The Doctor's Office

We do not prescribe chronic controlled medications for new patients.

If you are currently taking a controlled medication, please provide the name of the physician who manages that prescription. We are happy to refer you to a specialist if needed.

Please understand that we cannot take over prescribing or refilling controlled medications, even temporarily, until you are established with a specialist.

We understand this may mean we are not the right primary care office for your needs, and we respect that. However, this is our policy and it is non-negotiable.

Thank you for your understanding,
The Doctor's Office

Office Policies and Procedures

We are delighted to have the opportunity to care for our very own community. We hope that your visits to the office are helpful and pleasant.

Mission Statement: Our primary policy is to provide progressive healthcare to our patients of all ages in a warm, comfortable, small-town atmosphere.

Office hours: Monday–Friday 8:00 AM–5:00 PM (closed for lunch from 12:00 PM–1:00 PM).

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

Scheduling/Treatment Policies

_____ I understand that it is essential for my care that I be present for my scheduled appointments at The Doctor's Office. If I cancel or miss three consecutive appointments, or if I fail to be seen for an extended period of time (typically more than three years), my account with The Doctor's Office may 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 are 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.

_____ I understand that it is my responsibility to make all future doctor's appointments and lab appointments 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: _____

New Patient Form

The Doctor's Office

Date_____

Patient Information

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

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_____Email_____

Patient's Employer_____Occupation_____Work Phone_____
Include area code

Spouse's name_____
Last Name First Name Middle Name Name you go by

Spouse's Employer_____Occupation_____Work Phone_____
Include area code

Last Primary Care Physician_____

Emergency Contact

Contact's name_____Relationship_____Phone_____
Include area code

Name of Person Referring_____Email_____

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 Information 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

12935 Hwy 231-431 N Hazel Green, AL 35750

256-828-6766 Phone 866-782-9553 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

OFFICE USE ONLY
Received by_____
Approved by_____

Patient Name: _____

What primary care physician are you transferring from? _____

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 medication 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, substance abuse, asthma, kidney disease, etc.)*

Father _____ Mother _____

Brothers _____ Sisters_____

Paternal Grandfather _____ Paternal Grandmother _____

Maternal Grandfather _____ Maternal Grandmother _____

Uncles _____ Aunts _____

Specialists

Please list all specialists you currently see at least yearly:

_____

_____

_____

_____

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 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: Pap test _____

Age 40 and older: Mammogram _____

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

*Our office requires that our patients are compliant with the American Cancer Society Guidelines.

Mammograms

Women age 40 to 54 should get mammograms every year.

Women 55 and older can switch to mammograms every 2 years or can continue yearly screening.

When was your last mammogram?

Date: _____ Where?_____

If you have never had one and are a woman over the age of 40, can we schedule one for you upon becoming a new patient?

Yes_____ No _____ N/A _____

Colon Cancer Screening

All men and women over the age of 44 need to start colorectal cancer screenings.

When was your last colorectal screening?

Date: _____ Where? _____

If you have never had one and are over the age of 44, can we schedule one for you upon becoming a new patient?

Yes_____ No _____ N/A _____

Bone Mass Measurements

Bone Mass Measurements are to see if you are at risk for broken bones due to osteoporosis. Osteoporosis is a disease in which your bones become weak and brittle. It is recommended for women above the age of 65.

When was your last bone density test?

Date: _____ Where? _____

If you have never had one and are a female over the age of 65, can we schedule you for one upon becoming a new patient?

Yes_____ No _____ N/A _____

If any portion of this page is marked "no," I understand that it could affect my acceptance as a patient at The Doctor's Office. Signature: _____

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act - 45 CFR Parts 160 and 164)

1. I authorize all medical service sources and health care providers to use and/or disclose my protected health information ("PHI") to myself and/or my agent named in my **Durable Power of Attorney for Health Care.**
Patient Name: _____

2. Authorization for Release of PHI Covering the Period of Health Care (Check One):

☐ From (Date) _____ to (Date) _____ OR

☐ All past, present, and future periods

3. I authorize and give consent to The Doctor's Office to leave messages on my answering machine, voicemail, text message, and/or e-mail for the following: (Check All That Apply)

☐ Appointment Reminders ☐ Prescription Refills ☐ Medical Information ☐ Test Results

☐ Insurance/Payment Issues ☐ Email: _____ ☐ Text: _____ ☐ Mail

4. I authorize disclosure of my billing, health condition, treatment, and prognosis to:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

5. This medical information may be used by the authorized persons for medical treatment, consultation, billing, claims payment, or other purposes as I may direct.

6. This authorization remains in effect until nine (9) months after my death or until (date/event):

_____.

7. I understand I may revoke this authorization, in writing, at any time, except where actions have already been taken based on this authorization.

8. I understand that information disclosed under this authorization may be subject to re-disclosure and may no longer be protected by federal or state privacy laws.

9. I acknowledge that Apogee Clinical Research, LLC, in collaboration with Laura Lee Taylor, MD, LLC, may access my medical records only to determine my eligibility for a clinical trial.

Printed Name: _____

Patient Signature: _____ **Date:** _____