Digestive Disease Center
HUNTSVILLE HOSPITAL

PATIENT INFORMATION

Patient

Date: _____

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____ Work phone: _____

DOB: _____ SSN: _____ Sex: ☐ M ☐ F

Preferred language: ☐ English ☐ Spanish ☐ French ☐ Chinese ☐ Other: _____

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Unknown

Race: ☐ Black/African American ☐ White/Caucasian ☐ American Indian/Alaska Native ☐ Asian
☐ Native Hawaiian/Pacific Islander ☐ Unknown ☐ Other: _____

Email address: _____

___ Married ___Single ___Divorced ___Widowed

Spouse's name: _____ Spouse's DOB: _____ Spouse's SSN: _____

In case of emergency, notify: _____ Relationship: _____

City: _____ State: _____ Phone: _____

Insurance *(provide patient information unless patient is a minor, then provide guarantor's information*

PRIMARY INSURANCE

Insurance name: _____ Relationship to patient: _____
Subscriber's name: _____ Copay amount: _____
Subscriber ID/Contract Policy #: _____ Group #: _____
Subscriber's SSN: _____ Subscriber's DOB: _____
Subscriber's Employer: _____ Employer's Phone: _____

SECONDARY INSURANCE

Insurance name: _____ Relationship to patient: _____
Subscriber's name: _____ Copay amount: _____
Subscriber ID/Contract Policy #: _____ Group #: _____
Subscriber's SSN: _____ Subscriber's DOB: _____
Subscriber's Employer: _____ Employer's Phone: _____

ALTERNATE INSURANCE

Insurance name: _____ Relationship to patient: _____
Subscriber's name: _____ Copay amount: _____
Subscriber ID/Contract Policy #: _____ Group #: _____
Subscriber's SSN: _____ Subscriber's DOB: _____
Subscriber's Employer: _____ Employer's Phone: _____

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MEDICAL HISTORY WORK-UP SHEET

Date: _____

Name: _____ Date of birth: _____ Age: _____

Primary Care Physician: _____ Referring Physician _____

Reason for visit: _____

PAST MEDICAL HISTORY *(Please check if you have any of the below.)*

☐ AIDS/HIV	☐ Colon Cancer	☐ Gerd (Acid Reflux)	☐ Hepatitis C
☐ Anemia	☐ Crohn's Disease	☐ Hepatitis A	☐ Liver Disease
☐ Cirrhosis	☐ GI Bleed	☐ Hepatitis B	

Have you ever had a colonoscopy? Yes By whom: _____ Date: _____ No Were polyps removed? Yes No

Do you have a family history of colon polyps? Yes No Parent or Sibling

Do you have a family history of colon cancer? Yes No Parent or Sibling

PAST SURGICAL HISTORY

☐ Gastric Bypass	☐ Hemorrhoidectomy
☐ Gallbladder Removed	☐ Polyp Removal

Other _____

RISK FACTORS *(Check or circle appropriate)*

☐ Current tobacco use Year started _____
Type of tobacco: Cigarettes / Cigars / Snuff / Vapor

☐ Former tobacco use Year quit _____

☐ Never smoked Second hand smoke Yes / No

Alcohol use Yes / No Type _____

How many per day? _____

ALLERGIES OR MEDICATION REACTIONS

☐ **NO KNOWN DRUG ALLERGIES**

Allergic to: Reaction:

_____

_____

CURRENT MEDICATIONS ☐REFER TO LIST

Please include the dose and how often you take the medication. *(Skip if you brought a list or bottles)*

Name	Dosage	How many times per day?	As Needed (PRN)

Pharmacy _____ Phone # _____ Location _____

Do we have permission to receive medication history on patient via electronic prescription? Yes / No

Signature of patient/guardian _____ Date _____

PRESCRIPTION INSURANCE

Insurance name: _____ Relationship to patient: _____
Subscriber's name: _____ Copay amount: _____
Subscriber ID/Contract Policy #: _____ Group #: _____
Subscriber's SSN: _____ Subscriber's DOB: _____
Subscriber's Employer: _____ Employer's Phone: _____

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Digestive Disease Center
HUNTSVILLE HOSPITAL

Please fax these forms:
Huntsville: (256) 539-4240 | Madison: (256) 817-5840
Sheffield: (256) 314-2553

Patient Name: _____ SSN (opt):_____

Date of Birth: _____ Address:_____

Phone: _____ Date of Service: _____

Chart #: _____

Provider: _____

I authorize the use or disclosure of the above named individual's health information as described below:

- Huntsville Hospital Physician Network is authorized to make the disclosure.
- The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)
  - ☐ All/entire record
  - ☐ Visit/encounter notes
  - ☐ Laboratory results
  - ☐ X-ray and imaging reports
  - ☐ Problem list
  - ☐ Medication list
  - ☐ Allergies list
  - ☐ EKG report
  - ☐ Pathology report
  - ☐ Consultation report
  - ☐ Operative report
  - ☐ Immunization record
  - ☐ Drug and alcohol treatment
  - ☐ HIV/AIDS/STD treatment
  - ☐ Registration record
  - ☐ Other: _____

  Records release format:
  (choose one)
  - ☐ e-delivery (HealthPort connect)
  - ☐ CD
  - ☐ Paper
- I understand the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndroms (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
- This information may be disclosed to and used by the following individual or agency:

  Name: _____ Address: _____

  for the purpose of: _____
- I understand that I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Record Department. I understand the revocation will not apply to information already released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- Unless otherwise revoked, the authorization will expire on the following date, event or condition:

  _____
  If left blank, this authorization will expire six months from the date of signing.
- I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.
- I understand as the recipient, I am responsible for the security of these medical record copies and the health information contained therein, whether in paper format or on CD/DVD.
- I understand I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan or eligibility for benefits. HOWEVER, I understand that if I refuse to sign this form, under specific conditions the organization can refuse treatment enrollment in the health plan and/or eligibility for benefits.

_____ _____ _____
Signature Date Time

_____
Relationship to patient (if signed by legal representative)

_____ _____ _____
Signature of witness Date Time

OFFICE USE ONLY: Any portion of the record request found in paper chart? ☐ Yes ☐ No

HH SYSTEM CLINICS REGISTRATION UPDATE SHEET

Patient: _____ Date of Birth: _____ Fin #_____

AUTHORIZATION TO CALL

I authorize HH System Clinics to leave the following messages on my answering machine/voicemail:

_____ Reminder appointments calls

_____ Lab and/or test results

HH SYSTEM CLINICS ADVANCE DIRECTIVE POLICY

In our practices, we have decided that we will initiate resuscitative measures any time they are needed.

FINANCIAL FEES & ASSISTANCE

FINANCIAL FEES: I understand the following fee will be charged:

- A fee of $25 per form for completion of comprehensive forms. A fee will NOT be assessed for simple forms such as Work Excuse, School Excuse or application for Indigent Assistance for Medications.

FINANCIAL ASSISTANCE: I understand that financial assistance may be available for individual patients who are uninsured or who otherwise meet financial aid criteria. The hospital's overall ability to remain financially stable and provide essential health care services to all members of our community is dependent upon financial resources available to cover services provided to patients. My assistance in providing such information is necessary to determine possible financial aid available to me. If I am uninsured and need financial assistance, I may contact a Financial Counselor and make a request to see if I qualify at (256) 265-9438.

AUTHORIZATION OF TREATMENT

I hereby consent and authorize my physician and/or Allied Health professional to render usual and customary medical/emergency treatment that they deem advisable and necessary. I also authorize HH System Clinics to electronically request my medication history if my pharmacy participates in electronic prescribing in order to assist the provider in prescribing necessary medication therapy.

ASSIGNMENT OF BENEFITS, AGREEMENT & GUARANTY

I authorize HH System Clinics to release any information regarding services rendered to me to third-party payers in consideration of payment for my care or to other health care providers involved in my care. I understand payment of all insurance benefits, basic and major medical for this period of service must be made directly to HH System Clinics. If the check must be made out to me, I understand the check must be sent to this address: PN Billing, P.O. Box 2705, Huntsville, AL 35804. I understand the HH System Clinics must collect for all charges not covered by insurance payments. Payment for all collection costs, securing, or attempting to collect and secure including reasonable attorney fees or Collection Agency fees, whether suit be necessary or otherwise, is the financial responsibility of the patient and guardian. Patients who are considered a legal adult are financially responsible for all services rendered.

HH HEALTH SYSTEM NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I acknowledge that a copy of the Notice of Privacy Practices for HH Health System has been made available to me. In connection with the Notice, I also acknowledge that I have been provided with an opportunity to ask questions regarding the Notice and its contents. I understand that the most current version of the Notice will be posted with the Health System and on www.huntsvillehospital.org.

EXPRESS PERMISSION TO CONTACT PATIENT BY CELL PHONE

I agree in order for HH System Clinic to service my account or to collect monies I owe, HH System Clinics and/or our agents may contact me by any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. HH System Clinics may also contact me by sending text messages.

Patient**:** _____ Date of Birth: _____ Fin #_____

or emails, using any email address I provided. Methods of contact may include pre-recorded/artificial voice messages and/or use of automatic dialing devices, as applicable. I have read this disclosure and agree that HH System Clinics, its employees, and/or agents may contact me as described.

PHOTOGRAPHY CONSENT

I authorize photography for purposes of clinical treatment and staff education. I understand that any images or photographs will be used solely for these purposes and that I have the right to revoke this authorization or to refuse to be photographed at any time. I understand that only hospital authorized or issued equipment will be used to take photographs, and that my privacy and confidentiality will be maintained in the use of these images.

_____ Consent to Photography for Medical Treatment and Staff Education

_____ Decline Consent to Photography for Medical Treatment and Staff Education

Signature of Patient/Authorized Representative on behalf of patient:

Date: _____ Time: _____

Printed Name of Person Authorized to sign for patient: _____

Basis of Authority to sign for patient: _____

FOR USE BY HEALTH SYSTEM PERSONNEL ONLY

(Complete if patient Acknowledgment is not obtained)

The patient was provided with a copy of the Notice of Privacy Practices and a good faith attempt was made to obtain the patient's signature acknowledging receipt of the Notice. An Acknowledgment was not obtained because _____.

Witness/Employee Signature: _____ Employee ID: _____

Date _____ Time _____