Delmy Caton, MD
HeeEun Kang, MD
Pragya Katoch, MD
Ehtisham Khan, MD
Dianne Hartwig, CRNP
Jenny Lee Southwood, CRNP
Gail Prentice, CRNP

Lanier Campus
450 Lanier Road
Madison, AL 35758
o: (256) 265-5970
f: (256) 265-5971

Cindy McAdams, DO
Katy Shrode, CRNP
Shelley Whitney, CRNP

Madison Medical Park
8371 Hwy 72 W, Ste. 206
Madison, AL 35758
o: (256) 265-5640
f: (256) 265-5647

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,

Ashley Lambruschi

Ashley Lambruschi
Practice Administrator
Huntsville Hospital Physician Care - Madison

MADISON

8371 Hwy 72 West, Ste. 206
Madison, AL 35758
(256) 265-5640
Fax: (256) 265-5647

450 Lanier Road
Madison, AL 35758
(256) 265-5970
Fax: (256) 265-5971

Patient information Date ________________________

Name ____ Referred by ____________________

Address ________________________________ City ______________________ State _____ Zip __________________

Home Phone ______________________ Work Phone ______________________ Cell Phone ____________________

SS# ____________________________ Sex M F D.O.B. ____

Email Address ____

Patient's Occupation __________________________ Employer ____

Employer's Address ____ Employer's Phone ______________

Spouse's Name ______________________________ Spouse's D.O.B. _________________ Spouse's SS # ________

Spouse's Occupation __________________________ Spouse's Employer __________________________________

Employer's Address ____ Employer's Phone ______________

Notify in case of emergency ____ Relationship __________________

City _______________________________________ State _________________________ Phone ______________

If patient is a minor, list persons other than responsible party above, who have permission to bring child to office for treatment:

Name _____________________________________ Relationship ____________________ Phone _______________

Name _____________________________________ Relationship ____________________ Phone _______________

Name _____________________________________ Relationship ____________________ Phone _______________

Primary insurance to file

Policy #	Group #
Insured's Name	Relationship
Insured's SSN# or ID#	Insured's Date of Birth
Insurance Company Name	

Secondary insurance to file

Policy #	Group #
Insured's Name	Relationship
Insured's SSN# or ID#	Insured's Date of Birth
Insurance Company Name	

PERSON RESPONSIBLE FOR THIS ACCOUNT ____________________________ PHONE ________________________

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 __________________________

Madison

Date: ________________

Appointment today with:

Khan, Katoch, McAdams, Kang
Hartwig, Prentice, Shrode
Southwood, Whitney, Caton

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.)*

- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Anemia
- ☐ Anxiety
- ☐ Autoimmune Disease (Lupus)
- ☐ Biliary Cirrhosis
- ☐ Blood Transfusion
- ☐ Brain Tumor
- ☐ Cerebrovascular
- ☐ Disease (Stroke)
- ☐ Cirrhosis
- ☐ CVA/Stroke
- ☐ COPD (Lung Disease)
- ☐ Colon Cancer
- ☐ Coronary Heart Disease
- ☐ Crohn's Disease
- ☐ Chronic Renal Failure
- ☐ Depression
- ☐ Diabetes - Juvenile Onset
- ☐ Diabetes - Adult Onset
- ☐ Diverticulitis
- ☐ DVT (Blood Clot in Legs)
- ☐ GI Bleed
- ☐ Gerd (Acid Reflux)
- ☐ Hemochromatosis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Goiter
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Infertility
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ MI (Heart Attack)
- ☐ Neurological Disorder
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ PVD
- ☐ PUD (Stomach Ulcers)
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Valvular Heart Disease
- ☐ UTI - Recurrent
- ☐ Varicose Veins/Phlebitis
- ☐ Abnormal Pap Smear
- ☐ Breast Disease
- ☐ Breast Cancer
- ☐ Cervical Cancer
- ☐ Des Exposure
- ☐ 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
- ☐ Colon Resection
- ☐ Craniotomy
- ☐ Gastric Bypass
- ☐ Hemorrhoidectomy
- ☐ Hip Replacement
- ☐ Invasive Pain Procedure
- ☐ Kidney Transplant
- ☐ Knee Arthroscopy
- ☐ Knee Replacement
- ☐ Kyphoplasty
- ☐ Lumpectomy
- ☐ 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
- ☐ Breast Augmentation Right / Left
- ☐ Mastectomy Right / Left
- ☐ Lumpectomy Right / Left

Other______________________________

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

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.

(No need to list below if you brought a list or bottles)

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

Pharmacy Name ____ Phone # _________________________

Location ____

Patient name: ______________________________ DOB ___________________

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

General
- ☐ Weight Gain/Loss
- ☐ Diabetes
- ☐ Back Pain

Mouth
- ☐ Dentures
- ☐ Hoarseness
- ☐ Gums

Last dental exam:

____

Dentist:

____

Neuro
- ☐ Headache
- ☐ Head injury
- ☐ Blackouts/Dizzy
- ☐ Seizures/Tremors
- ☐ Memory Loss
- ☐ Depression/Anxiety

ENT
- ☐ Allergies
- ☐ Sinus Trouble
- ☐ Glasses/Contacts
- ☐ Blurred Vision
- ☐ Ringing

Last eye exam:

____

Eye doctor:

____

Skin
- ☐ Rashes
- ☐ Nail/Hair Problems
- ☐ Abdominal moles

Heart
- ☐ Chest Pain
- ☐ Hypertension
- ☐ High Cholesterol
- ☐ Congestive Heart Failure
- ☐ Heart Murmur
- ☐ Palpitations

Last EKG:

____

Lungs
- ☐ Persistent Cough
- ☐ Cough Up Blood
- ☐ Emphysema/ Bronchitis
- ☐ Shortness of Breath
- ☐ Pneumonia

Women
- ☐ Irregular Periods
- ☐ Pelvic Pain
- ☐ Birth Control Pills
- ☐ Nipple Discharge
- ☐ Lumps In Breasts
- ☐ Self Breast Exam

Extremities
- ☐ Joint Pain
- ☐ Gout
- ☐ Varicose Veins
- ☐ Leg Swelling

Gastrointestinal
- ☐ Trouble Swallowing
- ☐ Reflux/GERD
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloody/Black Stool
- ☐ Hemorrhoids
- ☐ Hepatitis

Last Colonoscopy:

____

Lifestyle
- ☐ Regular Exercise

______ Times A Week
- ☐ Low Salt Diet
- ☐ Low Fat Diet

Neck
- ☐ Goiter
- ☐ Swollen Glands
- ☐ Thyroid

Urinary
- ☐ Frequency
- ☐ Trouble starting or stopping
- ☐ Urinary pain
- ☐ Urinate at night
- ☐ Leakage
- ☐ Blood In Urine
- ☐ Kidney stones
- ☐ Infections
- ☐ Prostate trouble

Sexual
- ☐ Problems with sex
- ☐ Multiple Partners
- ☐ History Of Std
- ☐ HIV

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)	____________	____________________	___________________________________

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

MADISON

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:

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. Khan/ Dr. Katoch/ Dr. Caton/ Dr. Kang/ D. Hartwig, CRNP/ G. Prentice, CRNP/ J. Southwood, CRNP
450 Lanier Road
Madison, AL 35758
(256) 265-5970
Fax: (256) 265-5971

Signature ______________ Date ______________

Relationship to Patient ______________________

Witness ______________________

MADISON

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name ______________________________ SS Number (Optional)______________________________

Date of Birth ______________________________ Address ______________________________

Phone Number (_____)________________Date(s) of Service______________

Chart Number__________________________
Provider ______________________________

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)

Huntsville Hospital Physician Care Madison

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 sponsor's 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**

Patient Name: ________________________________ **Patient DOB:** ______________________

Patient DOS: ________________________________

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**