General and Vascular Surgery of Northwest Alabama, Inc.

Date: _____ EMAIL :_____

Patient's Full Name: _____

Mailing Address: _____

Home Phone: _____ Cell phone: _____

Patient Date of Birth: _____ Social Security Number: _____

Sex: Male Female Marital Status: Single Married Divorced Widowed Separated

Race: _____ Ethnicity: _____ Preferred Language: _____

Patient's Employer: _____ Employer Phone Number: _____

Person Responsible for Bill: _____ Relation to patient: _____

IF INSURANCE IS UNDER SOMEONE OTHER THAN PATIENT:

Name of Primary Insurance: _____ ID/Contract Number: _____

Subscriber Name: _____ Date of Birth: _____ SSN#: _____

Patient relationship to the subscriber: _____Subscriber Employer: _____

Who is your primary doctor (family doctor): _____

Who referred you to our office: _____

****Person to notify in case of a medical emergency**:** _____

Emergency contact phone number _____ Relationship to patient _____

REVIEW OF SYMPTOMS:

Please Indicate whether you've experienced these In the last week

General:

Chills Yes/No

Tired Yes/No

Fever Yes/No

Headache Yes/No

Weight Gain Yes/No

Weight Loss Yes/No

Neck:

Trouble Swallowing Yes/No

Lump/Swelling Yes/No

Breast:

Nipple Discharge Yes/No

Change in breast skin Yes/No

Breast Pain Yes/No

Breast Lump Yes/No

Respiratory:

Cough Yes/No

Wheezing Yes/No

Shortness of breath Yes/No

Can you walk up stairs? Yes/No

Cardiovascular:

Chest pain Yes/No

Swelling in Legs Yes/No

Gastrointestinal:

Abdominal pain Yes/No

Nausea Yes/No

Vomiting Yes/No

Diarrhea Yes/No

Constipation Yes/No

Blood in Stool Yes/No

Pharmacy:_____

PAYMENT is due from the patient at the time that services are rendered. The patient is responsible for payment and not the insurance company. As a courtesy to our patients we will file claims for any insurance coverage; however, co-payments, deductibles, and non covered charges must be paid at the time services are rendered. If there are any questions regarding payment/insurance filing policies, please see one the office staff at this time to make any necessary arrangements.

AGREEMENT TO PAY: The undersigned accepts the fee charged as a lawful debt and promises to pay said fee including the cost of collection, attorney fees, and court costs, if such are necessary, waiving now and forever the right to claim exemption under the constitution and laws of the State of Alabama or any other state. The undersigned understands that accounts may be referred to an outside collection agency if the balance remains unpaid for sixty days unless alternated arrangements have been made and followed.

SURGICAL BENEFITS: I authorize payment directly to General and Vascular Surgery of Northwest Alabama, Inc., for the surgical and/or medical benefits, if any, otherwise payable to me for services rendered by General and Vascular Surgery of Northwest Alabama, Inc. I understand the insurance may not pay the entire bill and I agree to pay the difference or the entire bill if necessary, excluding any contractual allowances.

CONSENT TO TREAT: I consent to all medical and surgical care, examinations and tests determined by my Physician that are necessary for me. Though I expect the care given will meet customary standards, I understand there are no guarantees concerning the results of my care. I also understand that if I do not follow my Physician's recommendations as they may relate to my health that the Physician and this Office will not be responsible for any injuries or damages that are the result of my non-compliance .

RELEASE OF MEDICAL RECORDS: I authorize General and Vascular Surgery of Northwest Alabama, Inc. and/or Russellville Hospital to request or release any medical information from or to another physician or medical institution as necessary for my medical care and for insurance filing purposes.

CONSENT TO WIRELESS TELEPHONE CALLS: If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls (including autodialed calls and prerecorded messages) at that wireless number from General and Vascular Surgery of Northwest Alabama, Inc., its successors and assigns, and the affiliates, agents and independent contractors, including servicers and collection agents, regarding my account, the services rendered, or my related financial obligations.

Print Patient Name: _____ Patient Date of Birth: _____

_____ _____ _____

Signature of Patient or Patient's Legal Representative Date of Signature **Date of Signature**

_____ _____

Print Name of Patient's Legal Representative and Relationship of Legal Representative to Patient
(e.g., parent, guardian, other, please explain)

CONSENT FORM FOR ePRESCRIBE PROGRAM

ePrescribe Program

ePrescribing is way for doctors to send electronically an accurate, error free, and understandable prescription from the doctor's office to the pharmacy. The ePrescribe Program also includes:

- **Formulary and benefit transactions** - Gives the health care provider information about which drugs are covered by your drug benefit plan.

- **Fill status notification** - Allows the health care provider to receive an electronic notice from the pharmacy telling them if your prescription has been picked up, not picked up, or partially filled.

- **Medication history transactions** - Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy.

The medication history information would include medications prescribed by your health care provider at General and Vascular Surgery of Northwest Alabama, Inc., as well as other health care providers involved in your care and may include sensitive information including, but not limited to, medications related to mental health conditions, venereal diseases/sexually transmitted diseases, abortion(s), rape/sexual assault, substance (drug and alcohol) abuse, genetic diseases, and HIV/AIDS.

As part of this Consent Form, you specifically consent to the release of this and other sensitive health information.

Consent

By signing this consent form you are agreeing that your provider at General and Vascular Surgery of Northwest Alabama, Inc. may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or to deny consent may not be the basis for denial of health services. You also have a right to receive a copy of this form after you have signed it.

This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

Understanding all of the above, I hereby provide informed consent to General and Vascular Surgery of Northwest Alabama, Inc. to enroll me in this ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____ _____

Signature Date of Birth

_____

Date

General and Vascular Surgery of Northwest Alabama, Inc.

15225 HWY 43 | RUSSELLVILLE AL, 35653 | (256) 332-1500

Written Financial Policy

Thank you for choosing General and Vascular Surgery of Northwest Alabama, Inc.. Our primary mission is to deliver the best and most comprehensive care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash/check, Visa®, MasterCard® or Discover Card®
- Convenient Monthly Payment Plans[1] from CareCredit
    - Allow you to pay over time
    - No annual fees or pre-payment penalties

Please note:

General and Vascular Surgery of Northwest Alabama, Inc. requires payment prior to the beginning of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For patients with insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[2]

General and Vascular Surgery of Northwest Alabama, Inc. charges $30 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the treatment and care you want and need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

[1]Subject to credit approval

[2]However, if we do not receive payment from your insurance carrier within 120 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

Notice of Privacy Practice Acknowledgement
General and Vascular Surgery of Northwest Alabama, Inc.

I understand that under the Health Insurance Portability and Accountability Act (HIPPA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____
Printed Patient Name or Legal Guardian (print)

_____ _____
Signature of Patient or Legal Guardian Date

I give Dr. Manord and/or his staff permission to leave detailed messages for me. I also give permission for my accounting records, insurance information, and for medical records to be discussed with the following individuals:

_____ _____
Name Relationship to patient

_____ _____
Name Relationship to patient

_____ _____
Name Relationship to patient

_____ _____
Name Relationship to patient

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date: _____ Attempt: _____

Staff Name: _____