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: ☐ Home phone ☐ Mobile phone ☐ Text

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** **Revised 12/20/2022**

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.
3 Mobile Infirmary Circle, Suite 212
Mobile, AL 36607

NOTICE OF PRIVACY PRACTICES

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

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide you a copy or summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
    - We are not required to agree to your request, and we may say **"no"** if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
    - We will say **"yes"** unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 2
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave., S.W., Washington, D.C. 20201, calling 1-877-696-6775 or visiting **www.hhs.gov/ocr/privacy/hipaa/complaings/**.
- We will not retaliate against you for filing a complaint.

For certain health information, you can tell us your choices about what we share. *If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.*

- In these cases, you have both the right and choice to tell us to:
    - Share information with your family, close friends, or others involved in your care
    - Share information in a disaster relief situation
    - Include your information in a hospital directory
    - Contact you for fundraising efforts

  If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- In these cases, we never share your information unless you give us written permission:
    - Marketing purposes
    - Sale of your information
    - Most sharing of psychotherapy notes

(over)

- In the case of fundraising:
    - We may contact you for fundraising efforts, but you can tell us not to contact you again.

How do we typically use or share your health information?

- **Treat you**. We can use your health information and share it with other professionals who are treating you.
    - **Example:** A doctor treating you for an injury asks another doctor about your overall condition.
- **Run our organization.** We can use and share your health information to run our practice, improve your care, and contact you when necessary.
    - **Example:** We use health information about you to manage your treatment and services.
- **Bill for your services.** We can use and share your health information to bill and get payment from health plans or other entities.
    - **Example:** We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

- **Help with public health and safety issues**
    - We can share health information about you for certain situations such as:
        - Preventing disease
        - Helping with product recalls
        - Reporting adverse reactions to medications
        - Reporting suspected abuse, neglect, or domestic violence
- **Do research**
    - We can use or share your information for health research.
- **Comply with the law**
    - We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- **Respond to organ and tissue donation requests**
    - We can share health information about you with organ procurement organizations
- **Work with a medical examiner or funeral director**
    - We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
- **Address workers' compensation, law enforcement, and other government requests**
    - We can use or share health information about you:
        - For workers' compensation claims
        - For law enforcement purposes or with a law enforcement officials
        - With health oversight agencies for activities authorized by law
        - For special government functions such as military, national security, and presidential protective services
- **Respond to lawsuits and legal actions**
    - We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities:

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We must not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site. **Effective Date February 16, 2026.**

This Notice of Privacy Practices applies to the following organizations: Surgical Association of Mobile, P.A.

Privacy Contact: Office Manager **(251) 433-2609** **privacy@sampadocs.com**

_____ _____

Patient or Personal Representative's Signature **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:** _____