Local Government Employees Health Clinic

1963 Memorial Parkway – Suite 9B, Huntsville AL,35801

Madison County Commission

Today's Date: _____

Name: _____ DOB: _____

SS# (Required): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell# _____ Alternate#: _____ ____

Email: _____

Marital Status: Single Married Separated Divorced Widowed Other

Assignment of Benefits, Agreement, & Guaranty:

LGEHC will only accept and process BCBS insurance through Madison County Employees covered by Madison County insurance as their primary insurance carrier. Any other carrier as primary or beyond will not be accepted at the clinic: LGEHC being out-of–network will not bill any insurance carrier and will require your permission to waive your right to have any other insurance coverage benefits for services received at clinic.

Madison County Insurance and any other carrier being out-of-network for LGEHC will require:

1) You to waive your right to have coverage benefits by any other carrier except BCBS through Madison County Commission.
2) Based on this waiver of coverage – we will require a $15 copay in support of your patient liability for your primary BCBS insurance through Madison County Commission.

Signature of Patient/Guardian _____ _____

LOCAL GOVERNMENT EMPLOYEE HEALTH CLINIC

1963 MEMORIAL PARKWAY, SUITE 9B • HUNTSVILLE, AL 35801 • 256-265-0220

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name _____ SS Number (Optional) _____

Date of Birth _____ Address _____

Phone Number (____) _____ Date(s) of Service _____

Chart Number _____
Provider _____

I authorize the use or disclosure of the above named individual's health information as described below:

1. Local Government Employees Health Clinic is authorized to make the disclosure.

2. **The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)**

- ☐ All /Entire Record
- ☐ Visit/Encounter Notes
- ☐ Laboratory Results
- ☐ X-Ray and Imaging Reports
- ☐ Problem list
- ☐ Medication List
- ☐ Allergies List
- ☐ EKG Report
- ☐ Pathology Report
- ☐ Consultation Report
- ☐ Operative Report
- ☐ Immunization Record
- ☐ Drug and Alcohol Treatment
- ☐ HIV/AIDS/STD Treatment
- ☐ Registration Record
- ☐ Other _____

☐ **Records Release Format (Choose one)**
- ☐ **e-delivery (HealthPort Connect)**
- ☐ **CD**
- ☐ **Paper**

3. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

4. **This information may be disclosed to, and used by, the following individual or organization:** (emergency contact)

Name: _____ Phone #: _____

Address: _____

5. relationship: _____

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Record Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

7. **Unless otherwise revoked, the authorization will expire on the following date, event, or condition:** Put "Lifetime" to keep from expiring.

If I fail to specify an expiration date, event or condition, this authorization will expire in six months from the date of signing.

8. I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.

9. I understand that as the recipient, I am responsible for the security of these medical record copies and the health information contained therein, whether in paper format or on CD/DVD.

10. I understand that I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits.

Or

I understand that if I refuse to sign this form, under specific conditions the organization can refuse:
Treatment Enrollment in the health plan Eligibility for benefits

_____ _____ _____
SIGNATURE DATE TIME

_____ _____ _____ _____
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT SIGNATURE OF WITNESS DATE TIME

For Office Use Only

Any portion of the record request found in paper chart? YES NO (Please circle one)

HH System Clinics Registration Update Sheet

Patient: _____ Date of Birth: _____ Fin #_____

----------AUTHORIZATION TO CALL---------

I authorize HH System Clinics to leave the following messages on my answering machine/voicemail:

_____ Reminder appointments calls

_____ Lab and/or Test results

----------HH SYSTEM CLINICS ADVANCE DIRECTIVE POLICY---------

In our practices we have decided that we will initiate resuscitative measures anytime they are needed.

----------FINANCIAL FEES AND ASSISTANCE---------

FINANCIAL FEES: I understand the following fee will be charged:

- A fee of $25 per form for completion of comprehensive forms. A fee will NOT be assessed for simple forms such as Work Excuse, School Excuse or application for Indigent Assistance for Medications.

FINANCIAL ASSISTANCE: I understand that financial assistance may be available for individual patients who are uninsured or who otherwise meet financial aid criteria. The hospital's overall ability to remain financially stable and provide essential health care services to all members of our community is dependent upon financial resources available to cover services provided to patients. My assistance in providing such information is necessary to determine possible financial aid available to me. If I am uninsured and need financial assistance, I may contact a Financial Counselor and make a request to see if I qualify at 256-265-9438.

----------AUTHORIZATION OF TREATMENT---------

I hereby consent and authorize my physician and/or Allied Health professional to render usual and customary medical/emergency treatment that they deem advisable and necessary. I also authorize HH System Clinics to electronically request my medication history if my pharmacy participates in electronic prescribing in order to assist the provider in prescribing necessary medication therapy.

----------ASSIGNMENT OF BENEFITS, AGREEMENT AND GUARANTY ----------

I authorize HH System Clinics to release any information regarding services rendered to me to third party payers in consideration of payment for my care or to other healthcare providers involved in my care. I understand payment of all insurance benefits, basic and major medical for this period of service must be made directly to HH System Clinics. If the check must be made out to me, I understand the check must be sent to this address: PN Billing P.O. Box 2705 Huntsville, AL 35804. I understand the HH System Clinics must collect for all charges not covered by insurance payments. Payment for all collection costs, securing, or attempting to collect and secure including reasonable attorney fees or Collection Agency fees, whether suit be necessary or otherwise is the financial responsibility of the patient and guardian. Patients who are considered a legal adult are financially responsible for all services rendered.

----------HH HEALTH SYSTEM NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT----------

I acknowledge that a copy of the Notice of Privacy Practices for HH Health System has been made available to me. In connection with the Notice, I also acknowledge that I have been provided with an opportunity to ask questions regarding the Notice and its contents. I understand that the most current version of the Notice will be posted with the Health System and on www.huntsvillehospital.org.

----------EXPRESS PERMISSION TO CONTACT PATIENT BY CELL PHONE----------

I agree in order for HH System Clinic to service my account or to collect monies I owe, HH System Clinics and/or our agents may contact me by any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. HH System Clinics may also contact me by sending text messages or emails, using any email address I provided. Methods of contact may include pre-recorded/artificial voice messages and/or use of automatic dialing devices, as applicable. I have read this disclosure and agree that HH System Clinics, its employees, and/or agents may contact me as described.

Patient: _____ Date of Birth: _____ Fin #_____

Name: _____

Date of Birth: _____

Huntsville Hospital System

Race and Ethnicity

This classification provides a minimum standard for maintaining, collecting and presenting data on race and ethnicity for all Federal reporting purposes. This is not to be used as determinants of eligibility for participation in any Federal Program.

Race: (select one or more)

_____ White (not of Hispanic origin) : All persons having origins in any of the original peoples of Europe, North Africa, or the Middle East.

_____ Black (not or Hispanic origin) : All persons having origins in any of the Black racial groups of Africa.

_____ Hispanic: All persons of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.

_____ Asian or Pacific Islander : All persons having origins in any of the original peoples of the Far East, Southeast Asia, the Indian Subcontinent, or the Pacific Islands. This area includes, for example, China, India, Japan, Korea, the Philippine Islands, and Samoa.

_____ American Indian or Alaskan Native: All persons having origins in any of the original peoples of North America, and who maintain cultural identification through tribal affiliation or community recognition.

_____Declined

Ethnicity: (select one)

_____ Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin, regardless of race. The term "Spanish origin" can be in addition to "Hispanic or Latino."

_____ Non-Hispanic or Latino

_____ Declined

Preferred Language: _____

Signature:_____

Date: _____

LGEHC (CONTINUED)

Name: _____ **DOB:** _____

Preferred Pharmacy: _____

Medications List: (how often/dosage)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Medication Allergies/Other Allergies:

_____

_____

_____

_____

_____

LGEHC (CONTINUED)

Name: _____ **DOB:** _____

Family History (Please Circle):

CHILDREN	FATHER	MOTHER	GRANDFATHER	GRANDMOTHER
HIGH BP	YES	YES	YES	YES
HEART DISEASE	YES	YES	YES	YES
HEART ATTACK	YES	YES	YES	YES
KIDNEY DISEASE	YES	YES	YES	YES
DIABETES	YES	YES	YES	YES
STROKE	YES	YES	YES	YES
ASTHMA	YES	YES	YES	YES
ARTHRITIS	YES	YES	YES	YES
THYROID DISORDER	YES	YES	YES	YES
CANCER	YES	YES	YES	YES

IF YES, TYPE:_____

OTHER:_____

NONE ☐

LGEHC (CONTINUED)

Name: _____ **DOB:** _____

Social History (Please Circle)

(CIRCLE APPROPRIATE)

TOBACCO USER? YES /NO YEARS: _____

(CIRCLE) CIGARETTES/CIGARS/VAPE

FORMER TOBACCO USER? YES/NO QUIT DATE: _____

COUNSELED TO QUIT OR CUT DOWN? YES/NO

PASSIVE SMOKER? YES/NO

NONSMOKER

CAFFEINE USE IF YES, HOW MANY PER DAY? _____

ALCOHOL USE IF YES, HOW MANY PER DAY? _____

EXERCISE TIMES PER WEEK _____

EXERCISE TYPE _____

REVIEW OF SYMPTOMS

ARE YOU CURRENTLY HAVING PROBLEMS? YES/NO

IF SO, PLEASE LIST BELOW

_____

_____

_____

_____

LGEHC (CONTINUED)

Past Surgical History (Please Circle):

AV GRAFT

AORTIC VALVE REPLACEMENT

APPENDECTOMY

BILATERAL LEG BYPASS

BACK SURGERY

BREAST SURGERY

BRONCHOSCOPY (LUNG SCOPE)

CABG (HEART BYPASS)

GALLBLADDER REMOVAL

CRANIOTOMY

GASTRIC BYPASS

HEMORRHOIDECTOMY

HIP REPLACEMENT

INVASIVE PAIN PROCEDURE

KIDNEY TRANSPLANT

KNEE ARTHROSCOPY

KNEE REPLACEMENT

KNEE SURGERY

MASTECTOMY

MITRAL VALVE REPLACEMENT

NEPHRECTOMY

PACEMAKER IMPLANT

PARATHYROIDECTOMY

PNEWMONECTOMY

PTCA (ANGIOPLASTY)

ROTATOR CUFF REPAIR

SLEEP APNEA SURGERY

THYROID SURGERY

TONSIL REMOVAL

VASCULAR SURGERY

ANESTHESIA PROBLEMS: YES OR NO

SURGICAL COMPLICATIONS: YES OR NO

POST-OP COMPLICATIONS: YES OR NO

LAST COLONOSCOPY DATE: _____

LAST MAMMOGRAM DATE: _____

LAST MENTRUAL PERIOD DATE: _____

LAST PAP SMEAR DATE: _____

LAST BONE DENSITY SCAN DATE: _____

FLU VACCINE DATE: _____

TETANUS VACCINE DATE: _____

PNEUMONIA VACCINE DATE: _____

LGEHC (CONTINUED)

Name: _____ **DOB:**_____

Past/Current Medical History: (Please Circle)

ASTHMA	CHROHN'S DISEASE	HEPATITIS A/B/C
ATRIAL FIBRILLATION	CHRONIC RENAL FAILURE	INFERTITLITY
ANEMIA	DEPRESSION	KIDNEY DISEASE
ANXIETY	DIABETES TYPE 1	KIDNEY STONES
AUTOIMMUNE DISEASE (LUPUS)	DIABETES TYPE 2	LIVER DISEASE
BRAIN TUMOR/MASS	DVT (BLOOD CLOT IN LEGS)	MI (HEART ATTACK)
CIRRHOSIS	GI BLEED	NEUROLOGICAL DISORDER
CVA (STROKE)	GERD (ACID REFLUX)	OSTEOARTHRITIS
COPD	HEMOCHROMATOSIS	OSTEOPOROSIS
COLON CANCER	HYPERTENSION (BP)	PVD/PUD (STOMACH ULCERS)
CORONARY HEART DISEASE	HIGH CHOLESTEROL	RHEUMATOID ARTHRITIS
SEIZURE DISORDER	THYROID DISORDER	TUBERCULOSIS
VALVULAR HEART DISEASE	RECURRENT UTI	VARICOSE VEINS/PHLEITIS
ABNORMAL PAP SMEAR	BREAST CANCER	OVARIAN CYST/CANCER
GESTATIONAL DIABETES	DES EXPOSURE	RH SENSITIZED

NONE ☐

OTHER (PLEASE EXPLAIN): _____