

# Capshaw Family Care

15024 East Limestone Road Suite F

Harvest, AL 35749

Phone: 256-216-1996 Fax: 256-216-1940

**We are a fragrance free facility!**

## Welcome to Our Practice!

Thank you for choosing us to be your new provider. In order to schedule we will need paperwork filled out in its entirety. We are pleased that you have selected us as your health care provider.

- **Insurance:** Our office participates in most insurance plans, the only plan we cannot accept is the market place Blue Cross policy that begins with BEG. If you are unsure about your healthcare coverage, please contact your insurance provider for clarification. We will try our best to assist you in getting full benefits from your insurance carrier. Your co-payment will be collected at the time of your 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 CFC), money orders, and all major credit/debit cards.
- **Billing:** Payment is expected at the time of service. If you do not have insurance 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 issues 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 visits. If you call for refills, please allow at least 3 business days for your medication to be sent to the pharmacy of your choice.
- **Hours/Location:** Our normal business hours are Monday through Thursday, 7 AM to 4:30 PM. We are closed for lunch daily from 12 to 1. We are located at the intersection of Capshaw Road and East Limestone Road in the complex next to Dollar General and Subway.

Would you like to be added to the cancellation list? \_\_\_\_ Yes \_\_\_\_ No

Type of Insurance Coverage: \_\_\_\_\_:

**\*\*Please note we do not accept the market place BCBS policy that begins with BEG\*\***

Once we receive completed paperwork, we will give it to the provider to review and sign off on. You may drop it off at the office, fax it to us at 256-216-1940, or email it to us at [CapshawFamilyCare@alhnet.org](mailto:CapshawFamilyCare@alhnet.org). Once the provider has approved the paperwork we will schedule for the next available and mail an appointment card to the address provider on the paperwork. Thanks!

**Capshaw Family Care**

15024 E. Limestone Rd. Suite F  
Harvest, AL 35749  
P:256-216-1996 F:256-216-1940

**PATIENT INFORMATION:**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle \_\_\_\_\_  
Birth Sex: 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 \_\_\_\_\_  
Street Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Marital Status \_\_\_\_\_ SS# \_\_\_\_\_ Relationship \_\_\_\_\_

I here by authorize and direct payment to Capshaw Family 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 Capshaw Family 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 \_\_\_\_\_

Patient Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

### Patient Health Assessment

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

- |  |   |
|--|---|
| <input type="checkbox"/> Vision              | <input type="checkbox"/> Mental Retardation |
| <input type="checkbox"/> Speech              | <input type="checkbox"/> Hearing            |
| <input type="checkbox"/> Learning disability | <input type="checkbox"/> Language: _____    |

Recent Immunizations. If yes, when?

Yes	No		Yes	No	
___	___	Hepatitis A _____	___	___	Tetanus _____
___	___	Hepatitis B _____	___	___	Pneumonia _____
___	___	Flu _____	___	___	TB Skin Testing _____
___	___	Chicken Pox _____	___	___	Other _____

### General Health Questions

- | Yes | No  |   |
|-----|-----|---|
| ___ | ___ | Do you live alone? If no, with whom do you live _____   |
| ___ | ___ | Do you have children? How many? What ages? _____  |
| ___ | ___ | Do you follow any special diets? (i.e. diabetic, low protein, low fat, low sodium)<br>If yes, explain: _____  |
| ___ | ___ | Have ever you used nicotine in the past? (i.e. cigarettes, cigar, smokeless tobacco): If yes, explain: What type?<br>How much per day? For how many years? Quit Date? _____                                     |
| ___ | ___ | Do you currently use nicotine? If yes, explain:<br>What type? 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? _____   |
| ___ | ___ | 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: _____  |
| ___ | ___ | Are you being abused, injured, or frightened by anyone at home or in another area of your life? _____   |
| ___ | ___ | Do you have ethnic, religious, spiritual, or cultural practices that need to be part of Your care? If so, explain: _____  |
| ___ | ___ | Do you have an advance directive? (i.e. living will, DNR, 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 donor? _____   |
| ___ | ___ | Do you have a guardian? If yes, whom? _____   |
| ___ | ___ | Do you have financial concerns related to your medical care? Job, Insurance, or other? _____  |

Patient Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

### Past Medical History

#### Cardiovascular

- Angina \_\_\_\_\_
- AFib \_\_\_\_\_
- CHF \_\_\_\_\_
- Coronary artery Dz \_\_\_\_\_
- Heart Disease \_\_\_\_\_
- Heart Attack \_\_\_\_\_
- High Blood Pressure \_\_\_\_\_
- High Cholesterol \_\_\_\_\_
- Pacemaker \_\_\_\_\_
- Peripheral artery Dz \_\_\_\_\_
- Valve problem \_\_\_\_\_
- Other \_\_\_\_\_

#### Gastrointestinal

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

#### Genitourinary

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

#### Musculoskeletal

- Arthritis \_\_\_\_\_
- Fibromyalgia \_\_\_\_\_
- Gout \_\_\_\_\_
- Lupus \_\_\_\_\_
- Osteoarthritis \_\_\_\_\_
- Osteopenia \_\_\_\_\_
- Osteoporosis \_\_\_\_\_
- Rheumatoid Arthritis \_\_\_\_\_
- Other \_\_\_\_\_

#### Neurological

- ADD/ADHD \_\_\_\_\_
- Autism \_\_\_\_\_
- Chronic Headaches \_\_\_\_\_
- Dementia \_\_\_\_\_
- Faint/Dizziness \_\_\_\_\_
- Migraines \_\_\_\_\_
- Numbness/weakness \_\_\_\_\_
- Seizures \_\_\_\_\_
- Stroke \_\_\_\_\_
- Other \_\_\_\_\_

#### Respiratory

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

#### Other Conditions

- Anemia \_\_\_\_\_
- Anxiety \_\_\_\_\_
- AIDS/HIV \_\_\_\_\_
- Cancer \_\_\_\_\_
- Cataracts \_\_\_\_\_
- Depression \_\_\_\_\_
- Diabetes \_\_\_\_\_
- Eye problems \_\_\_\_\_
- Glaucoma \_\_\_\_\_
- Hearing problems \_\_\_\_\_
- Insomnia \_\_\_\_\_
- Rheumatic fever \_\_\_\_\_
- STD \_\_\_\_\_
- Hypothyroid/hyperthyroid \_\_\_\_\_
- Other \_\_\_\_\_
- Other \_\_\_\_\_
- Other \_\_\_\_\_
- Other \_\_\_\_\_
- Other \_\_\_\_\_

Capshaw Family Care

Patient Name: \_\_\_\_\_

Family Medicine

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

## Family History

Disease	Family Member (Circle one)				
Alzheimer's or Dementia	Father	Mother	Sibling	Grandparent	Other: _____
Asthma or 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: _____
Stroke	Father	Mother	Sibling	Grandparent	Other: _____
COPD	Father	Mother	Sibling	Grandparent	Other: _____
Diabetes type 1/type 2	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 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: _____
Hyperthyroid/Hypothyroid	Father	Mother	Sibling	Grandparent	Other: _____
Other	Father	Mother	Sibling	Grandparent	Other: _____

Capshaw Family Care

Family Medicine

Patient Name: \_\_\_\_\_

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

List ALL current medications including over the counter supplements

**IF NO MEDICATIONS ARE TAKEN PLEASE CHECK HERE**

Medication name	Strength/Dose	Frequency	Prescribed by
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List ALL allergies

**IF NO ALLERGIES, PLEASE CHECK HERE**

_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had a vaccine for any of the following? If yes, please enter the date, if possible.

FLU: \_\_\_\_\_

TETANUS: \_\_\_\_\_

**COVID:**

**PNEUMONIA:**

Name of vaccine/Date \_\_\_\_\_

PREVAR 13: \_\_\_\_\_

PREVNAR 20: \_\_\_\_\_

PNEUMOVAX 23: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Capshaw Family Care**

**Family Medicine**

Patient Name: \_\_\_\_\_

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

Please list the names of all other providers/specialists and the reason for seeing them.

Your most recent primary care provider \_\_\_\_\_

Provider Name	Reason
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list all previous surgeries and procedures.

Date	Surgery/Procedure	Reason	Doctor
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

DATE OF LAST: PAP \_\_\_\_\_ Eye Exam \_\_\_\_\_ Mammo \_\_\_\_\_  
Bone Mineral Density \_\_\_\_\_ Colonoscopy \_\_\_\_\_ PSA \_\_\_\_\_

Are you a veteran? If so, are you active or retired? **Circle one please.**

How did you hear about our office? If referred by someone, please let us know whom we can thank for recommending our office \_\_\_\_\_

Please fill out the highlighted areas on this Medical Records Release that will be faxed to your most recent Primary Care Doctor once it is returned to our office with your new patient paperwork.

**Capshaw Family Care**

15024 East Limestone Road, Suite F Harvest, AL 35749

Phone: 256-216-1996

Fax: 256-216-1940

Patient Authorization for Use and/or Disclosure and/or Patient Request to Inspect/Copy Protected Health Information.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

I hereby authorize Capshaw Family Care to disclose my health information as follows:

\_\_\_\_\_ Disclose the following health information to: \_\_\_\_\_  
(Name of Physician or Facility)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(Phone & Fax Number)

\_\_\_\_\_ Obtain the following health information from: \_\_\_\_\_  
(Name of Physician or Facility)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(Phone & Fax Number)

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 Capshaw Family 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) Date: \_\_\_\_\_

\_\_\_\_\_  
(Signature of Witness) Date: \_\_\_\_\_

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

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

## PATIENT RIGHTS

Welcome to Capshaw Family 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 Capshaw Family 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.

If you have any concerns about the care you receive while you are a patient please ask to speak to the Office Manager at any time. If you have a patient safety or quality care concern you may also contact any one of the following:

1. **Joint Commission on Accreditation of Healthcare Organizations**  
Office of Quality Monitoring  
One Renaissance Boulevard  
Oakbrook Terrace, IL 60181  
(Fax) 630-792-5636  
(Email) [complaint@jcaho.org](mailto:complaint@jcaho.org)
2. **State of Alabama Dept of Public Health Hotline**  
1-800-356-9595 Monday-Friday 8 a.m. to 5 p.m.
3. **Athens-Limestone Hospital Patient Safety Officer**  
Administration Telephone: 256-233-9119.
4. **Centers for Medicare and Medicaid Services**  
7500 Security Blvd., Mail Stop S2-12-25  
Baltimore, MD 21244-1850

## PATIENT RESPONSIBILITIES

As a patient of Capshaw Family 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.



## SUMMARY OF NOTICE OF PRIVACY PRACTICES

**Our Legal Duty:** Our Health System has a duty to protect the confidentiality of medical information about you. This is a brief summary of our Notice of Privacy Practices. We are required to provide you with Notice explaining ways we may use and disclose your medical information and describing your legal rights and our obligations regarding the use and disclosure of your medical information.

**The Notice will be followed by:**

- The physician members of the hospital's medical staff and credentialed, non-physician health care professionals who may provide care in the hospital
- All departments and units of the hospital
- Any volunteers who perform volunteer work in the hospital, clinic, doctor's office, or other health care entity
- All employees, staff and other personnel at the hospital, clinics, physicians' offices, and all outpatient locations
- Athens-Limestone Hospital

**How We May Use and Disclose Medical Information About You:** We may use or disclose identifiable health information about you for many reasons, including but not limited to the following:

- |   |  |   |
|---|--|---|
| • Treatment, Payment and Healthcare Operations                | • Public health purposes                               | • Workers' compensation                                       |
| • Activities of managed care networks in which we participate | • Organ donation                                       | • To military command authorities                             |
| • Activities of our affiliates                                | • Auditing   | • Lawsuits, administrative hearings and reviews, and disputes |
| • Appointment reminders                                       | • To avert a serious threat to health or safety        | • As required by law  |
| • Health oversight activities                                 | • National security and protective services            | • Law enforcement purposes                                    |
| • Fundraising activities (unless you opt out)                 | • To coroners, medical examiners and funeral directors |   |
|   | • Research directors                                   |   |

We may use or disclose certain limited information about you, unless you object or request a limitation of the disclosure, for:

- Hospital directories
- Individuals involved in your care or payment

In general, other uses and disclosures of your medical information not described in our full Notice of Privacy Practices will require your written authorization. For example, most uses and disclosures of psychotherapy notes, uses and disclosures for marketing purposes and disclosures that constitute the sale of PHI require an authorization:

**Your Privacy Rights:**

You have the following rights with respect to your health information:

- The right to request confidential communications and alternative means of communication with you.
- The right to request restrictions on certain uses of your health information (including restriction of your information to your insurance company when you have paid in full)
- The right to inspect and copy certain medical information that we maintain.
- The right to request an amendment of your health information.
- The right to an accounting of certain disclosures of your health information.
- The right to receive notice of a breach of your unsecured health information.

**Changes to the Notice:** We reserve the right to change the Notice. We will post any revised Notice in our facilities and on our website at [www.athenslimestonehospital.com](http://www.athenslimestonehospital.com).

**Complaints:** If you believe your rights have been violated, you may file a written complaint with Athens-Limestone Hospital please contact the Privacy Officer at 256.262.2142. To file a complaint with the Office for Civil Rights, contact: U.S. Department of Health and Human Services 61 Forsyth St, SW • Suite 3870 • Atlanta, GA 30323

**Copy of Our Complete Notice:** Copies of our full Notice of Privacy Practices are available within our facilities at primary registration sites and on our website at [www.athenslimestonehospital.com](http://www.athenslimestonehospital.com). We will be happy to provide you a copy upon your request.

If you have any questions about this Summary Notice, please contact the Privacy Officer at 256.262.2142.