



All records, most recent, or specific description of the health information to be disclosed/obtained (please include dates of service; examples such as drug and alcohol test results, mental health information, etc.)

By providing this Authorization, I understand as follows:

1. I understand this Authorization is voluntary. I may refuse to sign this Authorization and my treatment and/or payment obligations will not be affected. However, PHI (protected health information) will not be released without signature.
2. I understand that I may revoke this Authorization at any time by notifying Quick Care in writing, but if I do, it will not have any effect on disclosures prior to the receipt of the revocation.
3. I understand that this Authorization will expire in one (1) year from the date signed.

\_\_\_\_\_  
(Signature of patient or patient's representative) Today's Date: \_\_\_\_\_

\_\_\_\_\_  
(Signature of Witness) Today's Date: \_\_\_\_\_

\_\_\_\_\_  
(Printed name of patient's representative, if applicable)

\_\_\_\_\_  
(Representative's relationship to patient, if applicable)

**PATIENT INFORMATION:**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle \_\_\_\_\_

Male/Female \_\_\_\_\_ SS# \_\_\_\_\_ Marital Status \_\_\_\_\_ Date of Birth \_\_\_\_\_

Race \_\_\_\_\_ Ethnic Group \_\_\_\_\_ Primary Language Spoken \_\_\_\_\_

Street Address \_\_\_\_\_ City/State \_\_\_\_\_

Zip \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work

Phone \_\_\_\_\_ Email Address \_\_\_\_\_ Preferred Reminder

Method \_\_\_\_\_ Preferred

Pharmacy \_\_\_\_\_

**EMERGENCY CONTACT:**

Name \_\_\_\_\_ Phone \_\_\_\_\_

Relationship \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION (If Not Self)**

Full

Name \_\_\_\_\_

StreetAddress \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

HomePhone \_\_\_\_\_ CellPhone \_\_\_\_\_ WorkPhone \_\_\_\_\_

DateofBirth \_\_\_\_\_ Marital Status \_\_\_\_\_ SS# \_\_\_\_\_ Relationship \_\_\_\_\_

Type of Insurance \_\_\_\_\_ Contract # \_\_\_\_\_ Group # \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Contract # \_\_\_\_\_ Group # \_\_\_\_\_

**\*How did you hear about us?  Facebook  Friend/Family  Internet search  Hospital**

**Inpatient  Billboard  Postcard  Radio  Other**

**I hereby authorize and direct payment to Quick Care for medical benefits, if any, otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for the charges not covered by this authorization. I understand that checks returned for non-payment will incur a \$30.00 fee. I hereby authorize Quick Care to release any information acquired in the course of my examination or treatment to my insurance company for the purpose of processing claims for medical services. I understand that regardless of my insurance status, I am solely responsible for payment of any services rendered to me, or on my behalf, whether or not paid by my insurance company.**

**Patient/Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_**

## **WELCOME TO OUR PRACTICE!**

Your appointment has been scheduled with one of our providers. We are pleased that you have selected our clinic as your healthcare provider. Please complete the enclosed forms with your signature where indicated and return them on your appointment day.

**APPOINTMENTS:** Your initial visit with the provider will consist of routine checking of your vital signs, weight, etc. and complete discussion of your medical history, medications you are taking, and health issues you may currently be experiencing. An actual “physical examination” will be scheduled for 1-2 weeks later with appropriate time allowed to focus on the actual examination by request. If you are sick, and seen on an urgent, work-in basis, only your acute problem will be addressed. You will need to schedule another appointment for any other medical questions or issues you may have. If your provider schedules lab work or x-rays for you, we will call you advising you of the results or requesting that you return to the office to discuss the results directly with the provider.

**INSURANCE:** Our office participates in most insurance plans. If you are unsure about your insurance coverage, please call your insurance provider for clarification. Remember that your health coverage is a contract between you and your insurance company. We will assist you in getting full benefits from your insurance carrier. **Your co-payment will be collected at the time of the visit.** If you accrue an unpaid balance with no effort to pay, you will be denied medical treatment from our office. We accept cash, checks (payable to Quick Care), Master Card, Visa, American Express, Money Orders and debit cards.

**BILLING:** Payment is expected at the time of service. If you do not have insurance coverage, please discuss financial options with the office staff prior to your visit. As a courtesy, if we accept your insurance, a statement will not be issued until after your insurance carrier has paid your allotted benefits. If your insurance carrier reimbursement is delinquent for 90 days, you may be asked to contact your insurance carrier. Please remember that any balance not covered by your insurance company is your responsibility.

**MEDICATIONS:** In order to maintain a harmonious flow within the office, we ask that you always ask for and obtain your medication refills at your visit with the physician. If you call for refills, always allow at least 3 business days for your medication to be sent to your pharmacy of choice.

**HOURS:** Our normal business hours are Monday through Friday, 8:00 a.m. until 5:00 p.m. Our office telephone number is **256-964-8338 Madison Location and 256-517-8317 for the Huntsville Location.** Please feel free to contact us with any questions or problems.

## **PATIENT RIGHTS**

**Welcome to Quick Care.** Our goal is to make your hospital stay as pleasant as possible. We want to ensure that each patient at our clinic receives information regarding patient rights. We are committed to provide a standard of care that ensures our patients are safe from accidental injury. These rights are stated to publish our commitment that each patient will receive the best possible care that we can offer.

**As a patient at Quick Care your rights include the following:**

- The right of access to treatment regardless of race, age, creed, sex or national origin in a safe setting, free from abuse or harassment.
- The right to reasonable access to care and acceptance for treatment within the clinic's capacity or referral to another facility when medically appropriate.
- The right to care that is considerate and respectful of your personal values, culture and beliefs.
- The right to personal privacy and confidentiality of your personal health
- The right to appropriate assessment and management of pain.
- The right to access information contained in your clinical record within a reasonable time frame.
- The right to participate in decisions regarding your care, to be involved in planning your care and treatment, and to receive information necessary to give informed consent.
- The right to accept medical care and refuse medical treatment, as permitted by law, and to be informed of the medical consequences if refused.
- The right to formulate an Advance Directive, such as a Living Will. Information will be provided to you upon your request.
- The right to legally designate a representative decision maker in the event you are incapable of understanding a proposed treatment or procedure or are unable to communicate your wishes regarding your care and to have effective communication.
- The right to receive an itemized, detailed explanation of your bill for services and explanation of benefits paid by insurance.
- The right to voice complaints concerning the quality of care you receive without fear of reprisal, to have those complaints reviewed, according to our Patient Grievance Resolution Policy, and, when possible, resolved.

**PATIENT RESPONSIBILITIES**

As a patient of Quick Care, your responsibilities include:

- To provide, to the best of your knowledge, complete and accurate information about your present condition, past illnesses, hospitalizations, medications, and other matters relating to your health.
- To report unexpected changes in your condition.
- To follow instructions and adhere to your plan of care.
- To review all educational materials given to you.
- To report the presence of pain to your physicians and nurses.
- To ask appropriate questions when you don't understand.
- To cooperate with nurses, physicians, and others who participate in administering your care.
- To recognize that your own behavior and actions influence treatment outcomes.
- To recognize that other patients and clinic personnel also have rights.
- To act with consideration and respect toward other patients and clinic personnel.

# HIPAA Notice of Privacy Practices

Quick Care

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

**1. Uses and Disclosures of Protected Health Information**

**Uses and Disclosures of Protected Health Information**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to

pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.**

**You may revoke this authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

#### 1. Patient Copy

##### **Your Rights**

Following is a statement of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

**You may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

**Complaints**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

## Quick Care Primary Care

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_



### **Inclement Weather Policy**

In the event of inclement weather, please call our office to confirm if we are open or closed.

### **Appointment No-Show Policy**

It is the policy of Quick Care to monitor and manage appointment no shows. Any patient who fails to arrive for a scheduled appointment without canceling the appointment less than twenty-four (24) hours prior to the scheduled time is considered a "no show." The first time a patient is a no show; they will be reminded of the no-show policy with a letter. Once the patient has been a no show for the second time, the no-show fee will be charged and another letter will be sent. The no-show patient fee is \$25.00, as set by Quick Care, for failure to show. A patient who consistently fails to present themselves more than five (5) times can be dismissed from Quick Care.

\_\_\_\_\_ **Please initial here**

### **Medication Refill Policy**

**It is the responsibility of each patient to bring all of their medications, in the original bottles, to each visit.** Lists of medicines are not acceptable due to possible error and lack of information.

It is imperative to notify the nurse if there is a need for any refills at the time of each visit. Calling at a later time for refills may cause a delay in receiving your medications.

Please allow at least 3 business days for medication refills that are requested by call in.

\_\_\_\_\_ **Please initial here**

### **Forms Requests**

**There will be a \$25.00 charge for certain forms that require that require the provider to complete. Please allow 5-7 business days to complete.**

---

**Patient's Signature Date**

DUE TO THE PRIVACY CONFIDENTIAL ACT, please list the people that you approve to have access to your information as stated below:

**BILLING INFORMATION:** \_\_\_\_\_ Relationship\_\_\_\_\_

\_\_\_\_\_ Relationship\_\_\_\_\_ **MEDICAL**

**INFORMATION:** \_\_\_\_\_ Relationship\_\_\_\_\_

\_\_\_\_\_ Relationship\_\_\_\_\_

**AUTHORIZATION TO LEAVE MESSAGES:**

I hereby authorize Quick Care staff to leave messages regarding my medical condition, such as lab reports, other test results, medications, and appointment reminders on my home answering machine. This authorization will be in effect until I have given written notice to Quick Care.

Check one of the following:

Agree \_\_\_\_\_ Disagree \_\_\_\_\_

We are required by law to maintain the privacy of, and provide individuals with a notice of our legal duties and privacy practices with respect to protected health information.

Signature below is acknowledgement that you have received this Notice of our Privacy Practices and agree to all information listed above.

Print the Patient's Name: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_

\_\_\_\_\_  
Signature of patient or patient's representative Date

## Quick Care

Name \_\_\_\_\_

## Patient Health Assessment

Telephone \_\_\_\_\_

Please use ink pen and fill in all applicable areas. If you have any questions, please discuss with doctor or nurse at your initial visit

Date of Birth \_\_\_\_\_

### Indicate special communication needs of which we should be aware

- Vision  Speech  Learning Disability  Mental Retardation  
 Hearing  Language

**Recent Immunizations** Indicate whether or not you have received the following immunizations. If yes, indicate approximate year received.

Yes No

- Hepatitis A \_\_\_\_\_  
  Flu \_\_\_\_\_  
  Hepatitis B \_\_\_\_\_  
  Chicken Pox \_\_\_\_\_  
  Pneumonia \_\_\_\_\_  
  TB Skin Testing \_\_\_\_\_  
  Tetanus \_\_\_\_\_  
  Other \_\_\_\_\_

**Alternative Medicine** Indicate whether or not you use any of the following.

Yes No

- Chiropractic \_\_\_\_\_  
  Acupuncture \_\_\_\_\_  
  Massage Therapy \_\_\_\_\_  
  Other \_\_\_\_\_

### Nutrition

Yes No

- Do you follow any special diet (diabetic, low protein, low sodium, low fat)? If yes, specify:

- Do you have any other nutrition needs (food preferences, food intolerance, texture modification)?

If yes, explain: \_\_\_\_\_

### Life Habits

Yes No

- Do you live alone? If no, with whom do you live? \_\_\_\_\_  
  Have you ever used nicotine? (Circle Cigarettes, pipe, cigar) How much per day? \_\_\_\_\_ For how many years? \_\_\_\_\_  
  Do you currently use nicotine? If yes, what do you use? (Circle Cigarettes, pipe, cigar, smokeless tobacco, nicotine gum/patch?) How much per day? \_\_\_\_\_ For how many years? \_\_\_\_\_  
  Are you regularly exposed to secondhand smoke?  
  Do you currently use alcohol? If yes, how much per day? \_\_\_\_\_ How often? \_\_\_\_\_ Past use? \_\_\_\_\_  
Do you currently use any illicit drugs? If yes, what? \_\_\_\_\_ How often? \_\_\_\_\_ Past use? \_\_\_\_\_  
  Are you currently exposed to occupational hazards?  
If yes, what kind? \_\_\_\_\_  
  Do you have problems sleeping?  
If yes, explain \_\_\_\_\_  
  Will you need help in planning for your care? \_\_\_\_\_  
  Do you walk independently? If not, explain \_\_\_\_\_  
  Do you need help with feeding dressing bathing toileting  
If yes, explain \_\_\_\_\_

**Domestic Violence**

Yes No

- Are you being abused, injured or frightened by anyone at home or in another area of your life?

**Beliefs, Rights, and Values**

Yes No

- Do you have ethnic, religious, spiritual or cultural practices that need to be part of your care?
- 
- Do you have financial concerns related to your medical care? Circle those that apply: job insurance other
- Do you have children? How many? Adult \_\_\_\_\_ Minor \_\_\_\_\_
- Do you have a guardian? If yes, whom? \_\_\_\_\_
- Do you have an Advance Directive (e.g. living will or durable medical power of attorney)? If yes, bring a copy with you to the office upon your admission. If not, information is available upon request.
- Are you an organ/tissue donor?

## Quick Care Primary Care PAST MEDICAL HISTORY FORM

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Check the box if the condition pertains to you and write comments if necessary.

### Respiratory

Comment \_\_\_\_\_

- Asthma \_\_\_\_\_
- COPD \_\_\_\_\_
- Emphysema \_\_\_\_\_
- Sinus problems \_\_\_\_\_
- Sleep Apnea \_\_\_\_\_
- TB \_\_\_\_\_
- Other \_\_\_\_\_

### Gastrointestinal

- Constipation \_\_\_\_\_
- Diarrhea \_\_\_\_\_
- Diverticulosis \_\_\_\_\_
- GERD \_\_\_\_\_
- Heartburn \_\_\_\_\_
- Hepatitis \_\_\_\_\_
- Hiatal hernia \_\_\_\_\_
- Jaundice \_\_\_\_\_
- Other \_\_\_\_\_

### Genitourinary

Comment \_\_\_\_\_

- Kidney Disease \_\_\_\_\_
- Kidney Stone \_\_\_\_\_
- Prostate Disease \_\_\_\_\_
- UTI \_\_\_\_\_
- Other \_\_\_\_\_

### Other Conditions

Comment \_\_\_\_\_

- Anxiety \_\_\_\_\_
- AIDS/HIV \_\_\_\_\_
- Cancer \_\_\_\_\_
- Cataracts \_\_\_\_\_
- Depression \_\_\_\_\_
- Diabetes \_\_\_\_\_
- Eye Problems \_\_\_\_\_
- Glaucoma \_\_\_\_\_
- Hearing Problems \_\_\_\_\_
- Peripheral Artery Dz \_\_\_\_\_
- Rheumatic Fever \_\_\_\_\_
- STD \_\_\_\_\_
- Thyroid Disease \_\_\_\_\_
- Other \_\_\_\_\_

### Neurological

Comment \_\_\_\_\_

- Dementia \_\_\_\_\_
- Fibromyalgia \_\_\_\_\_
- Osteoarthritis \_\_\_\_\_
- Osteopenia \_\_\_\_\_
- Osteoporosis \_\_\_\_\_
- Other \_\_\_\_\_

### Musculoskeletal Previous Surgeries Comment

- Arthritis \_\_\_\_\_ **Date Reason** \_\_\_\_\_
- Chronic Headaches \_\_\_\_\_
- Faint/Dizziness \_\_\_\_\_
- Migraines \_\_\_\_\_
- Numbness/Weakness \_\_\_\_\_
- Seizures \_\_\_\_\_
- Stroke \_\_\_\_\_
- Other \_\_\_\_\_

### Cardiovascular

Comment \_\_\_\_\_

- Anemia \_\_\_\_\_
- Angina \_\_\_\_\_
- Heart Dz \_\_\_\_\_
- CHF \_\_\_\_\_
- Heart Attack \_\_\_\_\_
- High Blood Pressure \_\_\_\_\_
- High Cholesterol \_\_\_\_\_
- Pacemaker \_\_\_\_\_
- Valve Problem \_\_\_\_\_
- Other \_\_\_\_\_ Are there any other medical conditions not listed above? Please list them on back of form.

**Patient's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Family History (Complete Health Information about your family)**

<b>Disease</b>	<b>Family Member (Circle one)</b>
Alzheimer's / Dementia	Father Mother Sibling Grandparent Other: _____
Asthma, Hay Fever	Father Mother Sibling Grandparent Other: _____
Cancer, Type: _____	Father Mother Sibling Grandparent Other: _____
Cataracts	Father Mother Sibling Grandparent Other: _____
CHF	Father Mother Sibling Grandparent Other: _____
CVA / Stroke	Father Mother Sibling Grandparent Other: _____
COPD	Father Mother Sibling Grandparent Other: _____
Diabetes	Father Mother Sibling Grandparent Other: _____
GI Problems	Father Mother Sibling Grandparent Other: _____
Glaucoma	Father Mother Sibling Grandparent Other: _____
Heart Attack	Father Mother Sibling Grandparent Other: _____
Heart Bypass	Father Mother Sibling Grandparent Other: _____
Heart Disease	Father Mother Sibling Grandparent Other: _____
Heart Stent	Father Mother Sibling Grandparent Other: _____
Hyperlipidemia	Father Mother Sibling Grandparent Other: _____
Hypertension	Father Mother Sibling Grandparent Other: _____
Kidney Problems	Father Mother Sibling Grandparent Other: _____
Seizures	Father Mother Sibling Grandparent Other: _____
Thyroid Disease	Father Mother Sibling Grandparent Other: _____
Other: _____	Father Mother Sibling Grandparent Other: _____
Other: _____	Father Mother Sibling Grandparent Other: _____

