

Digestive Disease Associates, PC Montgomery, Alabama

Welcome to the office of Digestive Disease Associates, P.C. Our patients are scheduled on Mondays, Wednesdays, and Thursdays. Every patient seen by Digestive Disease Associates, P.C. should have a primary care physician (internists or general practitioner). We accept patients on a physician-referral basis only.

NEW PATIENT INFORMATION

Please Print

Name _____ Date of Birth _____ Age _____
Address _____
City _____ State _____ Zip _____
Phone _____ Cell Phone _____ Mobile Carrier _____
Social Security Number _____ Email _____
Emergency Contact _____
Referring Physician _____

Insurance Information _____
Insurance Company _____
Contract Number _____ Group Number _____
Subscriber _____ Subscriber Date of Birth _____

I hereby authorize the release of any medical information that may be necessary for either medical care or in processing applications for financial benefit. I hereby authorize direct payment of benefits to Digestive Disease Associates, P.C. for services rendered by them in person or under their supervision. I understand that I am financially responsible for all charges regardless of insurance coverage.

AGREEMENT TO PAY: The undersigned accepts the fee charged as lawful debt and promises to pay said fee including the cost of collection, attorney fees and court costs if such be necessary, waiving now and forever the right to claim exemption under the Constitution and Laws of the State of Alabama, or any other state.

Signature _____ Date _____

Digestive Disease Associates, PC
7080 Sydney Curve, Montgomery, Al 36117
Office: (334) 271-1205
Fax: (334) 271-1204

Robert R. Brinson, M.D.

Leia Thornton, PA-C

Medical Release For: _____

Effective October 1, 2000 (due to federal guidelines under HIPPA) we are now required to have and maintain in a patient's medical chart medical release information on family members, friends, caregiver, etc. You must provide the names of those individuals who you wish to be given any or all your medical or financial information. ANYONE calling for medical or financial information on you who is not listed on this sheet will be told that no information can be released to them.

Please list the names, dates of birth and phone numbers of the authorized individuals below. The individuals listed below must agree to provide their D.O.B. or phone numbers for identification purposes.

1). If you DO NOT want your medical or financial information discussed with anyone other than yourself, please sign here: _____ Date: _____

I (sign here) _____ (patient's name) give authorization to the following individual(s) listed below to discuss my medical or financial information with your staff or the Doc- tor on my behalf.

Name	D.O.B.	Phone Number
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____

If there is any medical or financial information you do not wish to be given out please list:

May we leave medical information on your "home" answering machine? Yes _____ No _____

Signature of Patient: _____

Date _____

The above information is private and confidential and will be placed in your medical chart. This information must be updated and a new form signed one year from the date above.

MEDICAL RECORDS FAX TRANSMISSION AUTHORIZATION/HIPAA NOTICE OF PRIVACY PRACTICES/CONSENT TO CONTACT

I, _____, understand that you will be transmitting my medical records electronically and this is your authorization to do so. If they are received by another party in error, I absolve Robert R. Brinson, M.D. of any and all liability relating to such submission of said records.

Signature of Patient _____ Date _____

Although the law requires a signed and dated Privacy Notice, this office does not demand that you sign the agreement as a condition of receiving care. It is the law that your rights are communicated in this manner.

It is our practice to retain information about non-healthcare related requests for your health care information for a period of six years.

In complying with the Privacy Standard, we have appointed a Privacy Officer, trained our Privacy Officer and the staff in the law, and implemented policies to protect your PHI. We have instituted privacy and security processes to guard and protect your IIHI. This office is taking and continues to monitor and improve steps for the protection of your information and to remain in compliance with the law.

Please sign below and date the form indicating that you have received this Privacy Notice.

Signature of Patient _____ Date _____

This is to inform you that sometimes your procedure may go towards your deductible. We advise you to call your insurance company to ask if you have a deductible for your procedure. If the doctors portion of the procedure goes toward your deductible, you will be responsible for the remaining balance of the procedure. We will be happy to work with you in setting up payment arrangements if this happens to you. We will make every effort to work with you according to your financial needs. However, if no effort is made to make arrangements, you will be sent to an outside collection agency.

Signature of Patient _____ Date _____

You agree, in order for us to service your account or to collect monies you may owe Digestive Disease Associates, PC, that agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or the use of an automatic dialing device, if applicable.

By signing below, you acknowledge you have read this disclosure and agree that Digestive Disease Associates, PC, its employees or agents may contact you as described above.

Signature of Patient _____ Date _____

Digestive Disease Associates, PC

Robert R. Brinson MD

Leia Thornton PA-C

Medical History Questionnaire

Name: _____ Date of Birth _____ Todays Date _____

Marital Status: Single Married Widowed Divorced Male Female

Primary Care Physician: _____

Referred by: _____

Specialist Physicians: _____

Preferred Pharmacy _____ Phone Number _____

Reason for Today's Visit: _____

Section I: History of Present Illness (if applicable)

1. Location of problem _____

2. Quality (please check all that apply): sharp stabbing achy burning dull
 other _____

3. Severity (please check all that apply): mild moderate severe other _____

4. Duration (please check all that apply): continuous intermittent X _____ day _____ mths _____ yrs

5. Timing (when do you have symptoms): _____

Things that make it worse: _____

Things that make it better: _____

6. State other signs/symptoms: _____

Section II: Medications

Please list all medications (prescription and over the counter). Please include dosage and how often taken.

1)	8)
2)	9)
3)	10)
4)	11)
5)	12)
6)	13)
7)	14)

Section III: Allergies

NONE Latex other _____

	<u>Medication</u>	<u>Reaction</u>
1)		
2)		
3)		
4)		
5)		
6)		
7)		

Section VI: Social History

- Current Smoker Former Smoker If yes, how many packs per day? _____ How many years _____
- Current Smokless Tobacco Former If yes, how many packs per day? _____ How many years _____
- Drink Alcohol If yes, how much and how often? _____
- Drugs If yes, what, how much and how often? _____
- Exercise Regularly If yes, how often? _____
- Drink caffeine? If yes, what types? _____
- Eat Breakfast? Lunch? Dinner? Late at night?
- How long does it take to eat your meals? _____

Section VII: Immunizations (include year if known)

- | | | |
|--------------------------------|------------------------------------|--|
| <input type="checkbox"/> Flu | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tetanus |
| <input type="checkbox"/> Hep A | <input type="checkbox"/> Shingles | <input type="checkbox"/> Other |
| <input type="checkbox"/> Hep B | <input type="checkbox"/> HPV | <input type="checkbox"/> Immunizations Up-to-Date (12yr and younger) |

Section VIII: Wellness

Please mark the test you had, the last date, and place they were done

- | | | |
|---------------------------------------|---|------------------------------------|
| <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> PSA | <input type="checkbox"/> Pap Smear |
| <input type="checkbox"/> EGD | <input type="checkbox"/> Mammogram | |
| <input type="checkbox"/> Bone Density | <input type="checkbox"/> Other abnormal testing | |

By signing below, I give my authorization to request from personal physician, hospital, clinic, etc. information about my medical history, physical condition, or diagnosis when deemed necessary, and to release any information concerning my medical condition. I attest that this information is accurate to the best of my knowledge. I give Digestive Disease Associates (Dr. Brinson; Leia Thornton, PA-C) permission to treat me and file my insurance.

Signature: _____

Date: _____