The Doctor's Office

Laura Lee Taylor, M.D.

12935 Hwy 231/431 N.
Hazel Green, AL 35750
Phone: 256-828-6766 Fax: 866-782-9553

Office Policies and Procedures

Office hours: Monday- Friday 8:00 AM- 5:00 PM but closed for lunch from 12:00 PM- 1:00 PM and Saturdays from 8:00 AM- 12:00 PM for sick appointments.

Welcome to Dr. Laura Lee Taylor's Office. We are pleased that you have chosen our office to call you healthcare home. We are delighted to have the opportunity to care for our very own community. We hope that your visits to the office are enjoyable and enlightening.
Mission Statement:Our primary policy is to provide progressive healthcare to our patients of all ages in a warm, comfortable, small-town atmosphere.

Please read over our office policies and initial by each one indicating that you understand and will be in compliance of these.

Scheduling/Treatment Policies

_____ I understand that it is essential for my care that I be present to my scheduled appointments and that if I cancel or miss three consecutive appointments, or if I fail to be seen for an extended period of time, in excess of three or more years, that my account with The Doctor's Office will be considered inactive.

_____ I understand that I will be required to pay my copay at the time of the visit in full. Additionally, I understand that my account will be checked prior to each appointment to verify if there is any outstanding balances and I will be asked to pay any balances on my account at the time of each visit.

_____ I understand that any amount that is not covered by my insurance will be billed to me as my responsibility. I also understand that it is my responsibility to make sure that my insurance covers my visits and to verify if I have any deductible amounts prior to making an appointment with The Doctor's Office.

_____ I understand that any balance on my account that is not paid within 90 days is considered outstanding and I will not be seen until that balance is paid in full.

_____ I understand that if my deductible for the year has not been met, it is my responsibility to pay for the office visit prior to being seen that day in the office.

_____ I understand that my appointment time is set aside for me and if I fail to show up within 10 minutes of that set appointment time, I will be considered a no show for that appointment and will need to reschedule for the next available appointment.

_____ I understand that it is my responsibility to notify the office of any changes to my personal information, including insurance changes, phone number updates, and address updates.

Additionally, I understand that confirmation calls and texts are a courtesy and it is my responsibility to keep up with my appointment.

_____ I understand that the completion of forms: Employers, FMLA, insurance forms or any other paperwork that requires your provider's input needs an appointment with that provider to get completed.

_____ I understand that it is my responsibility to know which lab my insurance allows and pays for and if any bill arises from lab work done in The Doctor's Office and is not covered, it will be my responsibility and not that of the office.

_____ I understand that noncompliance in medication adherence, preventative screenings, or medical guidance given by your PCP will be reviewed by the physician and can be terms for dismissal from this office.

_____ I understand that I am not to personally contact any employee of this office about mine or my family's health care outside the HIPAA compliant ways of contact the office has set up: the office phone number or the portal. Contacting an employee by personal cell phone number, social media platform, or approaching in person outside of this office about my care will be grounds for immediate dismissal from this office.

Medication Compliance Policies

_____ Any refills of my prescriptions will be made only at the time of an office visit or during regular office hours. I understand that medication refill requests are not considered an emergency and will not be accepted outside of office hours (evenings/weekends). I understand that it is my responsibility to maintain my medications and make sure that I have enough supply until my scheduled appointment. Outside of office hours, I will go to the nearest Emergency Room if there are medications that I need urgently.

_____ I understand that it is my responsibility to make all future doctor's appointments and lab appointment and reschedule, if missed, to keep my medications current. If lab work or medication checks are not current, medication cannot be refilled.

_____ I will notify my prescriber immediately if any other prescriber adjusts or changes the dose of any medications that I am on, unless I am in the hospital. Upon discharge from any hospital or facility I will notify my prescriber of any changes to my medications.

_____ I agree that I will not share, sell, or trade my medications with anyone. I understand that controlled substances taken by anyone other than the patient will be considered drug diversion, and will result in my dismissal from the practice.

By signing this agreement I understand that I am agreeing to adhere to the policies listed in order to receive treatment from The Doctor's Office. I understand that if I do not comply with the policies listed in this agreement that my provider will be unable to treat me and I may be dismissed from the practice. Additionally, by signing this agreement I acknowledge that all of my questions and concerns regarding treatment have been adequately answered. I understand that a copy of this signed agreement can be given to me for my records.

Patient Signature: _____
Patient Name (printed): _____
Date: _____

Children 18 and Under

Patient Update Form

The Doctor's Office

Date_____

Patient Information

Patient's Name_____
Last Name First Name Middle Name Name you go by

Parent's Name_____
Last Name First Name Middle Name

Street_____ City, State, Zip_____

Home Phone_____ Cell Phone_____
Include area code Include area code

Sex____ Birth Date_____ Age_____ SSN_____
mm/dd/yyyy

Driver's Lic#_____ Marital Status_____

Patient's Employer_____ Occupation_____ Work Phone_____
Include area code

Race:_____ Language Preferred_____ Ethnicity:_____

Emergency Contact

Contact's name_____ Relationship_____ Phone_____
Include area code

Email Address_____

Insurance Information

Insurance #1_____

Group #_____ Contract #_____ Co-pay_____

Name of Insured_____ Relationship to Patient_____

Sex_____ Birth Date_____ SSN_____
mm/dd/yyyy

Insurance #2_____

Group #_____ Contract #_____ Co-pay_____

Name of Insured_____ Relationship to Patient_____

Sex_____ Birth Date_____ SSN_____
mm/dd/yyyy

Authorization to Release Infomation and Assignment of Benefits

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Signature_____ **Date**_____

I hereby authorize The Doctor's Office to apply benefits on my behalf for the covered services rendered by the office, or by the office's order. I request that payment from my insurance company be made directly to The Doctor's Office or to the party who accepts assignment. I certify that the information I have reported with regard to my insurance coverage is correct.

Signature_____ **Date**_____

The Doctor's Office

Laura Lee Taylor MD, LLC

12935 Hwy 231 431 Hazel Green, AL 35750

256-828-6766 Phone 256261-7877 Fax

MEANINGFUL USE

Race, Ethnicity, and Language Form

At the Doctor's Office, we are united with one common goal-to care for you and your family. As a part of this goal we have implemented an Electronic Medical Record system to help improve healthcare quality and patient safety. In order to fully implement this system we need your help with the following patient demographics. Please answer all questions below.

1. What race do you consider yourself to be?

   _____American Indian or Alaska Native

   _____Asian

   _____Black or African American

   _____Native Hawaiian or Pacific Islander

   _____White

   _____Other

2. Do you consider yourself to be...?
   _____Hispanic or Latino ethnicity

   _____Non-Hispanic or Latino ethnicity

3. What is your preferred language? _____
   (The language, including sign language, most preferred by patient for communication)

The Doctor's Office understands that this is very personal and sensitive information. We will protect all information as outlined in the HIPAA Guidelines.

Please Print Name:_____ Signature:_____

Date of Birth:_____ Date:_____

Health History

Patient Name: _____

Reason for today's visit: _____

Medical History

Do you have a personal medical history of (check all that apply):

__ Anemia	__Arthritis	__Asthma	__Allergic Rhinitis
__Cancer-please list type _____	__High Cholesterol	__Diabetes Mellitus	__Seizure Disorder
	__Heart Disease	__Hypertension	__Kidney Disease
__ Stroke	__Migraines	__Thyroid disorders	__Tuberculosis
__ HIV Infection	__Hepatitis	__Psychiatric Disorder	__ Peptic Ulcer
__ Eczema	__Substance Abuse	__ Glaucoma	

Please list any allergies: _____

Please list any medications you are currently taking:

_____

_____

_____

_____

Family History

Please list any chronic health problems: (e.g. *cancer-please list type, diabetes, high blood pressure, high cholesterol, heart disease, stroke, heart attack, thyroid disease, susbstance abuse, asthma, kidney disease, etc*)

Father_____ Mother_____

Brothers_____ Sisters_____

Paternal Grandfather_____ Paternal Grandmother_____

Maternal Grandfather_____ Maternal Grandmother_____

Uncles_____ Aunts_____

Health History

Social History

Marital Status: _____ Occupation:_____Hobbies/exercise?_____

Do you have children? (list gender and ages)_____

Are you currently in school? __public __private __home Level completed_____

Do you use tobacco? __Cigarettes __Chewing __Snuff How much/often? _____

Were you previously a smoker? __Yes __No When did you quit? _____

Do you live with a smoker? __Yes __No

Do you drink alcohol? __ Yes __ No Type and Amount? _____

Do you use any recreational drugs? __ Yes __ No Type and Amount? _____

Surgical History

Please list any surgeries, hospitalizations, injuries that you have had and the dates:

_____

_____

_____

_____

Health Maintenance

Please fill in the appropriate date you had your last screening tests.

Tetanus Shot_____ Age 65 and older: Pneumonia shot_____

Sexually Transmitted Diseases Screening (such as HIV, Gonorrhea, Syphilis, etc.)_____

Age ≥35/male or ≥ 45/female : Cholesterol level _____

Age 50 or older: Colon Cancer Screening_____

Age 65-75 if ever smoked 100 or more cigarettes: Abdominal Aortic Aneurysm Screening_____

Females Only:

Age 21-65 or sexually active for 3 years : Pap test_____

Age 40 and older: Mammogram_____

Age 65 and older OR 60-64 and weigh less than 155 pounds: Bone Density_____

The Doctor's Office

Laura Lee Taylor, M.D.

THE DOCTOR'S OFFICE VACCINE POLICY

It is the policy of Dr. Laura Lee Taylor that your child receives all immunizations listed below at the age and combinations required by the American Academy of Pediatrics.
THIS IS A NON-NEGOTIABLE POLICY OF THE PHYSICIAN, NURSE PRACTITIONER AND PHYSICIAN ASSISTANT OF THE DOCTOR'S OFFICE

IMMUNIZATION SCHEDULE

Newborn	Hepatitis B, Vitamin K given at hospital
2 Months	Dtap, Polio, Hepatitis B, HIB, Pneumococcal 13, Rotavirus
4 Months	Dtap, Poli, Hepatitis B, HIB, Pneumococcal 13, Rotavirus
6 Months	Dtap, Polio, Hepatitis B, HIB, Pneumococcal 13, Rotavirus
12 Months	MMR, Varicella, Hepatitis A
15 Months	Pneumococcal 13, HIB
18 Months	Dtap, Hepatitis A
4 year	MMR, Varicella, Dtap, Polio
11 years +	Tdap, Meningococcal, HPV
16 years+	Meningococcal B

The following immunizations are not required but strongly recommended-they are included in the above schedule.

**Meningococcal	**Hepatitis A
**Gardasil 9	**Rotavirus

I acknowledge receipt of the Vaccine Policy at The Doctor's Office and by registering my child as a patient, I agree to comply with required immunizations and schedule listed above or determined by my provider.

Name of Child	Date of Birth
Parent/Guardian Signature	Relationship to Patient
Printed name Parent/Guardian	Date