



Athens Community Care

22454 US Hwy 72 STE 310 • Athens, AL 35613
256-216-9744 Phone • 256-216-9754 Fax

Dr. Amy Clark
Dr. Jeremy Stocks
Dr. Andrea Dunn
Dr. Garrett Dunn

Thank you for choosing Athens Community Care for your medical needs. Please complete the enclosed paperwork and return it to our office as soon as possible to be reviewed and approved by our physicians. We will then request your medical records from your previous physician (if needed). The office will contact you regarding your request for an appointment.

Please arrive 10 - 15 minutes before your scheduled appointment time for new patients. If you arrive 15 minutes late for any appointment you will have to be rescheduled. Bring your driver's license and all insurance cards. Copays are due at check in. Please bring any medications that you are currently taking (prescription or over the counter), always bring the actual bottles with you.

If you have a preferred provider, please circle the name listed above.

We look forward to seeing you!

Athens Community Care

Athens Community Care
22454 US Hwy 72 Suite 310
Athens, Alabama 35613

WELCOME TO OUR PRACTICE!

We are so very pleased that you have selected our clinic as your health care provider. Please complete the enclosed forms with your signature where indicated and return them before your appointment day.

APPOINTMENTS: First time patients are asked to arrive at least 10-15 minutes early to allow adequate time for completing the initial registration. For purposes of maintaining continuity of care, we ask that you request that your latest, relevant records with the most recent test results and current medication list be faxed to us prior to your visit. Alternatively, you may bring those records with you to your first appointment. Your initial visit in establishing care with the doctor will consist of routine checking of vital signs and complete discussion of your medical history, medications you are currently taking, and health issues you may currently be experiencing. A "physical examination" or gynecological exam will be scheduled 1-2 weeks later with appropriate time allowed to focus on the examination, review of lab results, and discuss disease prevention. Once you are an established patient, we ask that you **have labs done 2-3 days before your appointment** so the doctor can go over the results with you in person.

If you are sick and seen on an urgent, work-in basis, only your acute medical problems will be addressed. You will need to schedule another appointment for any other medical questions or issues you may have. If your doctor schedules lab work or x-rays for you, you will be contacted via the patient portal with the results or with requests to return to the office to discuss the results directly with the physician.

WEB PORTAL: Most communications from the clinic will be sent through a secure online portal; so all patients are expected to register for the free service prior to their first appointment. You may submit refill requests, message clinic staff on non-urgent matters, and review your medical history including lab results through the portal. Registrations instructions are included with this packet.

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 must 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 Athens Community Care), Master Card, Visa, American Express, Discover 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 to pay.

MEDICATIONS: We utilize electronic prescription writing for most medications and routine medication refills will be handled during scheduled appointments. Generally, when a routine prescription has no more refills remaining, this indicates that it is time for an appointment to review that particular condition for which the medication was prescribed. If a refill is necessary, please notify the clinic **at least 3 days prior to the need for refill** to allow time for the doctor to confirm the prescription details, review records and fill the medication appropriately and in a timely manner. Medication refills should preferentially be requested using the secure online portal (not calling the office). No antibiotics or narcotics will be prescribed without an examination; this is not considered good medical practice. Please bring ALL medications that you are taking with you to each appointment. This includes prescription as well as over-the-counter medications such as vitamins and aspirin. An up-to-date list of all medications is sufficient if all necessary information is on the list, such as medications strength, and quantity.

HOURS: Our normal business hours are Monday-Thursday from 8:00am-4:30pm, excluding 12:00 to 1:00 for lunch each day and Friday from 8:00am-12pm.

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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 _____

Employer _____ Retired _____ Homemaker _____ Disabled _____ Unemployed _____

Preferred Pharmacy _____

INSURANCE: _____ Contract # _____ Group # _____

Secondary Insurance _____ Contract # _____ Group # _____

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 _____

***How did you hear about us?** ___ Source Magazine ___ Facebook ___ Friend/Family ___ Billboard

___ Internet search ___ Hospital Inpatient ___ Other, Please specify _____

I hereby authorize and direct payment to Athens Community 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 Athens Community 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 Health Assessment

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.

Indicate special communication needs of which we should be aware

- Vision Speech Learning Disability Hearing Language

Recent Immunizations

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

- | Yes | No | | Yes | No | |
|--------------------------|--------------------------|--------------------|--------------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Flu _____ | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis B _____ | <input type="checkbox"/> | <input type="checkbox"/> | Chicken Pox _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Pneumovax 23 _____ | <input type="checkbox"/> | <input type="checkbox"/> | TB Skin Testing _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Prevnar 13 _____ | <input type="checkbox"/> | <input type="checkbox"/> | T DAP _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Tetanus (TD) _____ | <input type="checkbox"/> | <input type="checkbox"/> | Meningitis _____ |

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? _____ 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?

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

Cardiovascular Comment

Arrhythmia _____

Angina _____

Atrial Fibrillation _____

CHF _____

Heart Disease _____

Heart Attack _____

High Blood Pressure _____

High Cholesterol _____

Pacemaker/Defibrillator _____

Vascular Disease _____

Other _____

Respiratory Comment

Asthma _____

COPD _____

Emphysema _____

Sleep Apnea _____

TB _____

Other _____

Gastrointestinal Comment

Celiac Disease _____

Constipation _____

Diarrhea _____

Diverticulitis _____

Diverticulosis _____

GERD _____

Heartburn _____

Hepatitis _____

Hiatal Hernia _____

IBS _____

Other _____

Renal/Genitourinary Comment

BPH _____

Endometriosis _____

Erectile Dysfunction _____

Kidney Stones _____

Polycystic Kidney Disease _____

Renal Failure _____

Urinary Incontinence _____

UTI, Recurrent _____

Other _____

Musculoskeletal Comment

Arthritis _____

Chronic Pain _____

Fibromyalgia _____

Gout _____

Numbness/Weakness _____

Osteoarthritis _____

Osteoporosis _____

RA _____

Other _____

Endocrine Comment

Addison Disease _____

Cushing Disease _____

Type I Diabetes _____

Type II Diabetes _____

Hyperthyroidism _____

Hypothyroidism _____

Other _____

Neurological Comment

Alzheimer's Disease _____

ADD/ADHD _____

Dementia _____

Faint/Dizziness _____

Headache-Migraine _____

Headache-Tension _____

MS _____

Neuropathy _____

Seizures _____

Neurological (Continued) Comment

Stroke _____

Cognitive Impairment _____

Other _____

Hematologic

Anemia _____

Hepatitis B _____

Hepatitis C _____

Iron Deficiency _____

ACC - PAST MEDICAL HISTORY FORM Cont.....

Allergy/Immunology/Dermatology

Comment

- Allergies _____
- Chicken Pox _____
- Eczema _____
- Sinus, frequent _____
- Other _____

Ears/Nose/Throat

- Vertigo/Dizziness _____
- Hearing Loss _____
- Otitis _____
- Tinnitus _____
- Other _____

Psychiatric

Comment

- Anxiety _____
- Depression _____
- Bipolar Disorder _____
- Schizophrenia _____
- Personality Disorder _____
- Substance Abuse _____
- Panic Attacks _____
- PTSD _____
- Eating Disorder _____

Other Conditions

Comment

- Insomnia _____
- AIDS/HIV _____
- Cancer _____
- Cataracts _____
- Glaucoma _____
- Other _____

ALLERGIES

Check Appropriate Allergy, Then Write Specific Allergy / Reaction

- NO KNOWN DRUG ALLERGIES**
- FOOD:** _____
- MEDICATIONS:** _____
- OTHER:** _____

Previous Surgeries

Date: _____ Surgery _____ Date: _____ Surgery _____
Date: _____ Surgery _____ Date: _____ Surgery _____
Date: _____ Surgery _____ Date: _____ Surgery _____

Last:

Colonoscopy Date: _____ Mammogram Date: _____ Bone Density Date: _____
Pap Smear Date: _____ Eye Exam Date: _____ Dental Exam Date: _____

Please list all other Healthcare Providers you see:

Doctor: _____ Specialty: _____
Doctor: _____ Specialty: _____
Doctor: _____ Specialty: _____
Doctor: _____ Specialty: _____
Doctor: _____ Specialty: _____
Doctor: _____ Specialty: _____

Patient's Name: _____ **Date of Birth:** _____



Authorization to Disclose and/or Obtain Protected Health Information

Patient Name: _____ Date of Birth: _____ SS #XXX-XX-____ Phone: _____
Address: _____ Date of Service: _____

I hereby authorize Athens Community Care to use, disclose, and/or obtain my health information as follows: (please check all that apply)

Disclose health information to **Athens Community Care**
22454 US Hwy 72 Suite 310
Athens, AL 35613
Phone: 256-216-9744 Fax: 256-216-9754

Obtain health information from: _____
(Patients check) (Name of Physician or Facility)

(City/State)

Request for Records: Chart Notes (ALL) _____
 Labs Radiology (Phone Number)

(Fax Number)

1. 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.

2. For the purpose of to Obtain or Disclose and treat the patient.

3. 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 clinic _____. 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.

4. Unless otherwise revoked, the authorization will expire on the following date, event, or condition:

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

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

6. 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.

7. 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



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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 _____



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Inclement Weather Policy

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

Appointment No-Show / Same Day Cancellation Policy

Effective August 15th , 2016

It is the policy of Athens Community Care to monitor and manage appointment no shows. Any patient who fails to arrive for a scheduled appointment without canceling the appointment at least 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 Athens Community Care, for failure to show, this fee is due prior to the next appointment. A patient who consistently fails to present themselves more than five (5) times will be dismissed from Athens Community Care.

It is the policy of Athens Community Care to monitor and manage appointments that are canceled the day of the appointment. The first 2 “Same Day Cancellations” fee will be waived, however, beginning with the 3rd occurrence a **\$25.00** charge will be billed and a letter sent. Payment must be made before the next appointment can be scheduled.

_____Please initial here

Medication Refill Policy Effective August 15th, 2016

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 charge for certain forms that require the doctor to complete, such as FMLA and Short Term Disability. Please allow 5-7 business days to complete.

Patient's Signature

Date



PATIENT RIGHTS

Welcome to Athens Community 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 Athens Community 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
- 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 Athens Community 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.



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We would like to invite you to the Patient Portal. It is a secure online website that gives you convenient 24-hour access to your personal health information and medical records, such as lab results and appointments. We have attached a pamphlet with further details.

Please mark whether you would like to be invited to our patient portal.

YES _____

NO _____

If yes, please provide and email _____

How to Register

There are two ways to register for the Patient Portal.

Option 1

Provide your email address so you can be given access to the Patient Portal. You will receive an email containing a link to register for the Patient Portal. Click on the link and follow the instructions. Enter the supplied Username and Password. You will be prompted to create a new Password. You will then have to enter information to verify your identity.

Option 2

You can also be registered for the Patient Portal without providing your email address. We will print out a registration card with detailed instructions to follow. After accessing the website, enter the supplied Username and Password. You will be prompted to create a new Password. You will then have to enter information to verify your identity.

Athens Limestone Health Services

Invites you to join Our Patient Portal

Access Your Health Information
– Anytime, Anywhere!

Athens Limestone Health Services

Portal URL:

alhclinics@mymedaccess.com



Patient Portal powered by eMDs, Inc.



Patient Portal Frequently Asked Questions

Here are our answers to the most commonly asked questions about our Patient Portal.

What is a Patient Portal?

A Patient Portal is a secure online website that gives you convenient 24-hour access to your personal health information and medical records—from anywhere with an Internet connection.

Why Should I Use a Patient Portal?

Accessing your personal medical records through a Patient Portal can help you to be more actively involved in your own health care. Accessing your family members' health information can help you take care of them more easily.

Also, patient portals offer self-service options that can eliminate phone tag with your doctor and might even save a trip to the doctor's office.

Is My Information Safe?

Yes. Patient portals have privacy and security safeguards in place to protect your health information.

Always remember to protect your Username and Password from others and make sure to only log on to the Patient Portal from a personal or secure computer.

Can My Family Access My Patient Portal?

You may choose to give family members or healthcare proxies access to your Patient Portal. They will have their own login once you set this up in your Portal.

What Do I Do If...

I Don't Receive a Registration Email?

The emails may take a few minutes to deliver. You may also check your junk mail or spam folders to see if the email was routed there by mistake. If necessary, you can call the office to resend the registration e-mail.

I Forgot My Password or Username?

Click on the link that says, "Forgot Password" or "Forgot Username" and follow the additional instructions. If you still need help, contact the office to reset your account.

I Have An Urgent Issue or Emergency?

DO NOT use the Patient Portal. Call the office if you need to speak with a staff member immediately. If you are experiencing an emergency, call 911 or go to the nearest emergency room.

Patient Portal Website

alhclinics@mymedaccess.com

Athens Limestone
Health Services

Visit us on the Web:

www.athenslimestonehospital.com

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 Athens Community 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 Athens Community 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. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at Athens-Limestone Hospital.

Signature below is acknowledgment that you have received this Notice of our Privacy Practices and agree to all information listed above. Signature below also indicates that you have received a copy of the Patient Rights & Responsibilities for Athens-Limestone Health Services Clinics.

Patient's Printed Name: _____

Patient's Date of Birth: _____

Signature of patient or patient's representative

Date