's waiting room. COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact the Robin Reynolds, Privacy Officer, 3 Mobile Infirmary Circle, Suite 212, Mobile, AL 36607 (251) 433-2609. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.** OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.

I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights.

_____ _____

Patient or Patient's Personal Representative **Date**

TO THE PATIENT:

If you are covered by medical insurance, this office will be glad to file the claim for you. You are responsible for all deductibles, co-pays and non-covered services.

If you have any questions or you are not covered under medical insurance, please contact the account's manager at (251) 433-2609. We will be glad to answer your questions or make arrangements for you.

- **By signing below, you hereby consent for this Practice to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purposes of treatment, payment and health care operations.**

PATIENT'S SIGNATURE: _____

- **I AUTHORIZE PAYMENT OF MEDICAL BENEFITS to the undersigned physician or supplier of services rendered:**

SURGICAL ASSOCIATION OF MOBILE, P.A.

INSURED SIGNATURE: _____

- **In consideration for the care and services to be rendered while a patient, I agree to pay all medical expenses (if covered by insurance, all deductibles, co-pays and non-covered services) and, in the event it becomes necessary to take legal action for the collection of said expenses from me, I agree to pay all reasonable attorney fees and collection expenses.**

PATIENT'S SIGNATURE: _____

GUARANTOR'S SIGNATURE: _____

WITNESS: _____ **DATE:** _____