Margaret F. Carter, MD

Dear patient and family,

Welcome to Huntsville Hospital Maternal Fetal Medicine. Maternal Fetal Medicine, also referred to as perinatology, is the study and care of complicated and high risk pregnancies. Our office, which has received accreditation from the American Institute of Ultrasound in Medicine (AIUM), includes one maternal fetal medicine physician and a team of clinical specialists including nurse practitioners, registered nurses and registered medical sonographers specializing in high risk pregnancy scans.

There are many reasons a patient may be referred to our office. These may include:

- Routine prenatal diagnosis
- Maternal age of 35 and older
- Previous pregnancy complications
- Multiples
- Chronic or acute medical disease such as diabetes, hypertension, autoimmune disease or clotting disorder
- Possible birth defect
- Family history of a genetic condition
- Current obstetric condition such as short cervix, preterm labor or abnormal placenta
- At the request of your OB-GYN upon admission to the hospital with pregnancy complications

It's important for you to know that, even while you are a patient of this office, your primary obstetrician will continue with your pregnancy care and the delivery of your baby. Your initial appointment at Huntsville Hospital Maternal Fetal Medicine may take two hours. Please plan accordingly. Your physician and staff will perform a detailed review of your past and present medical history. Depending on the reason for your visit, you may also receive an ultrasound and/or other fetal testing. Some of the testing will be determined by the findings of this visit. All results that are available will be discussed with you during your appointment. Your physician will also discuss those results and a plan of care, if indicated, with your primary obstetrician. It is not unusual for you to see our physician for only one visit, however, at any time your doctor may refer you for another appointment, ultrasound or other testing.

We expect that you and your family will have questions. We encourage you to talk with our staff about your concerns so you can be informed and comfortable with the care we provide. It may help to write your questions down and bring them with you to your appointment.

We are looking forward to assisting you and your doctor during this pregnancy. If you have questions regarding your scheduled appointment, please call (256) 265-0880 to talk with one of our staff.

Sincerely,
Huntsville Hospital Maternal Fetal Medicine

910 Adams St., Ste. 100
Huntsville, AL 35801
o: (256) 265-0880
f: (256) 265-0885

Maternal Fetal Medicine

PATIENT INFORMATION

Patient

Date: ______________

Name: ______________ Referred by: ______________

Address: ______________ City: ______________ State: ______ Zip: ______

Home phone: ______________ Cell phone: ______________ Work phone: ______________

DOB: ______________ SSN: ______________ Sex: ☐ M ☐ F

Email address: ______________

Patient's occupation: ______________ Employer: ______________

Employer's address: ______________ Employer phone: ______________

Spouse's name: ______________ Spouse's DOB: ______________ Spouse's SSN: ______________

Spouse's occupation: ______________ Employer: ______________

Employer's address: ______________ Employer phone: ______________

In case of emergency, notify: ______________ Relationship: ______________

City: ______________ State: ______________ Phone: ______________

If patient is a minor, list person/s other than emergency contact above who have permission to bring child to office for treatment:

Name: ______________ Relationship: ______________ Phone: ______________

Name: ______________ Relationship: ______________ Phone: ______________

Name: ______________ Relationship: ______________ 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: ______________

Person responsible for this account: ______________ Phone: ______________

I agree payment will be made at the time of service. I agree to pay all copays, 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 Maternal Fetal Medicine to release information to insurance carriers and for insurance carries to release information to HH Maternal Fetal Medicine concerning my illness, treatment and payments (including worker's compensation) and I hereby assign to the physician all payments for medical services rendered to myself or my dependents if assignment applies.

______________ ______________ ______________

Signature Date Time

Maternal Fetal Medicine

MEDICAL HISTORY WORK-UP SHEET

Date: ________________ Appointment with: ________________________

Name: ____ Date of birth: ____________ Age: __________

What other doctors/specialists do you see? Name/Specialty: ____

____

Reason for visit: ____

Any new or worsening problems? If yes, please describe: ____

____

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

- ☐ AIDS/HIV
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Anemia
- ☐ Anxiety
- ☐ Autoimmune Disease (Lupus)
- ☐ Biliary Cirrhosis
- ☐ Bipolar Disorder
- ☐ Blood Transfusion
- ☐ Brain Tumor
- ☐ Cirrhosis
- ☐ CVA/Stroke
- ☐ COPD (Lung Disease)
- ☐ Colon Cancer
- ☐ Coronary Heart Disease
- ☐ Crohn's Disease
- ☐ Chronic Kidney Disease
- ☐ Depression
- ☐ Diabetes - Type 1
- ☐ Diabetes - Type 2
- ☐ Diverticulitis
- ☐ DVT (Blood Clot in Legs)
- ☐ Eczema
- ☐ GI Bleed
- ☐ Gerd (Acid Reflux)
- ☐ Hemochromatosis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Goiter
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Infertility
- ☐ Insomnia
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Lung Cancer
- ☐ MI (Heart Attack)
- ☐ Migraine Headaches
- ☐ Neurological Disorder
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ PVD
- ☐ PUD (Stomach Ulcers)
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Thyroid Nodule
- ☐ Tuberculosis
- ☐ Valvular Heart Disease
- ☐ UTI - Recurrent
- ☐ Varicose Veins/Phlebitis
- ☐ Abnormal Pap Smear
- ☐ Breast Disease
- ☐ Breast Cancer
- ☐ Cervical Cancer
- ☐ Gestational Diabetes
- ☐ Rh Sensitized
- ☐ Sleep Apnea

Using a CPAP? Yes / No

Other____

PAST SURGICAL HISTORY

- ☐ Amputation
- ☐ AV Fistula Creation
- ☐ AV Graft
- ☐ Aortic Valve Replacement
- ☐ Aortic Valve Replaced
- ☐ Appendectomy
- ☐ Both Legs Bypassed
- ☐ Back Surgery
- ☐ Bronchoscopy (Lung Scope)
- ☐ CABG (Heart Bypass)
- ☐ Carotid Endarterectomy
- ☐ Carpal Tunnel Right / Left
- ☐ Cataract Extraction
- ☐ Colon Resection
- ☐ Craniotomy
- ☐ Gastric Bypass
- ☐ Gallbladder Removed
- ☐ Hemorrhoidectomy
- ☐ Hip Replacement Right / Left
- ☐ Invasive Pain Procedure
- ☐ Kidney Transplant Right / Left
- ☐ Knee Arthroscopy Right / Left
- ☐ Knee Replacement Right / Left
- ☐ Kyphoplasty
- ☐ Mitral Valve Replaced
- ☐ Nephrectomy Right / Left
- ☐ Pacemaker Implanted
- ☐ Parathyroidectomy
- ☐ Pneumonectomy Right / Left
- ☐ PTCA (Angioplasty)
- ☐ Rotator Cuff Repair Right / Left
- ☐ Abdominal Hysterectomy
- ☐ Ovaries Removed Yes / No
- ☐ Prostate Surgery
- ☐ Shoulder Surgery Right / Left
- ☐ Sleep Apnea Surgery
- ☐ Thyroid Surgery
- ☐ Tonsil's Removed
- ☐ Vascular Surgery
- ☐ Breast Augmentation Right / Left
- ☐ Mastectomy Right / Left
- ☐ Lumpectomy Right / Left

Other____

Patient name: ______________________ DOB ______________

FAMILY HISTORY	Father	Mother	Brother	Sister	Children
High Blood Pressure	☐	☐	☐	☐	☐
Heart Artery Disease/Heart Attack	☐	☐	☐	☐	☐
Kidney Disease (Chronic)	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐
Thyroid Disorder	☐	☐	☐	☐	☐
Cancer (Type)	☐	☐	☐	☐	☐

SOCIAL HISTORY *(Check or circle appropriate)*

☐ Married ☐ Single ☐ Divorced ☐ Widowed

Work ☐ Part-Time ☐ Full-Time ☐ Retired ☐ Disabled Occupation: ______________

Children: Yes / No Religious Affiliation ______________

ALLERGIES OR MEDICATION REACTIONS ☐ **NO KNOWN DRUG ALLERGIES**

Allergic to: Reaction:

____

____

____

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

Do you wear a seat belt? Yes / No

Multiple sexual partners? Yes / No

Caffeine Use Yes / No

How many drinks per day ________

Alcohol use Yes / No

How many per day? ________ Type ________

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. *(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 ______________

Patient name: ______________________ DOB ______________

MEDICAL PROBLEMS Have you had any recent or persistent problems with the following?

General

- ☐ Weight Gain/Loss
- ☐ Fever/Chills/Fatigue
- ☐ Snoring
- ☐ Sleep Troubles
- ☐ Depression/Anxiety

Neuro

- ☐ Headache
- ☐ Head injury
- ☐ Blackouts/Dizzy
- ☐ Seizures/Tremors
- ☐ Memory Loss
- ☐ Numbness/Tingling
- ☐ Forgetfullness/ Confusion
- ☐ Abnormal Coordination

Urinary

- ☐ Frequency
- ☐ Trouble starting or stopping urine stream
- ☐ Blood In Urine
- ☐ Painful Urination
- ☐ Urinating at Night
- ☐ Urine Leakage
- ☐ Unable to Urinate

ENT

- ☐ Allergies
- ☐ Sinus Congestion
- ☐ Glasses/Contacts
- ☐ Blurred Vision
- ☐ Ringing
- ☐ Hoarseness
- ☐ Runny Nose
- ☐ Hearing Loss
- ☐ Trouble Swallowing
- ☐ Neck Lump
- ☐ Swollen Glands
- ☐ Earache

Skin

- ☐ Rashes
- ☐ Abnormal moles
- ☐ Changes in Hair/ Hair Loss
- ☐ Wounds that will not heal

Heart

- ☐ Chest Pain
- ☐ Palpitations
- ☐ Shortness of Breath
- ☐ Ankle Swelling

Lungs

- ☐ Persistent Cough
- ☐ Cough Up Blood
- ☐ Shortness of Breath
- ☐ Wheezing

Women

- ☐ Irregular Periods
- ☐ Pelvic Pain
- ☐ Nipple Discharge
- ☐ Lumps In Breasts
- ☐ Frequent Sweats/ Hot Flashes
- ☐ Vaginal Discharge

Musculoskeletal

- ☐ Joint Pain
- ☐ Gout
- ☐ Varicose Veins
- ☐ Leg Swelling
- ☐ Back Pain
- ☐ Joint Stiffness
- ☐ Muscle Weakness
- ☐ Muscle Pain
- ☐ Muscle Cramps

Gastrointestinal

- ☐ Reflux/GERD
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloody/Black Stool
- ☐ Hemorrhoids
- ☐ Loss of Appetite
- ☐ Rectal Bleeding
- ☐ Abdominal Pain

Sexual

- ☐ Problems with sex
- ☐ Erectile Dysfunction
- ☐ Painful Intercourse
- ☐ Decreased Sexual Desire
- ☐ Blood in Semen

Endocrine

- ☐ Excessive Thirst
- ☐ Excessive Urination
- ☐ High Blood Sugars
- ☐ Heat Intolerance
- ☐ Cold Intolerance

Please enter the most recent date and results of the following:

	Date	**Results**	**Performed by (who/where)**
Colonoscopy	________	________	________
Pap Smear	________	________	________
Mammogram	________	________	________
Bone Density Scan	________	________	________
Menstural Period	________	________	________
PSA (Prostate Sceen)	________	________	________
Eye Exam	________	________	________

When was your last vaccine on the following:

	Date	**Would you like one?**
Flu Vaccine	________	Yes / No
Tetanus Vaccine	________	Yes / No
Pneumonia Vaccine	________	Yes / No
Shingles Vaccine	________	Yes / No

Maternal Fetal Medicine

OB-GYN HEALTH HISTORY

GYN HISTORY/PROBLEMS

☐ **No Previous GYN Problems**

Please check if you have or have ever been diagnosed with any of the following problems:

- ☐ Abnormal Pap Smear
- ☐ Bartholin Cyst
- ☐ Bleeding Between Periods
- ☐ Breast Cancer
- ☐ Breast Lump
- ☐ Cervical Cancer
- ☐ Cervical Dysplasia
- ☐ Chronic Vaginal Infections
- ☐ Chronic Pelvic Pain
- ☐ Endometrial Hyperplasia
- ☐ Endometriosis
- ☐ Fibrocystic Breast
- ☐ Habitual Aborter (>3 Miscarriages)
- ☐ Heavy Periods
- ☐ Infertility
- ☐ Irregular Periods
- ☐ Lichen Sclerosis
- ☐ Ovarian Cancer
- ☐ Ovarian Cyst
- ☐ Pelvic Inflammatory Disease
- ☐ Prolapse
- ☐ Severe Cramps
- ☐ Sexually Transmitted Disease
  - ☐ Chlamydia
  - ☐ Genital Warts
  - ☐ Gonorrhea
  - ☐ HIV
  - ☐ Herpes
  - ☐ Trichomonas
- ☐ Urinary Incontinence
- ☐ Uterine Cancer
- ☐ Uterine Fibroids
- ☐ Vaginal Burning
- ☐ Vaginal Discharge
- ☐ Vaginal Itching
- ☐ Other ______________________________

  ____

GYN PERIOD HISTORY

Age at first period:	Length of period:	Frequency of period:
Menstrual flow: ☐ Light ☐ Medium ☐ Heavy	HPV Vaccine? ☐ Yes ☐ No	Self breast exams? ☐ Yes ☐ No

If menopausal, have you had or are you doing hormone replacement therapy? ☐ Yes ☐ No

GYN SURGICAL HISTORY

☐ **No Previous Surgeries**

Have you ever had any of the following surgeries, and if so when:

Surgery	AGE	YEAR
☐ Breast Augmentation		
☐ Breast Biopsy		
☐ Breast Reduction		
☐ Cesarean Section		
☐ Cervical Procedure		
☐ Cone Biopsy		
☐ Cryo		
☐ Laser		
☐ LEEP		
☐ Colposcopy		

Surgery	AGE	YEAR
☐ D&C		
☐ Endometrial Biopsy		
☐ Tubal Ligation		
☐ Hysterectomy Abd / Vag		
☐ Laparoscopy		
☐ Laparotomy		
☐ Mastectomy R / L / B		
☐ Ovaries Removed R / L / B		
☐ Other: ______________________		
______________________________		

OBSTETRICIAL SOCIAL HISTORY

☐ **Not Pregnant**

Father of baby:	Father's race: ☐ African-American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other: ________
Any change in family/social situation? ☐ Yes ☐ No	Do you have cats? ☐ No ☐ Indoor Only ☐ Indoor/Outdoor ☐ Outdoor Only

Passive smoke exposure?	Smoke/CO2 detectors?	Occupational health risks?	Frequent air travel?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Have you recently (within the last 12 weeks or during current pregnancy) travel to or lived in a zika-affected area? ☐ Yes ☐ No

If so, do you have symptoms associated with zika virus (fever, rash, join pain, conjunctivitis)? ☐ Yes ☐ No

OBSTETRICIAL HISTORY

☐ **No Previous Pregnancy**

Please fill out for each pregnancy even if it was a miscarriage or abortion. *If you've had a tubal ligation, hysterectomy, or are over the age of 60, only date and type of delivery are necessary.*

Preg. #	Type of Delivery	Date of Birth	Gestational Age	Birth Weight	Sex	Hospital	Doctor	Complications
	☐ Miscarriage ☐ Vaginal Del. ☐ C-Section ☐ Abortion		☐ Term (>37 wks) ☐ Preterm (<37 wks)		☐ M ☐ F			
	☐ Miscarriage ☐ Vaginal Del. ☐ C-Section ☐ Abortion		☐ Term (>37 wks) ☐ Preterm (<37 wks)		☐ M ☐ F			
	☐ Miscarriage ☐ Vaginal Del. ☐ C-Section ☐ Abortion		☐ Term (>37 wks) ☐ Preterm (<37 wks)		☐ M ☐ F			
	☐ Miscarriage ☐ Vaginal Del. ☐ C-Section ☐ Abortion		☐ Term (>37 wks) ☐ Preterm (<37 wks)		☐ M ☐ F			
	☐ Miscarriage ☐ Vaginal Del. ☐ C-Section ☐ Abortion		☐ Term (>37 wks) ☐ Preterm (<37 wks)		☐ M ☐ F			
	☐ Miscarriage ☐ Vaginal Del. ☐ C-Section ☐ Abortion		☐ Term (>37 wks) ☐ Preterm (<37 wks)		☐ M ☐ F			
	☐ Miscarriage ☐ Vaginal Del. ☐ C-Section ☐ Abortion		☐ Term (>37 wks) ☐ Preterm (<37 wks)		☐ M ☐ F			

Maternal Fetal Medicine

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

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

Maternal Fetal Medicine

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
- ☐ History and physical
- ☐ Operative note
- ☐ Pathology report
- ☐ Consultation report
- ☐ EKG report
- ☐ Nurses' notes
- ☐ Progress notes
- ☐ Physicians' orders
- ☐ Outpatient record
- ☐ Emergency dept record
- ☐ Laboratory results
- ☐ Imaging results
- ☐ Other: ____________________

____

____

____

____

Please send to:

HH Maternal Fetal Medicine

910 Adams Street, Ste. 100
Huntsville, AL 35801

Fax: (256) 265-0885

______________________________ ____________________
Signature Date

______________________________ ____________________
Relationship to patient Witness

Maternal Fetal Medicine

REGISTRATION UPDATE SHEET

Fin #: ______________

Patient name: ____ Date of birth:_________________________

Authorization to call

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

☐ Appointment reminder calls ☐ Lab and/or test results

Advance Directive policy

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

Financial fees

I understand 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 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 up financial resources available to over service provided to patient. 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 request to see if I quality 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 they deem advisable and necessary. I also authorize Health 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 and guaranty

I authorize Health System Clinics to release any information regarding service rendered to me to third party payers in considerations 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 Health System Clinics, If the check must be made out to me, I understand the check must be sent to this address: 420 Lowell Dr, Ste. 204, Huntsville, AL 35801. I understand that Health System Clinics must collect all charge not covered by insurance payments. Payment for all collection costs, securing or attempting to college and secure, including reasonable attorney fees or Collection Agency fees, whether suit be necessary or the otherwise is the financial responsibility of the patient of 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 in regard to the Notice and it's contents. I understand that the most current version of the Notice will be posted with the Health System and on *huntsvillehospital.org*.

Express permission to contact patient by cell phone

I agree in order for Health System Clinics to service my account or to collect monies I owe, Health System Clinics, and/or agents may contact me by any telephone number associated with my account, including wireless telephone numbers, which may result in charges to me. Health System Clinics may also contact me be sending text messages or emails, using any email address I provided. Methods of contact may include pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable. I have read this disclosure and agree that Health System Clinics, its employees and/or agents may contact me as described.

Signature of patient or legally authorized representative	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:

____

____

Signature of witness/employee	Date	Time

Employee ID

HUNTSVILLE HOSPITAL / Medical District