Welcome To Margaret Medical Clinic

Date: ________/________/________ Chart #: ______________

PATIENT INFORMATION

Patient Name: ____ Date of Birth: ________/________/_________

Address: ____

Street City State Zip Code

Home Phone #: ( ) ______-________ Cell #: ( ) ________-__________ I want to receive text reminders: _________

Email: ____ (Required for Patient Portal Access)

Social Security Number: __________-_______-___________ Sex: ____ : Male ____ :Female

Race: __________________ Ethnicity: __________________________ Primary Language: ___________________

Employer: ____ Work Phone: ( ) ________-___________

Marital Status: ____ :Single ____ :Divorced ____ :Widowed If married, spouse's name: _______________________

Spouse's Phone #: ( ) ________-___________ Spouse's Employer: _______________________________________

Do you have a Living Will? _____ :Yes _____ :No Do you have a Power Of Attorney? _____ :Yes _____ :No

If yes, who? ____ Relationship to Patient: _____________

Emergency Contact: ____ Relationship to Patient: _____________

Home Phone #: ( ) __________-_____________ Cell #: ( ) __________-___________

INSURANCE INFORMATION

Primary Insurance

Insurance Company: _____________________________

Subscriber Name: _______________________________

Subscriber Date of Birth: ________/_______/_________

Policy Number/Plan ID: __________________________

Group Number: _________________________________

Secondary Insurance

Insurance Company: ______________________________

Subscriber Name: _________________________________

Subscriber Date of Birth: ________/________/__________

Policy Number/Plan ID: ____________________________

Group Number: __________________________________

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Margaret Medical Clinic

NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGEMENT

A Notice of Privacy Practices (NPP) is provided to all patients and explains:

(1) How your Protected Health Information (PHI) may be used or shared.
(2) Your rights to access or amend your PHI, request information on disclosure of your PHI, and request additional restrictions on our uses and disclosures of PHI.
(3) Your rights to complain if you believe your privacy rights have been violated.
(4) Our responsibilities for maintaining the privacy of your PHI.

Print Name of Patient/or (If Minor) Guardian: ____
Signature of Patient/ or Guardian: ____ Date: _______/_______/___________

Patient Communication Consent:

We may need to contact YOU regarding our medical care. This is to acknowledge that you authorize Margaret Medical Clinic to check all that apply:

______:Leave a detailed message on voice mail/machine.
______:Call my workplace phone number and leave a message.
______:Call my workplace phone number and speak only to me.
______:Transmit and Receive messages through Patient Portal.
______:None of the above.

I further authorize the disclosure of my PHI to the following Individuals or Family Members:

NAME: ____ RELATIONSHIP TO PATIENT: ____________________________
PHONE #: (   ) ______________-_________________
MMC MAY CONTACT THE ABOVE NAME VIA: ______:CALL ______:LEAVE A VOICEMAIL ______:PATIENT PORTAL ______:OTHER
MMCMAY RELEASE INFORMATION REGARDING: _____:ALL _____:APPOINTMENTS _____:TEST RESULTS _____:FINANCIAL

NAME: ____ RELATIONSHIP TO PATIENT: ____________________________
PHONE #: (   ) ______________-_________________
MMC MAY CONTACT THE ABOVE NAME VIA: ______:CALL ______:LEAVE A VOICEMAIL ______:PATIENT PORTAL ______:OTHER
MMC MAY RELEASE INFORMATION REGARDING: _____:ALL _____:APPOINTMENTS _____:TEST RESULTS _____:FINANCIAL

NAME: ____ RELATIONSHIP TO PATIENT: ____________________________
PHONE #: (   ) ______________-_________________
MMC MAY CONTACT THE ABOVE NAME VIA: ______:CALL ______:LEAVE A VOICEMAIL ______:PATIENT PORTAL ______:OTHER
MMC MAY RELEASE INFORMATION REGARDING: _____:ALL _____:APPOINTMENTS _____:TEST RESULTS _____:FINANCIAL

NAME: ____ RELATIONSHIP TO PATIENT: ____________________________
PHONE #: (   ) ______________-_________________
MMC MAY CONTACT THE ABOVE NAME VIA: ______:CALL ______:LEAVE A VOICEMAIL ______:PATIENT PORTAL ______:OTHER
MMC MAY RELEASE INFORMATION REGARDING: _____:ALL _____:APPOINTMENTS _____:TEST RESULTS _____:FINANCIAL

SIGNATURE OF PATIENT/GUARDIAN: ____ DATE: ________/________/__________

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PAPER WORK CHARGE/AUTHORIZATION & CONSENT TO TREAT/NO SHOW POLICY ACKNOWLEDGEMENT

PAPER WORK: There is a charge for filling out any forms (FMLA, VA Forms, Disability Forms & any letters) by your physician and/or staff when needed. If you have any questions regarding this policy, please reach out to your provider Monday - Thursday 10am - 4pm.

AUTHORIZATION & CONSENT TO TREAT

Assignment and Release: I hereby assign my insurance or other third party carrier benefits to be paid directly to the Physician Practice, realizing I am responsible for any resulting balance. I also authorize the Physician to release any information required to process this claim to my insurance carrier and/or to my employer or prospective employer. I acknowledge that I am financially responsible for services rendered, and failure to pay any outstanding balances may result in collection procedures being taken. Further, I agree that if this account results in a credit balance, the credit amount will be applied to any outstanding accounts of mine, or to a family member whose account I am guarantor for.

Consent for Treatment: I hereby authorize the physicians, midlevel providers, nurses, medical assistants, and other practice staff to conduct such examinations, and to administer treatment and medications as they deem necessary and advisable.

No Show Policy: I understand if I fail to come for a scheduled appointment or cancel less than 24 hours prior to the appointment, I will be considered a "no show". A no show fee of $25.00 per occurrence may be charged. Ongoing occurrences of no shows may result in dismissal from the Practice.

I understand the Financial and No Show Policy, Authorization and Consent for Treatment, and hereby agree to them:

SIGNATURE OF PATIENT OR GUARDIAN: ____ **DATE:** _______/_______/_________

SSN: ___________-________-____________

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Margaret Medical Clinic

PAYMENT POLICY

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. INSURANCE: We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. CO-PAYMENTS & DEDUCTIBLES: All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. NON-COVERED SERVICES: Please be aware that some - and perhaps all - of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other Insurers. You must pay for these services in full at the time of visit.

4.PROOF OF INSURANCE: All patients must complete our patient information forms before seeing the doctor, and these forms must be updated yearly. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance at every visit. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. CLAIMS SUBMISSION: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.

6. COVERAGE CHANGES: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. NON-PAYMENT: If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. MISSED APPOINTMENTS: Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

____ ________/________/________

Signature of Patient or Responsible Party Date

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Margaret Medical Clinic
MEDICATION POLICY

Effective 10/01/2022 Margaret Medical Clinic providers will **no longer** be prescribing Narcotics, Class C Drugs or medication for ADD/ADHD.

If you require chronic pain management, or treatment for ADD/ADHD, we will provide a referral to a provider of your choice for an evaluation and treatment.

If you are injured and require pain relief, we will prescribe the necessary medication, this will be determined on a case-by-case basis, at the providers discretion. If you have any questions about this policy, please contact us at 205-352-0001 Monday - Friday, 10am - 4pm and we will be happy to discuss this with you.

Thank you,
Management

Patient/Guardian Signature: ______________________________

Date: ________/________/________

Patient Printed Name: ______________________________

Guardian Printed Name: ________/________/________

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Margaret Medical Clinic

PATIENT AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize the disclosure of my individually identifiable health information as described below, I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the release information may no longer be protected by federal privacy regulations.

Patient Name: ____ **Date of Birth:** ______/______/______

Persons/Organizations providing the information:
____
____
____
____
____
____

Sending or Receiving: ______________________
Margaret Medical Clinic
CIRCLE YOUR PROVIDER:
Dr. Ilinca Prisacaru / Jessica Earnest, CRNP/ William Weller, CRNP
125 Jeffrey Wilson Dr
Odenville, AL 35120
Phone: (205) 352-0001 Fax: (205) 352-3355

Specific description of information (including patient demographics and dates of treatment/office visits).

- All medical records and office notes from the last 3 years (including HIV/AIDS, STDs, mental illness records and alcohol and/ or drug abuse).
- Other: ____.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Officer at 125 Jeffrey Wilson Drive Odenville, AL 35120. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information, or if my authorization was obtaining insurance coverage and the insurer has a legal right to contest a claim.

Margaret Medical Clinic will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

I understand I have the right to:
- Inspect or copy the health information to be used or disclosed as permitted under the law.
- Refuse to sign the authorization.

The use or disclosure requested under this authorization may result in financial gain to my physician from a third party.

This authorization will expire on _______/_______/_______. After this date Margaret Medical Clinic can no longer disclose the patient's protected health information without first obtaining a new authorization form.

I fully understand and accept the terms of this authorization.

____ ___________/___________/___________
Signature of Patient or Patient's Representative **Date**

____ ______________________________________
Printed Name of Patient or Patient’s Representative **Relationship to Patient**

PHYSICIAN(S) INFORMATION

Primary Care Physician: ______________________________ **Phone #:** ( ) ________-__________

Referring Physician: ______________________________ **Phone #:** ( ) ________-__________

Other Physicians involved in your care: ______________________________

____

____

PATIENT MEDICAL HISTORY

DO YOU HAVE ANY HISTORY OF THE FOLLOWING? PLEASE CHECK ALL THAT APPLY.

_______ **:ADHD**
_______ **:Alcoholism**
_______ **:Allergies, Seasonal**
_______ **:Angina/Chest Pain**
_______ **:Anemia**
_______ **:Anxiety**
_______ **:Arrhythmia (irregular heart beat)**
_______ **:Arthritis**
_______ **:Asthma**
_______ **:Bipolar Disorder**
_______ **:Bladder Problems/Incontinence**
_______ **:Bleeding Problems**
_______ **:Cancer**
_______ **:Chronic Bronchitis**
_______ **:Cirrhosis**
_______ **:Clotting Disorder**

_______ **:COPD/Emphysema**
_______ **:Diabetes __ :Type 1 __:Type 2**
_______ **:Depression**
_______ **: Diverticulitis**
_______ **:DVT (Blood Clot)**
_______ **:Emphysema**
_______ **:Epilepsy**
_______ **:Fractures**
_______ **:Gallstones**
_______ **:GERD (Acid Reflux)**
_______ **:Glaucoma**
_______ **:Headaches**
_______ **:Heart Disease**
_______ **:Heart Attack (MI)**
_______ **:Heavy Murmur**
_______ **:Hepatitis**

_______ **: High Blood Pressure**
_______ **:High Cholesterol**
_______ **:HIV Positive (AIDS)**
_______ **:Irritable Bowel (IBS)**
_______ **:Kidney Disease**
_______ **:Liver Disease**
_______ **:Lupus**
_______ **:Migraines**
_______ **:Neuropathy**
_______ **:Osteopenia/porosis**
_______ **:Parkinson's Disease**
_______ **:PVD**
_______ **:Peptic Ulcer**
_______ **:Positive TB Test**
_______ **:Psoriasis**
_______ **:Pulmonary Embolism**

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PATIENT MEDICAL HISTORY (continued)

DO YOU HAVE ANY HISTORY OF THE FOLLOWING? PLEASE CHECK ALL THAT APPLY.

_______ :Rheumatic Fever	_______ :Rheumatoid Arthritis	_______ :Seizure Disorder
_______ :Sleep Apnea	_______ :Stroke	_______ :Thrombophlebitis
_______ :Thyroid Disease	_______ :Tuberculosis	_______ :Ulcerative Colitis
_______ :MRSA	_______ :Toxic Shock Syndrome	_______ :Endometriosis
_______ :Fibromyalgia	_______ :Celiac Disease	_______ :OTHER ___________________
		___________________

FAMILY MEDICAL HISTORY

HAS ANYONE IN YOUR FAMILY HAD ANY OF THE FOLLOWING? PLEASE CHECK ALL THAT APPLY.

_______ :Anemia	Relationship to you:______________________	Living or Deceased? _____________________
_______ :Bleeding Disorders	Relationship to you:____________________	Living or Deceased? _____________________
_______ :Blood Clots	Relationship to you:______________________	Living or Deceased? _____________________
_______ :Cancer/Polyps	Relationship to you:______________________	Living or Deceased? _____________________
_______ :Diabetes	Relationship to you:______________________	Living or Deceased? _____________________
_______ :Allergies	Relationship to you:______________________	Living or Deceased? _____________________
_______ :Heart Attack	Relationship to you:______________________	Living or Deceased? _____________________
_______ :Heart Disease	Relationship to you:______________________	Living or Deceased? _____________________
_______ :High Blood Pressure	Relationship to you:_________________	Living or Deceased? _____________________
_______ :High Cholesterol	Relationship to you:____________________	Living or Deceased? _____________________
_______ :Hepatitis	Relationship to you:______________________	Living or Deceased? _____________________
_______ :Kidney Disease	Relationship to you:______________________	Living or Deceased? _____________________
_______ :Lung Disease	Relationship to you:______________________	Living or Deceased? _____________________
_______ :Migraine	Relationship to you:______________________	Living or Deceased? _____________________
_______ :Stroke	Relationship to you:______________________	Living or Deceased? _____________________

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OPERATIONS AND/OR HOSPITALIZATIONS

LIST ANY OPERATIONS, PROCEDURES OR HOSPITALIZATIONS BELOW w/APPROXIMATE DATES:

PROCEDURE/HOSPITAL STAY:	WHAT LOCATION:	DATE:

REVIEW OF SYMPTOMS

CHECK ANY SYMPTOMS THAT YOU MAY BE HAVING (CURRENTLY OR RECENTLY):

RESPIRATORY:

_______ **:shortness of breath**

_______ **:congestion**

_______ **:cough**

_______ **:shortness of breath caused by exertion**

CARDIOLOGY:

_______ **:chest pain**

_______ **:palpitations**

_______ **:varicose veins**

_______ **:sweating**

_______ **:swelling**

_______ **:fluttering sensation**

GENERAL:

_______ **:weight gain**

_______ **:weight loss**

_______ **:loss of appetite**

_______ **:fevers**

_______ **:weakness**

_______ **:fatigue**

ENDOCRINE:

_______ **:cold intolerance**

_______ **:heat intolerance**

_______ **:increased thirst**

FEMALE REPRODUCTIVE:

_______ **:pregnant**

_______ **:menopause**

MALE REPRODUCTIVE:

_______ **:difficulty with erection**

OPHTHALMOLOGY:

_______ **:diminished vision**

_______ **:blurring of vision**

_______ **:loss of vision**

_______ **:vision floaters**

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REVIEW OF SYMPTOMS (continued)

CHECK ANY SYMPTOMS THAT YOU MAY BE HAVING (CURRENTLY OR RECENTLY):

GASTROENTEROLOGY:

_______ :nausea
_______ :heartburn
_______ :constipation
_______ :diarrhea
_______ :difficulty swallowing
_______ :indigestion
_______ :abdominal pain

HEMATOLOGY:

_______ :easy bruising
_______ :bleeding

PSYCHOLOGY:

_______ :depression
_______ :anxiety
_______ :high stress

NEUROLOGY:

_______ :headaches
_______ :tingling
_______ :fainting
_______ :dizziness
_______ :difficulty walking
_______ :memory loss

UROLOGY:

_______ :frequent urination
_______ :difficulty or painful urination
_______ :blood in urine

DERMATOLOGY:

_______ :rash
_______ :flushing
_______ :wound
_______ : dry skin
_______ :cystic acne

MUSCULOSKELETAL:

_______ :joint pain
_______ :leg cramps
_______ :back pain
_______ :arm pain
_______ :neck pain
_______ :leg pain
_______ :muscle pain

HABITS

PLEASE CHECK ALL THAT APPLY:

_______ :Smoking _______ :Packs Daily?
_______ :How Long?
_______ :Vaping _______ :Puffs Daily?
_______ :How Long?
_______ :Dipping _______ :Dips Daily?
_______ :How Long?

_______ :Coffee _______ :Cups Daily
Other Caffeine? ______________________
_______ :Alcohol _______ :Type
_______ :Frequency _______ :Amount
_______ :Diet _______ :Salt Intake
_______ :Fat Intake ______________________

Do you routinely exercise? __:Yes ___:No
What do you do for exercise? _____________
Have you ever used illegal drugs? _:Yes _:No
If yes, what type of drugs? _______________

Are you interested in stopping any of the above habits? _______ :Yes _______ :No
If you have already quit, when did you quit? ____

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WELLNESS SCREENINGS/VACCINATIONS

PLEASE CHECK ANY SCREENINGS, DIAGNOSTIC TESTING OR VACCINATIONS YOU HAVE HAD WITH THE DATE & LOCATION OF WHERE THESE WERE ADMINISTERED.

FEMALES ONLY:

MAMMOGRAM: _______ WHEN? ______________________________ WHERE? ___________________________________

DEXA (BONE DENSITY): _______ WHEN? ______________________________ WHERE? ___________________________________

PAP SMEAR: :_______ WHEN? ______________________________ WHERE? ___________________________________

BIRTH CONTROL METHOD? _______:NONE NEEDED _______:OTHER - PLEASE SPECIFY: ___________________________________

LAST MENSTRUAL CYCLE: ______________________

MALES ONLY:

PSA/PROSTATE EXAM: _______ WHEN? ____________________________ WHERE? ___________________________________

ABDOMINAL AORTA ULTRASOUND: ______ WHEN? ____________________________ WHERE? ___________________________________

MALES & FEMALES:

COLONOSCOPY/SIGMOIDOSCOPY: _____ WHEN? ____________________________ WHERE? ___________________________________

INFLUENZA VACCINE (FLU SHOT): _______ WHEN? ____________________________ WHERE? ___________________________________

PNEUMONIA VACCINE: _______ WHEN? ____________________________ WHERE? ___________________________________

TD/TDAP VACCINE (TETANUS): _______ WHEN? ____________________________ WHERE? ___________________________________

COVID VACCINE: _______ WHEN? ____________________________ WHERE? ___________________________________

OTHER VACCINES:_______ PLEASE LIST: ____

__________________________________ WHEN? ____________________________ WHERE? ___________________________________

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MEDICATIONS

LIST ALL MEDICATIONS YOU TAKE: INCLUDING - PILLS, INHALERS, HOME REMEDIES & OVER THE COUNTER MEDICATIONS. YOU MAY ATTACH AN ADDITIONAL SHEET IF NECESSARY:

MEDICATION NAME:	DOSAGE (MG)	AMOUNT	HOW MANY TIMES A DAY?

ALLERGIES TO ANY MEDICATION? ______:NO ______:YES - IF YES, PLEASE LIST ALL ALLERGIES & REACTIONS BELOW:

____

____

____

PHARMACY NAME: ______________________________ LOCATION: ________________________ PHONE#: (   ) _______-___________

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