INTEGRITY **FAMILY CARE**

DEMOGRAPHIC INFORMATION

PATIENT INFORMATION

FIRST NAME MIDDLE LAST NAME

SEX DATE OF BIRTH SSN

HOME ADDRESS CITY STATE ZIP

HOME TEL MOBILE TEL WORK TEL

EMAIL

LANGUAGE ETHNICITY ☐ White/Caucasian ☐ Hispanic/Latino ☐ Black/African American ☐ Asian ☐ American Indian ☐ Alaskan Native ☐ Native Hawaain/ Other Pacific Islander ☐ Other:

MARITAL STATUS ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

EMPLOYER OCCUPATION

HOW DID YOU HEAR ABOUT US?

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY INSURED'S NAME

RELATIONSHIP TO INSURED INSURED'S DOB INSURED'S SSN

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY INSURED'S NAME

RELATIONSHIP TO INSURED INSURED'S DOB INSURED'S SSN

PREFERRED PHARMACY

NAME OF LOCAL PHARMACY LOCATION

NAME OF MAIL ORDER PHARMACY

PREFERRED LAB

If you do not know if your insurance carrier requires you to use a particular lab, please contact your insurance carrier.

LAB NAME LOCATION

☐ My insurance carrier does NOT require me to use a particular lab.

PRINT NAME SIGNATURE TODAY'S DATE

INTEGRITY **FAMILY CARE**

CONTACTS

EMERGENCY CONTACT

NAME RELATIONSHIP TEL

NEXT OF KIN

NAME RELATIONSHIP TEL

AUTHORIZED PEOPLE

☐ I do not wish to authorize anyone but myself to be involved in my care.

Please list the names and relations of anyone you authorize to be involved in your care and payment and with whom we may share your medical information.

NAME RELATIONSHIP

NAME RELATIONSHIP

NAME RELATIONSHIP

NAME RELATIONSHIP

NAME RELATIONSHIP

MEDICAL POWER OF ATTORNEY

if you have a medical power of attorney, please provide documentation to Integrity Family Care.

NAME RELATIONSHIP TEL

PRINT NAME SIGNATURE TODAY'S DATE

CONSENTS

CONSENT TO CALL OR TEXT

I hereby consent to provide my telephone number(s), including my wireless telephone number(s), so that representatives from Integrity Family Care, Inc., its successors or assigns, can contact me in any manner including but not limited to, manually placing a call, using an automatic telephone dialing system or an artificial or prerecorded voice, texting, or by emailing, regarding any matter. This may include but is not limited to my medical treatment, prescriptions, insurance eligibility, insurance coverage, scheduling, billing, or collection matters. This consent includes any updated or additional contact information that I may provide.

I understand that I will be able to change my preference at any time. I understand that I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

☐ **ACCEPT**

CONSENT FOR MEDICAL PHOTOGRAPHY

I consent for medical imaging (photo, video, and/or audio) to be made of me or my child (or for person whom I am legal guardian). I understand that the information will be used in my medical record. Examples: skin disorders and wounds.

By signing this form below, I confirm that this consent form has been explained to me in terms which I understand.

I agree to the use of my image for medical records ONLY.

☐ **ACCEPT**

CONSENT FOR CHRONIC CARE MANAGEMENT

I consent to Integrity Family Care providing chronic care management services (referred to as "CCM Services") as more fully described below.

CCM Services are available to you if you are covered under Medicare Part B and have been diagnosed with two (2) or more chronic conditions which are expected to last at least twelve (12) months and which place you at significant risk of further decline.

CCM Services include 24-hours-a-day, 7-days-a-week access to a health care provider at Integrity Family Care to address acute chronic care needs; systematic assessment of your health care needs; processes to assure that you timely receive preventative care services; medication reviews and oversight; a plan of care covering your health issues; and management of care transitions among health care providers and settings. The Provider will discuss with you the specific services that will be available to you and how to access those services.

With the CCM Program your doctor can spend more time on your care – even when you aren't in the office!

Benefits include:

- Chart review in advance of every visit to identify issues that should be discussed and addressed.
- Follow-up after each visit to make sure you're feeling well and that your medications are working.
- Coordinated care between specialists, testing centers, and hospitals to make sure everyone is working together.
- More personalized attention to you and your health management goals.

☐ **ACCEPT**

ACKNOWLEDGEMENT OF RIGHT TO REVIEW NOTICE OF PRIVACY PRACTICES

I understand I have a right to review Integrity Famly Care's Notice of Privacy Practices prior to signing this document.The Notice of Privacy Practices is available at the welcome desk. Periodically, regulations may change which could require an update to our policy. I understand that I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail, or by requesting a revised copy at the time of my next appointment.

☐ **ACCEPT**

PRINT NAME	SIGNATURE	TODAY'S DATE

INTEGRITY **FAMILY CARE**

OFFICE POLICIES

We are dedicated to providing you the best possible care, and want you to be aware and understand our office policies. We hope that these efforts will make your visits to our office more efficient and less stressful for you.

FINANCIAL POLICY

Payment is due at the time of service unless arrangements have been made in **advance** with written approval by the office manager. We accept cash, check, and credit/debit card payments. Please keep in mind that your insurance policy is a contract between you and your insurance company. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them, and you are required to pay all co-payments, deductibles, and non-covered services at the time of your visit.

If you are insured by a plan that we do not have a prior arrangement with, we will file the claim for you on an unassigned basis as a courtesy to you, provided we have accurate claims billing information. Charges for your care are due in full at the time of service.

Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered," you will be responsible for the complete charge. Health plan coverage varies significantly by carrier, by employer, and/or by contract. We cannot know the benefits and exclusions of each patient's health plan. It is the patient's responsibility to know and understand their plan coverage and benefits.

All questions regarding your policy benefits should be directed to your insurance carrier. Please contact your insurance carrier prior to your appointment as our office utilizes NP/PAs. Do not assume your visit is covered unless your carrier confirms these visits are a covered benefit. Also, please verify if your insurance requires you to use a particular lab and/or radiological (imaging) facility.

If your payment is made via check and is returned from the bank as dishonored, a $30 returned check fee will apply. Checks may be returned for a variety of reasons, no matter the reason, the payer will be responsible for payment of the owed amount in addition to the returned check fee.

PLEASE NOTE: After one returned check, our office reserves the right to restrict payment options.

COLLECTION POLICY

It is the policy of Integrity Family Care ("IFC") to pursue collection of patient balances from patients who have payments due past ninety (90) days. Collection procedures will be applied consistently and fairly for all patients regardless of insurance status. All collection procedures will comply with applicable laws and with IFC's mission.

Collection agencies may be enlisted after three (3) attempts to contact the patient have been made by IFC in order to collect payment. Agencies may help resolve accounts for services where patients are uncooperative in paying their balance in full.

THIRD PARTY FORMS/APPLICATIONS

We realize that special forms are sometimes necessary to provide documentation of medical conditions. Completing forms is time consuming and generally falls outside the contractual relationship between you and your insurance company. All forms requested without an appointment will need to be reviewed by the office to determine if an appointment is necessary. All FMLA papers require an appointment with a provider. Fees for these forms will vary according to the complexity of the paperwork. Please refer to our website for fees.

PRESCRIPTION REFILLS

Our office utlizes ePrescribing per mandate of health insurance companies. Our ePrescribing program sends prescriptions over the internet to your pharmacy in a safe, secure manner, which helps protect the privacy of your personal information as well as loss of a written prescription. ePrescribing also lets our medical providers know which medications are covered by your formulary as well as drug interactions and your prescription history with medical providers.

If a prescription is not approved, we will contact you. Antibiotics will not be approved without your seeing the practitioner first, and the providers reserve the right to decline a refill at his/her discretion for proper continued care.

Please be sure you have received an appropriate number of refills so that your medications will not run out prior to your next scheduled appointment. We do not honor refill requests sent by pharmacies.

WORK/SCHOOL EXCUSE

Please notify the medical assistant or receptionist at the time of your visit, if you will require an excuse.

TEST RESULTS

Please allow five to seven (5-7) business days for test results to be reviewed by the providers. We will contact you by secure messaging through your patient portal or by phone. At times, appointments may be required by the practitioner to review these results with you. If you do not have an appointment, and are not notified within seven (7) days, please contact us for results.

LATE APPOINTMENT POLICY

If a patient is more than 10 minutes late for an appointment, the appointment may need to be rescheduled. This is to ensure that the patients who arrive on time do not wait longer than necessary to see the provider. You may be given the option to wait for another appointment time on the same day if one is available. We will try to accommodate late-comers as best as possible but cannot compromise on the quality and timely care provided to our other patients.

MISSED APPOINTMENTS AND NON-COMPLIANCE

You will be notified of your upcoming appointments through your patient portal and reminder calls/texts. If you are unable to keep your scheduled appointment please contact our office twenty-four (24) hours prior to your scheduled visit. Missed appointments and failure to notify the office of such cancellations may result in charges for missed appointments. It is the policy of Integrity Family Care to document non-compliance to treatment recommendations including but not limited to the frequency of treatment recommended in the patient's treatment plan. Also, be reminded your prescriptions are advised for your well-being and it is important you comply with your provider's treatment plan. Continued missed appointments as well as non-compliance with your provider's treatment plan may result in dismissal from the practice.

In signing this form, you have read and understand the office policies of Integrity Family Care in addition to authorizing the use of prescription medication history from other healthcare providers or third-party pharmacy benefit payers for treatment purposes.

PRINT NAME　　　SIGNATURE　　　TODAY'S DATE

Please turn in the forms you have already completed so we can let your care team know you are ready!

Once you have done this please return to your seat to complete the remaining forms.

Thank you for allowing us to be your healthcare provider.

1041 Balch Road, Suite 300, Madison, AL 35758 | IntegrityFamilyCare.com | P:256.325.1540 F:256.774.9040

INTEGRITY **FAMILY CARE**

NEW PATIENT HEALTH HISTORY

PRINT NAME | DATE OF BIRTH | TODAY'S DATE

To help us get the most out of today's visit, please answer the following questions.

WHAT IS YOUR MAIN PURPOSE IN COMING TO OUR OFFICE TODAY?

If you have a new complaint, indicate how long it has been present, what it feels like, what makes it better or worse, and what you are concerned the problem might be.

____

____

____

____

ARE YOU EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS IN RELATION TO YOUR MAIN CONCERN?

Answer "YES" by checking the box next to the appropriate symptom.

Constitutional Symptoms
- ☐ Fever
- ☐ Weight loss/weight gain
- ☐ Extreme fatigue

Eyes
- ☐ Vision Change
- ☐ Eye Pain/itching

Ears, Nose Mouth, and Throat
- ☐ Sore throat
- ☐ Runny nose
- ☐ Ear pain

Cardiovascular
- ☐ Chest pain
- ☐ Palpitations
- ☐ Ankle swelling

Allergic
- ☐ Hay fever
- ☐ Itching

Respiratory
- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of breath

Gastrointestinal
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in stool
- ☐ heartburn/reflux

Genitourinary
- ☐ Irregular menses
- ☐ Vaginal bleeding after menopause
- ☐ Frequent or painful urination
- ☐ Cloudy or dark urine
- ☐ Impotence

Skin
- ☐ Rash
- ☐ Changing mole

Neurological
- ☐ Headache
- ☐ Weakness on one side of the body
- ☐ Falling
- ☐ Tingling or numbness

Musculoskeletal
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Back pain
- ☐ Neck pain
- ☐ Muscle pain

Hematologic
- ☐ Unusual bruising or bleeding
- ☐ Swollen glands

Psychiatric
- ☐ Depression
- ☐ Anxiety
- ☐ Suicidal thoughts
- ☐ Memory loss
- ☐ Restless sleep

Endocrine
- ☐ Excessive thirst
- ☐ Cold or heat intolerance
- ☐ Breast mass
- ☐ Hair loss

Other

____

MEDICATIONS

NAME	DOSAGE	FREQUENCY	PRESCRIBER

INTEGRITY FAMILY CARE

NEW PATIENT HEALTH HISTORY

PRINT NAME DATE OF BIRTH TODAY'S DATE

FAMILY HISTORY

	Mother	Father	Sibling	Grandmother	Grandfather
Autoimmune	☐	☐	☐	☐	☐
Bleeding Disorders	☐	☐	☐	☐	☐
Blood Clots	☐	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐
Lung Cancer	☐	☐	☐	☐	☐
Ovarian Cancer	☐	☐	☐	☐	☐
Pancreatic Cancer	☐	☐	☐	☐	☐
Prostate Cancer	☐	☐	☐	☐	☐
Skin Cancer	☐	☐	☐	☐	☐
Other Cancer: ______________	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Thyroid	☐	☐	☐	☐	☐

SOCIAL HISTORY

Exercise Level
☐ None
☐ Occasional
☐ Moderate
☐ Heavy

Tobacco: cigarettes or chewing tobacco
☐ None
☐ Former
Quit: __________
☐ Current
Tobacco Years: __________

Alcohol Intake
☐ None
☐ Occasional
☐ Moderate
☐ Heavy

Caffeine
☐ Occasional
☐ Moderate
☐ Heavy

Illicit Drugs
☐ Marijuana
☐ Cocaine
☐ Other:
____

Sexually Active
☐ Yes
☐ No

HEALTH MAINTENANCE/IMMUNIZATIONS

Last Blood Work ______________
Last Colonoscopy ______________
Last Eye Exam ______________
Last Mammogram ______________
Last Pap Smear ______________
Last Flu Vaccine ______________
Last Pneumonia Vaccine ______________
Last Tetanus Vaccine ______________

SURGICAL HISTORY

☐ Appendectomy
☐ Bowel
Specify: ______________
☐ Gallbladder
☐ Joint Replacement
☐ Left: ______________
☐ Right: ______________
☐ Heart Surgery
Specify: ______________
☐ Hysterectomy
☐ Total
☐ Partial (still have ovaries)

☐ Sinus Surgery
☐ Skin Cancer/lesion removal
Location: ______________
☐ Tonsillectomy
☐ Vein Surgery
☐ Wisdom Teeth
☐ Other:
____
____
____

FEMALES

Date of last menstrual period
____

How many pads/tampons used per day?
☐ 1-3
☐ 3-5
☐ >5

Are your periods regular?
☐ Yes
☐ No

Are you using birth control?
☐ Yes
☐ No

Any bleeding since menopause?
☐ Yes
☐ No

INTEGRITY FAMILY CARE

NEW PATIENT HEALTH HISTORY

PRINT NAME ____________________ DATE OF BIRTH ____________________ TODAY'S DATE ____________________

PAST MEDICAL HISTORY

Allergic/Immunologic
- ☐ HIV
- ☐ Frequent Infections
- ☐ Hepatitis C

Cardiovascular
- ☐ Congestive heart Failure
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Murmur

Constitutional
- ☐ Chronic Fatigue

Endocrine
- ☐ Diabetes
- ☐ Thyroid Disorder

ENT
- ☐ Chronic Sinusitis
- ☐ Hearing Loss
- ☐ Seasonal Allergies
- ☐ Vertigo/dizziness

Eyes
- ☐ Cataracts
- ☐ Glaucoma

Gastrointestinal
- ☐ GERD (reflux)
- ☐ Bowel Irregularities
- ☐ Liver Disease
- ☐ Stomach Ulcers
- ☐ Pancreatitis

Genitourinary
- ☐ Enlarged Prostate
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Recurrent UTIs

Hematologic/Lymphatic:
- ☐ Osteoporosis/Osteopenia
- ☐ Poor Circulation
- ☐ Anemia
- ☐ Blood Clots
- ☐ Bleeding Disorder

Integumentary
- ☐ Eczema
- ☐ Psoriasis
- ☐ Chronic Rash

Musculoskeletal
- ☐ Arthritis
- ☐ Gout
- ☐ Fibromyalgia
- ☐ Multiple Sclerosis

Neurologic
- ☐ Stroke
- ☐ Migraines
- ☐ Seizure Disorder
- ☐ Parkinson's Disease
- ☐ History of falls

Psychiatric
- ☐ Alzheimer's Disease
- ☐ Anxiety
- ☐ Depression
- ☐ ADHD/ADD
- ☐ Insomnia

Respiratory
- ☐ Asthma
- ☐ COPD
- ☐ Chronic Bronchitis
- ☐ Sleep Apnea

Other

____

CURRENT MEDICAL SPECIALISTS

NAME	SPECIALTY TYPE

MEDICATION ALLERGIES

☐ None

ALLERGEN	REACTION