Alpha Internal Medicine

Patient History Form

Patient Name: ______________________________ Date of Birth: __________

PERSONAL HISTORY: Put a check by any condition you have ever had. If known, add date and type.

___ Heart Attack	___ Migraine	___ Depression
___ Heart Failure	___ Epilepsy/Seizures	___ Anxiety
___ Stroke	___ Thyroid Disease	___ Insomnia
___ Diabetes	___ Osteoporosis	___ Alcohol/drug problem
___ Cholesterol high	___ Blood clots (DVT,PE)	___ Mental illness
___ Blood pressure high	___ Anemia	___ Cataract
___ Chest pain	___ Easily bleeding	___ Glaucoma
___ COPD/Emphysema	___ Blood disorder	___ HIV/AIDS
___ Asthma	___ Cancer(s) ________	___ Sexually transmitted disease
___ Acid Reflux/GERD	________	___ Tuberculosis
___ Stomach ulcer	___ Arthritis	___ Kidney Stones
___ Hepatitis	___ Back pain	___ Incontinence
___ Skin disorder	___ Gout	___ Prostate enlargement

___ OTHER ____

CURRENT MEDICATIONS (attach another page if needed)

Medication	Dosage and Frequency	Purpose

ALLERGIES (list all known drug, food, and environmental reactions; attach another page if needed)

Drug / Food / Other	Reaction Date, if known	Reaction Description

SIGNATURE OF PATIENT / LEGAL GUARDIAN ______________________ DATE __________

SURGERIES / INJURIES / HOSPITALIZATIONS (attach another page if needed)

Brief Description ______ Date ______

______ ______ ______
______ ______ ______
______ ______ ______

FAMILY HISTORY: check any condition a blood relative has ever had. If known, add relative, age and type.

___ Heart Attack
___ Heart Failure
___ Stroke
___ Diabetes
___ Cholesterol high
___ Blood pressure high
___ COPD/Emphysema
___ Asthma
___ Acid Reflux/GERD
___ Stomach ulcer
___ Hepatitis
___ Skin disorder
___ OTHER ______

___ Migraine
___ Epilepsy/Seizures
___ Thyroid Disease
___ Osteoporosis
___ Blood clots (DVT,PE)
___ Anemia
___ Easily bleeding
___ Blood disorder
___ Cancer(s) ______ ______
___ Arthritis
___ Gout

___ Depression
___ Anxiety
___ Insomnia
___ Alcohol/drug problem
___ Mental illness
___ Cataract
___ Glaucoma
___ HIV/AIDS
___ Tuberculosis
___ Kidney Stones
___ Incontinence
___ Prostate enlargement

SCREENING AND VACCINATIONS: (if known, add the most recent date and location)

Colonoscopy ______
Mammogram ______
Pap smear ______
Prostate ______
Bone density ______
OTHER screening ______

Flu shot ______
Pneumonia shot ______
Shingles shot ______
Whooping cough shot ______
Tetanus shot ______
OTHER vaccine ______

ALCOHOL: indicate your current and past usage

__ I never drink alcohol ___ I rarely drink alcohol ___ per day I average the amounts below
___ cans of beer ___ glasses of wine ___ mixed drinks ___ licquor shots

TOBACCO: indicate your current and past usage

__ I never smoked ___ In the past, I smoked ___ cigarettes ___ cigars but quit on date ______
__ I currently smoke cigarettes ___ packs per day and/or cigars ___ per day
__ I never chewed tobacco ___ In the past, I used chewing tobacco but quit on date ______
__ I currently use ___ chewing tobacco and/or ___ snuff

SIGNATURE OF PATIENT / LEGAL GUARDIAN ______ DATE ______

OTHER DOCTORS

Doctor Name	Doctor Specialty	Reason for Seeing

ADDITIONAL INFORMATION (MEDICATIONS, ALLERGIES, SURGERIES, DOCTORS, ETC)

SIGNATURE OF PATIENT / LEGAL GUARDIAN ______________________ DATE ____________

HOW DID YOU HEAR ABOUT US/WHO REFERRED YOU?

ALPHA INTERNAL MEDICINE
REGISTRATION FORM

(Please Print)

Today's date: | PCP:

PATIENT INFORMATION: (ALL FIELDS MUST BE COMPLETED)

Patient's last name: First: Middle: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ☐ Yes ☐ No | If not, what is your legal name? (Former name): | Birth date: / / | Age: | GENDER: ☐ M ☐ F

Mailing address: | Social Security #: - - | Race: (circle one) Caucasian/African American/ Asian/American Indian/Other:

City: | State: | ZIP Code: | Ethnicity: (circle one) Hispanic / Non-Hispanic

Occupation: | Employer: | Preferred Language: (Circle one) English/Spanish/French/German/ Bulgarian/Other:

Home phone #: ( ) - | Cell #: ( ) - | Work #: ( ) -

Email Address: Religious Preference:

Our office has the ability to e-prescribe certain medications to your pharmacy. Please provide us with your preferred pharmacy information:

Pharmacy Name: Pharmacy Location: Pharmacy Phone #: ( ) -

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: | Birth date: / / | Address (if different): | Home phone no.: ( )

Is this person a patient here? ☐ Yes ☐ No

Occupation: | Employer: | Employer address: | Employer phone no.: ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance ☐ Medicare ☐ Blue Cross ☐ United Healthcare ☐ Aetna ☐ Humana

☐ Cigna ☐ PHCS ☐ Tricare ☐ Coventry ☐ Other:

**Subscriber's name: | **Subscriber's S.S. #: | ** Subscriber Birth date: / / | Group #: | Policy #:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other **Must be completed if Subscriber is not "Self"

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.: ( ) | Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Alpha Internal Medicine or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

ALPHA INTERNAL MEDICINE

745 S. Glynn St.
770-719-5490

This office in accordance with HIPPA has a policy to keep patient information confidential. You may designate below if you want a spouse or family member to have access to your private healthcare information. If you do not designate anyone below, the physicians and nurses at our office will not be permitted to speak anyone else regarding questions about your test results, medications, etc. You are responsible for updating this form if you wish to allow someone to speak to our staff about your condition. Thank you for your understanding.

RELEASE OF INFORMATION TO PERSONS OTHER THAN MYSELF

I allow the people listed below to receive medical information about my condition at any time.

Name:______________________________ Relationship:____________

Name:______________________________ Relationship:____________

Name:______________________________ Relationship:____________

______________________________ ________________________

Signature of Patient Date

ACKNOWLEDGEMENT OF RECIEPT OF PRIVACY PRACTICES

Our Notice of Privacy Practices is posted on the bulletin board in our waiting room. If you require a written copy of the Privacy Policies, we will be more than happy to provide you with one for your records. Please ask the receptionist for the information packet.

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices of Alpha Internal Medicine.

______________________________ ________________________

Patient Name (please print) Date of Birth

______________________________ ________________________

Signature of Patient Today's Date

Alpha Internal Medicine
Medical Records Release Form

Date: ______________________________

I, _________________________________ hereby authorize Alpha Internal Medicine to obtain medical records from:

Physician/Hospital Name: ____

Address: ____

____

Telephone Number: ___________________________________

Fax Number: ___________________________________

The release of information to which I consent is for the purpose of my Primary Care Physician's medical records.

Please release the following information:

____

I understand this authorization includes release of ALL medical records including HIV records, Psychiatric Mental Illness, Drug/Alcohol abuse records, Venereal Disease and any other statutory protected disease. This authorization and consent will expire (90) days following the date signed. I understand that I may revoke this authorization and consent at any time except to the extent that action has previously been taken in reliance hereof.

Signature of Patient/Guardian: ____

Print Name: ____

Date of Birth: ____

Witness Signature: ____

745 S. Glynn Street
Fayetteville, GA 30214

Phone: 770-719-5490

Fax: 770-719-3113

Payment and Appointment Policies

Alpha Internal Medicine participates with most insurance plans. If you are not insured by a plan in which we participate, payment in full is expected at the time of your visit.

Understanding your insurance benefits is your responsibility. Therefore, please be sure that you verify that our physicians are in your network, what your out-of-network benefits are, and what your insurance covers. If you have questions about your coverage, please contact your insurance company with any questions before your appointment. Also, please look over your insurance EOB when you receive it by mail which will tell you what you will be billed for by our office.

Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service.

Check Policy. All checks must be made payable to Alpha Internal Medicine. A service charge of $40.00 will be assessed for each returned check. If we have received more than one returned check from your bank, we will no longer accept payment by check. You will be required to pay by credit card, cash or money order.

Non-covered services. Please be aware that some - and perhaps all - of the services you receive may not be covered by your insurance plan. If you receive such services, you will be required to pay for these services in full at the time of visit.

Proof of insurance. All patients must have a picture ID and an insurance card on file. If you cannot provide proof of insurance, you may be responsible for the claim.

Claims submission. We will submit claims on your behalf to your insurance company for payment. Your insurance company may require that you supply certain information directly. It is your responsibility to coordinate your benefits with your carrier. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.

Coverage changes. If your insurance changes, please notify us before your next visit, so we can update your insurance information in our system. Providing us

with this information prior to your visit will reduce your wait time. We will also do our best to verify your insurance coverage prior to your visit to minimize surprises at the time of visit.

Non-payment. Final notices are sent after 30, 60 and 90 days for non-payment. If your account is more than 90 days past due, you will receive a letter stating that you have 15 days to pay your account in full. To avoid having your invoice sent to a collection agency, you are welcome to set up a payment plan. If you are dismissed from the practice as a result of non-payment, you will be notified by certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physicians will only be able to treat you for emergency care.

Missed appointments. Keeping your regularly scheduled appointment is important – for your health, for the convenience of other patients, and for more efficient operations at our offices. If you must cancel or reschedule your appointment, please let us know 24 hours before your scheduled time. We have an automated system that allows patients to confirm appointments by phone.

If you have not been seen at our practice, the first visit is a new patient visit. At this visit we will gather a full history including medications, immunizations etc. We do wellcare/preventive physicals after the new patient visit. We will gladly schedule your wellcare/preventive physical after you have been seen in our office at least one time.

Some insurances require that you pay a deductible for labs and diagnostic tests in addition to your copay for your visit. We use an outside reference lab (Labcorp) for labs that we do not perform here in our office. You may be billed by them for any balance not covered by your insurance plan.

Our practice is committed to providing the best possible treatment for our patients at a fair and reasonable cost. Our prices are representative of the usual and customary charges for our area. Payment is expected at the time of service unless prior arrangements have been made with our business office.

_______________________________________ ______________

Signature of patient Date

Alpha Internal Medicine
Patient Policy & Procedure Update

Please read and sign the following updated patient policies and return to the staff to be filed in your chart. The purpose of this update is to make all of our patients aware of how to make requests for refills and results as well as make changes to patient information for billing purposes. We want to provide the best care possible for you.

1. If your labs are normal, we will **not** notify you. You will be notified in 10 days if your labs or test results are abnormal. If you call our office to request information about a lab or test result, please allow 48 hours for a return call.

2. Prescription refills require 24 hours notice to be called into your pharmacy or written for pick up here at the office. Do not wait until you are out of medication to contact us for a refill. Please plan ahead when you come in for a doctor visit by asking your provider to write any prescriptions that you will need refilled in the near future. This will save you time later.

3. All insurance and demographic information should be updated any time you have a change. We ask that you give your home, work and cell phone numbers so that we can reach you in a timely manner. A number where you can be reached during the hours of 8:00am and 5:00pm should be on file with our office or there may be a delay in contacting you with results, etc. If your insurance changes and you do not notify us, you will be responsible for any unpaid balances.

4. If you are an HMO or POS patient and you need a referral to a specialist, you must give our referral department 72 hours notice.

5. If you use email and have a question about your bill, you may email us at billing@alphainternalmedicine.com .

6. Your insurance plan may require that you pay a deductible for labs and diagnostic tests in addition to your visit copay. We use an outside lab (Labcorp) for labs that we do not perform here in our office. They are on most insurance plans, however you may be billed by them for any balance not covered by your insurance.

7. All balances including deductibles and copays are due at the time of service. We will file up to 2 insurance plans for you. Any balances that are due by you must be paid within 30 days unless prior arrangements are made with the billing office. If you have a question, feel free to speak to one of our billing staff.

***Please see back of this page.*

PLEASE SIGN AND RETURN TO A STAFF MEMBER DURING TODAY'S VISIT.

I have read and understand the above policies

______________________________ ____________

Patient Signature Date

Alpha Internal Medicine

Confirming appointments and No Show policy

Our patients care is our utmost concern here at AIM, therefore ,we do have to set policies in regards to your appointment. We have a confirmation system that can call, text, or email you to remind you of your upcoming appointment up to 4 days in advance. We ask that every patient inform our front office of your preference on how you would like to be notified.

We also ask that you do confirm, cancel, or reschedule your appointments by responding to this notification system or by calling and speaking to one of our front office staff members.

If you do need to cancel your appointment, it is our policy that you call 24 hours in advance to do so. If your appointment falls on a Monday or a day after our office is closed for 24hours **(ex: A holiday in the middle of the week)** you ***must*** cancel your appointment on the *business* day prior by noon.***(ex: your appointment is on a Monday, you must cancel by noon on the Friday preceding your appointment. Or Your appointment is a Thursday but our office is closed on the day before. You must call that Tuesday by noon to cancel.)*** This will allow our office to fill your appointment slot.

Failure to call our office and cancel 24 hours before your appointment or by the above time for Monday/special occasion appointment requirements will result in a $100 No Show fee.

Patient signature____Date_______________

The physicians and staff at Alpha Internal Medicine make every effort to provide efficient check-in and minimal waiting time. While there are occasions you may have to wait, please remember that you will always receive the care and attention you need from our physicians and medical professionals.

To make your office visit go more smoothly, follow these easy steps:

- Always bring a list of your current medications with you.
- Please arrive 15 minutes before your scheduled appointment to complete all necessary information.

APPOINTMENT CONFIRMATION: We normally call to remind you of your appointment two days prior to your appointment. This is a courtesy for our patients and you will be prompted to confirm the appointment during the call. Please make sure to call our office 24 hours in advance if you need to cancel an appointment. We will charge a $100 fee for failure to cancel appointments with a 24hour notice.

Checking In

Each time you visit us, please bring a photo ID and your current insurance card with you. Please check in at the front desk. If you have a co-pay or a past due balance, you will be able to make your payment at check-in. Patients with high deductibles will be asked to pay $100 at each visit until the calendar year deductible is paid in full.

Appointment

When the Medical Assistant calls your name, you will be escorted to one of the examination rooms. Once there, the reason for your visit and other basic information will be taken. Then your physician or mid-level provider will see you.

Checking Out

After your appointment, you will be directed to the check-out desk where you will:

- receive a summary of your visit and special instructions from your physician
- pick up your receipt or make a payment
- schedule your next appointment if needed

Please note that it is very important to check out.

Medication Refills

To request a prescription refill, you may call the number below, or email nurse@alphainternalmedicine.com.

PH: (770)719-5490

Please make sure that you provide the following information:

- Patient's name and date of birth
- Caller's name (if different) and phone number
- Drug name, dosage and how it is taken
- The pharmacy name and phone number

Refills are processed within 48 hours of the request. Please call your pharmacy directly to check on the status of the medication refill and plan accordingly.

Calls after 12 noon on Fridays or the day before a holiday may not be addressed until the next business day.

Remember: Physicians who are 'on-call' cannot complete routine medication refill requests.

Patient Tips

To get the best possible care:

- Make sure your physician knows all the medications you are taking. This includes prescription and over-the-counter medicines, as well as dietary supplements such as vitamins and herbs.
- Make sure your doctor knows about any allergies and adverse reactions you have had to medicines. This will help you avoid getting a medicine that can harm you.
- Make sure you know the prescriptions your physician prescribes. And verify that it is the medication your pharmacy dispenses to you.
- Ask for information about possible side effects of medicines prescribed to you. If you know what might happen, you will be better prepared if it does, or if something unexpected happens instead.
- If you have tests performed at our office – and you don't hear from us within five (5) days, call the office at 770-719-5490.
- If you have outside (performed at the hospital or other facility) diagnostic tests such as xrays, CT scans, MRI that were ordered by one of our providers, please call our office to let us know so we can get the results, once they have been read and are available.