Dear Patient,

We would like to take this opportunity to thank you for choosing Huntsville Hospital Physician Care - Madison for your primary medical care and to welcome you to our office. We are pleased that you have chosen us to provide you with medical services.

Our website should help answer any questions about our office. We want you to know about our office services and what to expect at the time of your first visit.

Please call the office to schedule your new patient appointment prior to completing the New Patient Forms. Bring the completed forms with you on your appointment date, along with your identification cards, insurance cards, medication bottles, as well as your co-payments and/or deductibles.

We ask that all new patients arrive 30 minutes prior to your appointment time, so you can be seen by the doctor at your scheduled time.

If you are unable to keep your appointment for any reason or if you are going to be 15 minutes or more late, please call our office as soon as possible. We will be happy to reschedule a more convenient time for you.

Sincerely,

Sherry Fussell
Practice Administrator
Huntsville Hospital Physician Care - Madison
**Patient information**

<table>
<thead>
<tr>
<th>Date</th>
<th>Referred by</th>
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<th>Zip</th>
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<th>Work Phone</th>
<th>Cell Phone</th>
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<tr>
<th>SS#</th>
<th>Sex</th>
<th>D.O.B.</th>
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<th>Employer</th>
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<th>Spouse’s SS#</th>
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<table>
<thead>
<tr>
<th>Notify in case of emergency</th>
<th>Relationship</th>
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**Primary insurance to file**

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<th>Insured’s Name</th>
<th>Relationship</th>
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<table>
<thead>
<tr>
<th>Insured’s SSN# or ID#</th>
<th>Insured’s Date of Birth</th>
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<thead>
<tr>
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<th>Policy #</th>
<th>Group #</th>
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**Secondary insurance to file**

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<th>Insured’s Name</th>
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</table>

<table>
<thead>
<tr>
<th>Insured’s SSN# or ID#</th>
<th>Insured’s Date of Birth</th>
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<table>
<thead>
<tr>
<th>Insurance Company Name</th>
<th>Policy #</th>
<th>Group #</th>
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**PERSON RESPONSIBLE FOR THIS ACCOUNT**

<table>
<thead>
<tr>
<th>PERSON RESPONSIBLE FOR THIS ACCOUNT</th>
<th>PHONE</th>
</tr>
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</table>

I agree that payment will be made at the time of service. I agree to pay all co-pays, non-covered or routine charges, deductibles and co-insurance amounts that apply. In the event this account is turned over to a collection agency for collection, I will be responsible for all collection fees, court costs and attorney's fees. I authorize HH Physician Care to release information to insurance carriers and for insurance carriers to release information to HH Physician Care concerning my illness, treatment and payments (including workmen's compensation) and I hereby assign to the physicians all payments for medical services rendered to myself or my dependents if assignment applies.

Signature ______________________ Date __________________ Time __________________
APPT. TODAY WITH:

Cole-Suttlar       Khan      Katoch
McAdams Hartwig Prentice
Shrode Southwood Whitney

DATE: _________________

NAME: ____________________________________________

WHAT OTHER DOCTORS/SPECIALIST DO YOU SEE:

DATE OF BIRTH: _________ NAME/SPECIALTY __________________________________

AGE: _________ ___________________________________________________

REASON FOR VISIT: __________________________________________________________________________________

ANY NEW OR WORSENING PROBLEMS? IF YES, PLEASE DESCRIBE: _______________________________________
_____________________________________________________________________________________________________

PLEASE CHECK IF YOU HAVE ANY OF THE BELOW:

PAST MEDICAL HISTORY:

ASTHMA
ATRIAL FIBRILLATION
ANEMIA
ANXIETY
AUTOIMMUNE DISEASE (LUPUS)
BILIARY CIRRHOSIS
BLOOD TRANSFUSION
BRAIN TUMOR
CEREBROVASCULAR
DISEASE (STROKE)
CIRRHOsis
COPD (LUNG DISEASE)
COLON CANCER
CORONARY HEART DISEASE

CROHN'S DISEASE
CHRONIC RENAL FAILURE
DEPRESSION
DIABETES - JUVENILE ONSET
DIABETES - ADULT ONSET
DIVERTICULITIS
DV (BLOOD CLOT IN LEGS)
GI BLEED
GERD (ACID REFLUX)
HYPERTENSION
HIGH BLOOD PRESSURE
HIGH CHOLESTEROL
HYPOGLYCEMIA
HYPERRHOIDISM
HIP REPLACEMENT
HEPATITIS A
HEPATITIS B
HEPATITIS C
HEPATITIS D
HEPATITIS E
INFERTILITY
KIDNEY DISEASE
KIDNEY STONES
LIVER DISEASE
LIVER TRANSFUSION
MI (HEART ATTACK)
NEUROLOGIC DISORDER
NEPHRITIS
NEPHROTIC SYNDROME
OSTEOARTHRITIS
OSTEOPOROSIS
PUD (STOMACH ULCERS)
RAHARTITIS
RAPTOR CUFF REPAIR
RENAL FAILURE
STROKE
SYRUPHOSIS
TUBERCULOSIS
VALVULAR HEART DISEASE
VARICOSE VEINS/PHLEBITIS
UTI - RECURRENT
ABNORMAL PAP SMEAR
BREAST DISEASE
BREAST TUMOR
CERVICAL CANCER
DES EXPOSURE
GESTATIONAL DIABETES
RH SENSITIZED
SLEEP APNEA
SEIZURE DISORDER
***USING CPAP YES/NO

OTHER ______________________________________________________________________________________________

PAST SURGICAL HISTORY:

AMPUTATION
AV FISTULA CREATION
AV GRAFT
AORTIC VALVE REPLACEMENT
AORTIC VALVE REPLACED
APPENDICOTMY
BOTH LEGS BYPASSED
BACK SURGERY
BRONCHOSCOPY (LUNG SCOPE)
CABG (HEART BYPASS)
CAROTID ENDARTERECTOMY
CARPAL TUNNEL
CATARACT EXTRACTION
GALLBLADDER REMOVED
COLO RESECTION
CRANIOLOGY
GASTRIC BYPASS
HEMORRHOIDECTOMY
HIP REPLACEMENT
INVASIVE PAIN PROCEDURE
KIDNEY TRANSPLANT
KNEE ARTHROSCOPY
KNEE REPLACEMENT
LUMPECTOMY
MAGNETIC RESONANCE IMAGING
MAMMOGRAPHY
MASTECTOMY
MITRAL VALVE REPLACED
NEPHRECTOMY
PACEMAKER IMPLANTED
PARATHYROIDECTOMY
PNEUMONECTOMY
PTCA (ANGIOPLASTY)
ROTATOR CUFF REPAIR
ABD. Hysterectomy
Hysterectomy/Ovaries
**OVARIES REMOVED YES/NO
PROSTATE SURGERY
SHOULDER SURGERY
SLEEP APNEA SURGERY
THYROID SURGERY
TONSIL'S REMOVED
VASCULAR SURGERY

OTHER ______________________________________________________________________________________________

Page 1
### FAMILY HISTORY:

<table>
<thead>
<tr>
<th></th>
<th>FATHER</th>
<th>MOTHER</th>
<th>BROTHER</th>
<th>SISTER</th>
<th>CHILDREN</th>
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<tbody>
<tr>
<td>High Blood Pressure</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Heart Artery Disease / Heart Attack</td>
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<tr>
<td>Kidney Disease (Chronic)</td>
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<td></td>
</tr>
<tr>
<td>Diabetes</td>
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<tr>
<td>Stroke</td>
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<tr>
<td>Asthma</td>
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<td>Arthritis</td>
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<td>Thyroid Disorder</td>
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<tr>
<td>Cancer (Type)</td>
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### SOCIAL HISTORY: (CHECK OR CIRCLE APPROPRIATE)

- Married/Single/Divorced/Widowed
- Religious Affiliation
- Works Part-Time/Full-Time
- Occupation: _______________________
- Retired
- Disabled
- Children - Yes or No

### ALLERGIES OR MEDICATION REACTIONS:

- No Known Drug Allergies

**Allergic To:**

- ________________________________________________________
- ________________________________________________________
- ________________________________________________________
- ________________________________________________________

### RISK FACTORS: (CHECK OR CIRCLE APPROPRIATE)

- Current Tobacco Use
  - Year Started: ___________
  - Caffeine Use: Yes/No
  - Type of Tobacco: (Circle Appropriate)
  - How Many Drinks Per Day ______
  - Alcohol Use: Yes/No
  - Former Tobacco Use
  - Year Quit: ___________
  - How Many Per Day ______
  - Never Smoked
  - Type: ___________________
  - Second Hand Smoke
  - Yes/No
  - How Many Drinks Per Day ______
  - Do You Wear Your Seat Belt?
  - Yes/No
  - Exercise: Yes/No
  - Times Per Week: ______
  - Type: ___________________

### CURRENT MEDICATIONS:  Refer to List Refer to Bottles

Please include the dose and how often you take the medication (No need to list below if you brought a list or bottles)

<table>
<thead>
<tr>
<th>NAME</th>
<th>DOSAGE</th>
<th>How Many Times Per Day</th>
<th>As Needed (PRN)</th>
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</tbody>
</table>
### MEDICAL PROBLEMS: HAVE YOU HAD ANY RECENT OR PERSISTENT PROBLEMS WITH THE FOLLOWING?

<table>
<thead>
<tr>
<th>General:</th>
<th>Skin:</th>
<th>Extremities:</th>
<th>Neck:</th>
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<tbody>
<tr>
<td>○ WEIGHT GAIN / LOSS</td>
<td>○ RASHES</td>
<td>○ JOINT PAIN</td>
<td>○ GOITER</td>
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<tr>
<td>○ DIABETES</td>
<td>○ NAIL / HAIR PROBLEMS</td>
<td>○ GOUT</td>
<td>○ SWOLLEN GLANDS</td>
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<tr>
<td>○ BACK PAIN</td>
<td>○ ABDOMINAL MOLES</td>
<td>○ VARICOSE VEINS</td>
<td>○ THYROID</td>
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<table>
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<th>Mouth:</th>
<th>Heart:</th>
<th>Gastrointestinal:</th>
<th>Urinary:</th>
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<tr>
<td>○ DENTURES</td>
<td>○ CHEST PAIN</td>
<td>○ TROUBLE SWALLOWING</td>
<td>○ FREQUENCY</td>
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<tr>
<td>○ HOARSENESS</td>
<td>○ HYPERTENSION</td>
<td>○ REFLUX / GERD</td>
<td>○ TROUBLE STARTING OR</td>
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<td>○ GUMS</td>
<td>○ HIGH CHOLESTEROL</td>
<td>○ VOMITING</td>
<td>STOPPING</td>
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<td>○ CONGESTIVE HEART</td>
<td>○ DIARRHEA</td>
<td>○ URINARY PAIN</td>
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<td>○ FAILURE</td>
<td>○ CONSTIPATION</td>
<td>○ URINATE AT NIGHT</td>
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<td>○ HEART MURMUR</td>
<td>○ BLOODY / BLACK STOOL</td>
<td>○ LEAKAGE</td>
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<td>○ PALPITATIONS</td>
<td>○ HEMORRHiods</td>
<td>○ BLOOD IN URINE</td>
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<td>○ HEPATITIS</td>
<td>○ KIDNEY STONES</td>
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<td>○ PERSISTANT COUGH</td>
<td>○ REGULAR EXERCISE</td>
<td>○ PROBLEMS WITH SEX</td>
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<td>○ COUGH UP BLOOD</td>
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<td>○ MULTIPLE PARTNERS</td>
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<td>○ BLACKOUTS / DIZZY</td>
<td>○ EMPHYSEMA /</td>
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<td>○ HISTORY OF STD</td>
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<td>○ SEIZURES / TREMORS</td>
<td>○ BRONCHITIS</td>
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<td>○ DEPRESSION / ANXIETY</td>
<td>○ BREATH</td>
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<td>○ PNEUMONIA</td>
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<td>○ BLURRED VISION</td>
<td>○ LUMPS IN BREASTS</td>
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<tr>
<td>○ RINGING</td>
<td>○ SELF BREAST EXAM</td>
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### PLEASE ENTER THE MOST RECENT DATE AND RESULTS OF THE FOLLOWING:

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<th></th>
<th>DATE</th>
<th>RESULTS</th>
<th>PERFORMED BY WHO/WHERE</th>
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<tr>
<td>COLONOSCOPY</td>
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<td>PAP SMEAR</td>
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<tr>
<td>MAMMOGRAM</td>
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<td></td>
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<tr>
<td>BONE DENSITY SCAN</td>
<td></td>
<td></td>
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<tr>
<td>MENSTRUAL PERIOD</td>
<td></td>
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<tr>
<td>PSA (PROSTATE SCEEN)</td>
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### WHEN WAS YOUR LAST VACCINE ON THE FOLLOWING:

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<th></th>
<th>DATE</th>
<th>Would you like one?</th>
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<tr>
<td>FLU VACCINE</td>
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<td>Yes / No</td>
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<tr>
<td>TETANUS VACCINE</td>
<td></td>
<td>Yes / No</td>
</tr>
<tr>
<td>PNEUMONIA VACCINE</td>
<td></td>
<td>Yes / No</td>
</tr>
<tr>
<td>SHINGLES VACCINE</td>
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<td>Yes / No</td>
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</tbody>
</table>
Medicare Secondary Payer Questionnaire

Patient Name: __________________________    Patient DOB: __________________

Patient DOS: __________________________

Part I

1. Are you receiving Black Lung Benefits?
   □ No
   □ Yes – (Date Benefits began: ____________________) Black Lung is Primary Only for
   Claims Related to Black Lung

2. Are the services to be paid by the government program such as research grant?
   □ No
   □ Yes – Government Program will be Primary

3. Has the Department of Veterans Affairs authorized and agreed to pay for care at this
   facility?
   □ No
   □ Yes – Department of Veterans Affairs is Primary

4. Was the illness or injury due to work related accident or condition?
   □ No – Go to Part II
   □ Yes – (Date of Injury/Illness: ____________________) Worker’s Comp is
   Primary Go to Part III

Part II

1. Was illness or injury due to non-work related accident?
   □ No – Go to Part III
   □ Yes – (Date of Accident: ____________________)

2. What type of accident caused the illness or injury?
   □ Automobile – Motor Vehicle Insurance is Primary
   □ Non-Automobile – Go to question 3

3. Was another party responsible for this accident?
   □ No – Go to Part III
   □ Yes – Liability Insurance Carrier is Primary

Part III

1. Are you entitled to Medicare based on:
   □ Age – 65 and over – Go to Part IV
   □ Disability – Go to Part V
   □ Dialysis (End Stage Renal Disease) – Go to Part VI
Patient Name: ________________________________           Patient DOB: ______________________

Patient DOS: ________________________________

Part IV – Age

1. Are you currently employed?
   □ No (Date of Retirement: _________________)
   □ Never Worked
   □ Yes
       Employer Name: ________________________________________
       Employer Address: ______________________________________

2. Is your spouse currently employed?
   □ No (Date of Retirement: _________________)
   □ Never Worked
   □ Yes
       Employer Name: ________________________________________
       Employer Address: ______________________________________

IF THE ANSWER TO BOTH QUESTIONS ABOVE ARE NO, MEDICARE IS PRIMARY. DO NOT PROCEED ANY FURTHER.

3. Do you have Group Health Plan coverage based on your own or a spouse’s current employment?
   □ No – Stop
   □ Yes – Go to Question 4

4. Does the employer that sponsors your Group Health Plan employ 20 or more employees?
   □ No – Stop
   □ Yes – Stop Group Health Plan is Primary

Part V – Disability

1. Are you currently employed?
   □ No (Date of Retirement: __________________________)
   □ Yes
       Employer Name: ________________________________________
       Employer Address: ______________________________________

2. Is a family member currently employed?
   □ No
   □ Yes
       Employer Name: ________________________________________
       Employer Address: ______________________________________

IF THE ANSWER TO BOTH QUESTIONS ABOVE ARE NO, MEDICARE IS PRIMARY. DO NOT PROCEED ANY FURTHER.

3. Do you have Group Health Plan coverage based on your own or family member’s current employment?
   □ No – Stop
   □ Yes – Go to Question 4

4. Does the employer that sponsors the Group Health Plan employ 100 or more employees?
   □ No – Stop Medicare is Primary
   □ Yes – Stop Group Health Plan is Primary
Part VI – Dialysis (End Stage Renal Disease)

1. Do you have Group Health Plan coverage?
   □ No  – Stop Medicare is Primary
   □ Yes
     Employer Name: ______________________________
     Employer Address: ______________________________

2. Have you received a kidney transplant?
   □ No
   □ Yes (Date of Transplant: ____________________)

3. Have you received maintenance dialysis treatments?
   □ No
   □ Yes (Date Dialysis Began: ______________________)
     If you participated in a self dialysis training program provide date training started:

4. Are you within 30 month coordination period?
   □ No  – Stop Medicare is Primary
   □ Yes

5. Are you entitled to Medicare on the basis of either End Stage Renal Disease and age or End Stage Renal Disease and Disability?
   □ No  – Stop Group Health Plan is Primary During the 30 Month Coordination Period
   □ Yes

6. Was your initial entitlement to Medicare (including simultaneous entitlement) based on End Stage Renal Disease?
   □ No  – Initial entitlement based on age or disability
   □ Yes – Stop Group Health Plan Continues to Pay Primary During 30 Month Coordination Period

7. Does the working aged or disability Medicare Secondary Payer apply (i.e. is the Group Health Plan primary based on age or disability entitlement)?
   □ No  – Medicare Continues to Pay Primary
   □ Yes – Group Health Plan Continues To Pay Primary During 30 Month Coordination Period
132 REQUEST FOR HEALTH INFORMATION FROM HOSPITALS OR OTHER PROVIDERS

Name of Organization/Person ________________________________

Address __________________________________________________________________________________________

Fax/Phone __________________________________________________________________________________________

Huntsville Hospital Requests Information for the Following Patient:

Patient Name ________________________________

SS# (Optional) __________________ Date of Birth

Address __________________________________________________________________________________________

Phone __________________________________________________________________________________________

Signature __________________ Date of Service __________________

Patient Number __________________

Requested information for treatment, payment, or operations:

☐ Discharge Summary  ☐ EKG Report  ☐ Emergency Dept Record
☐ History and Physical  ☐ Nurses’ Notes  ☐ Laboratory Results
☐ Operative Note  ☐ Progress Notes  ☐ Imaging Results
☐ Pathology Report  ☐ Physicians’ Orders  ☐ Other __________________
☐ Consultation Report  ☐ Outpatient Record

Please send to:

Dr. Khan/
J. Southwood, CRNP
HH Physician Care
Madison
8371 Hwy 72 West, Suite 104
Madison, AL 35758
(256) 265-5970
Fax: (256) 265-5969

Dr. McAdams/K. Shrode, CRNP/S. Whitney, CRNP
HH Physician Care
Madison
8371 Hwy 72 West, Suite 206
Madison, AL 35758
(256) 265-5640
Fax: (256) 265-5647

Dr. Katoch
HH Physician Care
Madison
44 Hughes Road, Suite 1300
Madison, AL 35758
(256) 265-5970
Fax: (256) 265-5971

Dr. Cole-Suttlar
HH Physician Care
Madison
3810 Sullivan Street, Suite B
Madison, AL 35758
(256) 265-5970
Fax: (256) 265-5960

Signature __________________ Date __________________

Relationship to Patient __________________

Witness __________________

08/17
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name __________________________________________ SS Number (Optional) __________________________

Date of Birth ________________________________________ Address _______________________________________

Phone Number (_____) __________________ Date(s) of Service __________________

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

1. Huntsville Hospital Physician’s Network is authorized to make the disclosure.

2. 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

3. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

4. This information may be disclosed to, and used by, the following individual or organization:

   Name: _______________________________________________________________________________________________
   Address: _____________________________________________________________________________________________

5. For the purpose of ________________________________________________________________________________________

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Record Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that 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.

7. Unless otherwise revoked, the authorization will expire on the following date, event, or condition:

   _______________________________________________________________________________________________________
   If I fail to specify an expiration date, event or condition, this authorization will expire in six months from the date of signing.

8. 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.

9. I understand that 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.

10. I understand that I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits.

    Or

    I understand that if I refuse to sign this form, under specific conditions the organization can refuse:

    Treatment Enrollment in the health plan
    Eligibility for benefits

SIGNATURE __________________________ DATE ________________ TIME _____________

IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT SIGNATURE OF WITNESS ________________ DATE ________________ TIME ________________

*For Office Use Only*

Any portion of the record request found in paper chart? YES NO (Please circle one)