Limestone Medical Associates
15243 Greenfield Dr., Suite A
Athens, AL 35613
P: 256-262-5700 F: 256-262-5710

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.

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 by our office. We accept cash, checks (payable to LMA), 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 during 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 Thursday, 8:00 a.m. until 4:30 p.m., excluding 12:00 to 1:00 for lunch, as well as Fridays 8:00 a.m. until noon. Our office telephone number is 256-262-5700. Please feel free to contact us with any questions or concerns.

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Phone: 256-262-5700 Fax: 256-262-5710

PATIENT INFO:

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? Text___Call____

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 hereby authorize and direct payment to Limestone Medical Associates 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 Limestone Medical Associates 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_____

Limestone Medical Associates

Appointment No-Show Policy

Effective August 1, 2023

It is the policy of Limestone Medical Associates 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 Limestone Medical Associates, for failure to show. Patients who consistently fails to present themselves more than five (5) times can be dismissed from Limestone Medical Associates.

Medication Refill Policy

Effective August 1, 2023

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 or provider if there is a need for any refills at the time of each visit, since calling the office 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.

Patient signature_____

Date_____

Limestone Medical Associates

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.

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

Limestone Medical Associates
15243 Greenfield Dr., Suite A
Athens, AL 35613
P: 256-262-5700 F: 256-262-5710

Patient Name _____ DOB_____

I hereby authorize Limestone Medial Associates 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 Limestone Medical Associates 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.

_____ Date: _____
(Signature of patient or patient's representative)

_____ Date: _____
(Signature of Witness)

_____ Date: _____
(Printed name of patient's representative, if applicable

Limestone Medical Associates

List **ALL** allergies

IF NO ALLERGIES PLEASE CHECK HERE ☐

_____ _____ _____

_____ _____ _____

List **ALL** current medications, including over the counter supplements

IF NO MEDICATIONS ARE TAKEN PLEASE CHECK HERE ☐

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

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

Flu:_____ Tetanus:_____

Hepatitis: _____ TB Skin Test: _____

Shingles:_____ Chicken Pox: _____

PNEUMONIA

Prevnar 13:_____

Prevnar 20:_____

Pneumovax 23:_____

COVID (please provide name of vaccine and date received)

1.) _____ 2.) _____

3.) _____ 4.) _____

5.) _____ 6.) _____

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

Limestone Medical Associates

Past Medical History

Patient Name: _____

Cardiovascular

- ☐ AFIB_ _____
- ☐ Angina_____
- ☐ Coronary Artery Disease _____
- ☐ CHF_____
- ☐ Heart Attack_____
- ☐ Heart Disease_____
- ☐ High Blood Pressure_____
- ☐ High Cholesterol_____
- ☐ Pacemaker_____
- ☐ Peripheral Artery Disease_____
- ☐ Valve Problem_____

Gastrointestinal

- ☐ Constipation_____
- ☐ Diarrhea_____
- ☐ Diverticulosis_____
- ☐ GERD_____
- ☐ Heartburn_____
- ☐ Hepatitis_____
- ☐ Hiatal Hernia_____
- ☐ IBS_____
- ☐ Jaundice_____

Genitourinary

- ☐ Kidney Disease_____
- ☐ Kidney Stone_____
- ☐ Prostate Disease_____
- ☐ UTI_____

Musculoskeletal

- ☐ Arthritis_____
- ☐ Fibromyalgia_____
- ☐ Gout_____
- ☐ Lupus_____
- ☐ Osteoarthritis_____

Musculoskeletal cont'd

- ☐ Osteopenia_____
- ☐ Osteoporosis_____
- ☐ Rheumatoid Arthritis_____

Neurological

- ☐ ADD/ADHD_____
- ☐ Autism_____
- ☐ Chronic Headaches_____
- ☐ Dementia_____
- ☐ Faint/Dizziness_____
- ☐ Migraines_____
- ☐ Numbness/weakness_____
- ☐ Seizures_____
- ☐ Stroke_____

Respiratory

- ☐ Asthma_____
- ☐ COPD_____
- ☐ Sinus problems_____
- ☐ Sleep Apnea_____
- ☐ TB_____

Other Conditions

- ☐ AIDS/HIV_____
- ☐ Anemia_____
- ☐ Anxiety_____
- ☐ Cancer_____
- ☐ Cataracts_____
- ☐ Depression_____
- ☐ Diabetes_____
- ☐ Eye Problems_____
- ☐ Insomnia_____
- ☐ Rheumatic Fever_____
- ☐ STD_____
- ☐ Hypothyroid / Hyperthyroid_____
- ☐ Other_____

Limestone Medical Associates

PREVENTATIVE HEALTH

DATE OF LAST: *PAP*_____*Eye Exam*_____*Mammo*_____

*Bone Mineral Density*_____*PSA*_____*Colonoscopy*_____

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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

Limestone Medical Associates

Family History

Disease	Family Member (Circle one)				
Alzheimers/Demenita	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:
COPD	Father	Mother	Sibling	Grandparent	Other:
Diabetes Type l Type 2	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 Issues	Father	Mother	Sibling	Grandparent	Other:
Seizures	Father	Mother	Sibling	Grandparent	Other:
Stroke	Father	Mother	Sibling	Grandparent	Other:
Thyroid Issues	Father	Mother	Sibling	Grandparent	Other
Other:_____	Father	Mother	Sibling	Grandparent	Other:

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

Limestone Medical Associates

Patient Health Assessment

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

[ ] Vision
[ ] Speech
[ ] Learning Disability
[ ] Mental Retardation
[ ] Hearing
[ ] Other:_____

General Health Questions

Yes No

____ ____ Do you live alone? If no, with whom do you live? _____
____ ____ Do you have any children? If so, How Many? What ages?_____
_____
____ ____ Do you follow any special diets? If yes, explain: _____
____ ____ Have ever you used nicotine in the past? (i.e. cigarettes, cigars, smokeless tobacco):
If yes, explain: What type? How much per day? For how many years? Quit Date? _____
_____
____ ____ Do you currently use nicotine? If yes, explain:_____
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? _____

Patient Name: _____ Date of Birth:_____

Limestone Medical Associates

PATIENT RIGHTS

Welcome to Limestone Medical Associates. 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 Limestone Medical Associates, 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 Limestone Medical Associates, 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.

Limestone Medical Associates

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

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 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.

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. 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

Effective Date: 04/25/17

Only to be filled out if establishing with Morgan Dean for psych services

Mental Health History

Diagnoses: list all previously diagnosed mental health disorders that apply to you

_____

Current mental health medications:

_____

Past mental health treatment: medications (provide name and response), therapy/counseling, ECT, etc.

_____

_____

Have you ever attempted suicide? _____ If yes, provide year and means of attempt/s.

_____

Have you been hospitalized inpatient for mental health reasons? _____ If yes, provide year and reason.

_____

Family Psychiatric history: list family member and mental health disorder (include completed suicides)

_____

_____

Did someone refer you for this appointment?_____ If yes, who? _____

Reason for appointment: _____