Athens Community Care

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

Dr. Amy Clark
Dr. Garrett Dunn
Dr. Andrea 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	
□	□	Flu _____			
□	□	Hepatitis B _____	□	□	Chicken Pox _____
□	□	Pneumovax 23 _____	□	□	TB Skin Testing_____
□	□	Prevnar 13_____	□	□	T DAP_____
□	□	Tetanus (TD) _____	□	□	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?

ACC - PAST MEDICAL HISTORY FORM Name_____ Date of Birth _____

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/Defibulator	
☐ 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:** _____

Family History (Complete Health Information about your family)

Disease	Family Member (Circle one)				
Alzheimer's / Dementia	Father	Mother	Sibling	Grandparent	Other: _____
Asthma, 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: _____
CVA / Stroke	Father	Mother	Sibling	Grandparent	Other: _____
COPD	Father	Mother	Sibling	Grandparent	Other: _____
Diabetes	Father	Mother	Sibling	Grandparent	Other: _____
GI Problems	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 Disease	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: _____
Thyroid Disease	Father	Mother	Sibling	Grandparent	Other: _____
Other: _____	Father	Mother	Sibling	Grandparent	Other: _____
Other: _____	Father	Mother	Sibling	Grandparent	Other: _____

List any other family history on back of this form.

MEDICATIONS CURRENTLY IN USE ******NO APPOINTMENT WILL BE MADE WITHOUT A COMPLETE LIST OF MEDS******

Medication Name	Dose	Frequency	Check here if NO MEDS ____

List any additional medications on back of this form.

Athens-Limestone Hospital

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

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

_____
(City/State)

Request for Records: __X_ Chart Notes (ALL) _____
__X_ Labs _X__Radiolgy (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**

Athens-Limestone Health Services

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

Portal URL:
alhclinics@mymedaccess.com

Patient Portal powered by eMDs, Inc.

Athens Limestone Health Services

Invites you to join Our Patient Portal

Access Your Health Information – Anytime, Anywhere!

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