Caton Family Physician Care, PC
8121 Madison Blvd Suite 101-A Madison, AL 35758-2080
Phone 256-325-0041 Fax 833-913-2404

New Patient Registration

Patient Info:

First Name: _____ MI_____ Last Name:_____
Address: _____City: _____ State:_____ Zip Code:_____
Home Phone: _____Cell Phone: _____ Work Phone: _____
DOB: ____/____/_____ Gender: M or F SSN: _____-_____-_____ Race: _____
Hispanic? Yes or No Primary Language: _____Marital Status: _____
Email: _____
Employers Name: _____Phone #_____

Name of Emergency Contact
Name: _____ Relationship: _____
Phone Number: _____

Insurance Information:
Primary Insurance Company: _____ Address: _____
Policy / Contract Number: _____Group Number: _____
Name of Policy Holder: _____ Relationship: _____

Secondary Insurance Company: _____Address: _____
Policy / Contract Number: _____ Group Number: _____
Name of Policy Holder: _____ Relationship: _____

Assignments of benefits and/or guarantee of account: I hereby authorize payment directly to Caton Family Physician Care for the benefits payable under the terms of my policy for my illness. I understand that I am financially responsible for charges not covered by my insurance, including ALL collection costs and reasonable attorney's fees.

Date: ____/_____/_____ Signature:_____

PAYMENT IS DUE AT THE TIME OF SERVICE

YOUR RIGHT TO PRIVACY

We at Caton Family Physician Care respect your right to privacy. Therefore, our physicians and staff will only access and use your PHI (Protected Health Information) for the following PTO (Treatment, Payment, and Healthcare operations):

1. To provide your care here in our office
2. To collect payment from your insurance company
3. To assist your pharmacy in filling your prescriptions
4. To coordinate your care with your other physicians, past or present. It is important that your care be coordinated with all your doctors.
5. When a minor reaches the age of fourteen, we can no longer discuss the child's private medical information with a parent without the child's present or written consent. The exceptions are as follows: if a minor seeks medical treatment and wishes to use the parent's insurance policy, it is the policy holder's right to know what their insurance company has been billed for.

- All other releases of your PHI (Protected Health Information) will only be with your permission, authorized with a signature from you. THIS INCLUDES YOUR IMMEDIATE FAMILY UNLESS OTHERWISE DESIGNATED BELOW!! In the event of an emergency, we will contact your designated emergency contact.
- You have the right to review or request copies of your records at any time. We request that you give us 48-hour notice to accommodate your request.

I give permission for information to be left on my answering machine/voicemail at the following number: _____-_____-_____

I authorize the staff of Caton Family Physician Care to discuss my care with the following people:

Name: _____ Relationship: _____ Phone number: _____

Name: _____ Relationship: _____ Phone number: _____

I understand and consent to the use of my PHI (Protected Health Information) for the above purposes.

Printed Name:_____ Signature: _____ Date: _____

Information and Policies

In order to make your transition to our practice as simple as possible, below are some policies that you will need to read and sign. We look forward to serving you as our patient!

1. Office Hours are from 8:00 am to 5:00 pm Monday through Thursday & 8:00 am to 12:00 pm on Fridays. During the week we will be available to you 24 hours a day. After-hour calls are for emergencies only. In the event of an emergency, call our office number and our answering service will contact the physician on call**.** **Initial: _____**
2. Controlled Substances: Because we do not provide care for chronic pain management with controlled substances, such as narcotics, any chronic pain needs or other medical conditions requiring long-term controlled substances will be referred to chronic pain management who can offer the best care for you. **Initial: _____**
3. Prescriptions request REQUIRE 24-hour notice. Antibiotics will not be called in under any circumstances without first seeing the doctor. Any routine medication refills will be called in during regular office hours only so that we can have your medical records available. Please bring all your medications to your visit and request refills at the time **Initial: _____**
4. We prefer good quality preventive medicine to emergency-only care. This is better medical care for you and your family. Please make an effort to establish with your caregiver a standard routine for medical care appropriate for your age and medical history. We are familiar with up-to-date standards for good health care for you. We also prefer to see you in the office instead of providing care via phone or portal. **Initial: _____**
5. YOUR INSURANCE WILL BE FILED FOR YOU AS A COURTESY. Please be familiar with the terms and policies of your insurance plan. If you have a deductible, which has not been met, or your insurance deems your visit as a non-covered service (even with BCBS), you will be responsible for the balance. THE TERMS OF YOUR INSURANCE POLICY ARE BETWEEN YOU AND YOUR INSURANCE COMPANY. All copayments are due at the time of service. Collection fees will be charged if your account is turned over to our collection agency. In the case of divorced parents, the primary caregiver will be responsible for any copayments or balances covered by insurance unless legal documentation is provided showing otherwise. **Initial: _____**
6. There will be a $20.00 charge on all returned checks. If you miss an appointment without notifying the office staff at least 24 hours prior to your appointment, a $25.00 fee will be charged to your account. If you arrive more than 15 minutes late for your appointment, you may be asked to reschedule in order to be fair to other patients who arrive on time. In the same regard, we make our best effort to see our patients at the time of their appointment, but in the event of unforeseen medical situations, please understand that if we are running behind, you will receive your physician's best care as soon as possible. We appreciate your patience. **Initial: _____**
7. All patients will need to bring a current driver's license or photo ID and an updated insurance card. If you do not bring your insurance card you will be expected to pay in full. **Initial: _____**
8. Health Forms: We understand that health forms are required by many agencies, and we will be happy to fill these out during your appointment free of charge if it does not delay the care of other patients. Lengthy forms may have to be completed and picked up later. Any form completion requested outside of an office visit will be subject to a $25 charge. **Initial: _____**

Dismissal: We sincerely hope that we never have to part ways with a patient. However, some extreme circumstances may make this necessary. If this occurs, you will be notified by certified mail. You will have 30 days to find another doctor. During those 30 days, we will continue to offer only urgent care. **Initial: _____**

Having read the above, I agree to abide by the policies set by Caton Family Physician care, PC, and the staff. I realize that all charges incurred by me, and my dependents, are my financial responsibility and all court fees, attorney's fees, or other fees necessary to collect any past due balances are my responsibility. Failure to follow these policies could result in my immediate dismissal as a patient. I have signed these policies of my own free will and in my right mind.

Patient Name: _____ Patient Signature: _____Date: _____

HIPPA COMPLAINT AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Patient Name: _____DOB: ____/____/_____

Address: _____ City, State & Zip Code: _____

Social Security Number: _____/_____/_____ Phone Number: _____-_____-_____

I, _____ authorize _____

Name of Patient or Name of Legal Representative Name of Organization / Provider to Release Information

to release information concerning the patient identified above, in accordance with state and federal laws, to the following: _____

Address: _____ Phone Number: _____Fax Number: _____

1. Specific information to be disclosed (mark all that apply)

____ Discharge summary ____ Psychological Evaluations ____ Progress Notes ___ History and Physical Examination

____ Lab Reports ____ Radiology Reports _____ Consultation Reports ___ EKG / Stress Test

____ ER Records ____ Home health ____ Other _____

For the following date(s) of treatment or medical conditions: _____

2. With the exception of psychotherapy notes, I authorize all information that may be contained in my medical records pertaining to psychiatric/ mental health, chemical dependence, and or AIDS/HIV-related illness/testing to be released unless otherwise specified here: _____
3. I am requesting this information be released for one of the following purposes:
    a. Continued Care
    b. Insurance Claim
    c. Personal use
    d. Attorney Review
4. I understand I may revoke this authorization by written request at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization
5. I understand there may be a fee to process this information
6. This authorization will automatically expire one year from the date of my signature
7. Caton Family Physician Care, PC will not condition my continued treatment upon me signing this authorization, except for research–related treatment.
8. I understand that once my health information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure or release public Act 258 in which case it cannot be re-disclosed by the receiving party without my written authorization.
9. I hereby agree to indemnify and hold Caton Family Physician Care, PC, their employees, and agents free and harmless any actions against them for alleged invasion of privacy, libel or slander, or defamation arising from or related to disclosure of such information.

_____ _____

Patient or Patient's Legal representative's Signature Date

_____ _____

"Relationship if other than patient" Witness

REASON PATIENT IS UNABLE TO SIGN ___ Minor ___ Deceased ____ Other: _____

___ Authority Attached (If non-emergency situations documentation of authority must be attached if anyone other than the patient signs the authorization)

Name: **DOB:**

Reason for today's visit? _____

Drug Allergies: (please list the reaction to the medication)

_____

_____

Pharmacy:_____

Medication Name:	**Instructions:**	**MG / Dose:**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

<u>Social History:</u> Circle the following

Exercise Level:	**None**	**Occasional**	**Moderate**	**Heavy**
Alcohol Level:	**None**	**Occasional**	**Moderate**	**Heavy**
Caffeine Level:	**None**	**Occasional**	**Moderate**	**Heavy**

Tobacco: Cigarettes, Vape, or Chewing Tobacco?
Never
Former? How many packs per year? _____ **Quit Date:** _____
Current? Tobacco Years? _____**Year Started:** _____ **Age:** _____

Illicit / Recreational Drugs? Yes / No? If yes, what drug? _____

Marital Status: _____ **Sexual Orientation:** _____
Occupation: _____ **Education Level:** _____

Family History: Please list major medical problems below.

- **Mother: _____**
- **Father: _____**
- **Sister: _____**
- **Brother: _____**
- **Grandparents (please state maternal or paternal) _____**
- **Other: _____**

Surgical History: List all surgeries that you have had and include dates, if possible.

_____

_____

Health Maintenance:

Previous Primary Care Provider: _____

(Please List Dates Below)

Immunizations / Vaccines

COVID: _____/_____/_____ _____/_____/_____ _____/_____/_____
(Pfizer, Moderna or J&J)
Flu Vaccine: _____/_____/_____
Pneumonia: _____/_____/_____
Shingles: _____/_____/_____ _____/_____/_____
Tetanus: _____/_____/_____

Last Lab work: _____/_____/_____ Fasting today? _____
Last Physical: _____/_____/_____
Last Colonoscopy: _____/_____/_____ Repeat due: _____
Last Eye Exam: _____/_____/_____

MALE:
Last PSA _____/_____/_____

FEMALE:
Last Mammogram _____/_____/_____ Where was it completed? _____
Last Pap Smear _____/_____/_____ GYN? _____
Last Bone Density_____/_____/_____ Where was it completed? _____
Last Menstrual Period _____/_____/_____ Type of birth control: _____

Specialist:
Providers Name: Specialty:
_____
_____
_____

Past Medical History: (Please circle)

ADD/ADHD
Allergies
Anemia
Anxiety
Arthritis
Asthma
Bladder or Kidney problems
Blood Disease
Blood Transfusion
Breast Cancer
Breast Problems
COPD
Cancer
Chicken Pox
Chronic Ear Infections
Congestive Heart Failure
Constipation
Depression
Diabetes
Difficulty Swallowing
Diverticulitis
Eating Disorder
Eczema
Endometriosis
Fibromyalgia
GI Problems
Gout
Headache
Heart Disease
Heart Problems
High Cholesterol
High Blood Pressure
Liver Disease
Mental Disorder
Osteoporosis
Polyps
Pulmonary Embolism
Reflux / GERD
Seizures
Skin Problems
Thyroid Problems
Vision or Eye Problems