integra
FAMILY MEDICINE

Fabian Berru, MD

Phone: 256.849.0440
Fax: 833.468.5230

New Patient Application

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

□ **Male** □ **Female** **Race:** □ Non-Hispanic □ Hispanic **Language:** _____

Address: _____ **City:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Patient Employer: _____ **Patient Occupation:** _____

Email Address: _____

Pharmacy: _____ **City:** _____

Referred by: _____ **Previous Primary Care Physician:** _____

Primary Insurance Carrier: _____

Insurance Identification Number: _____

Secondary Insurance Carrier (if applicable): _____

Secondary Insurance Identification Number (if applicable): _____

Current Medical Conditions:

Current Medications: *(include prescription, non-prescription, over-the-counter, supplements, etc.)*

Please note: We do not specialize in or offer ongoing chronic pain management services. If you currently take chronic pain medication, please list the Physician that is currently writing the prescription for the medication and what specialty the Physician practices.

Physician: _____ **Specialty:** _____

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Phone: 256.849.0440
Fax: 833.468.5230

Please complete this form and return to our office by fax, mail or in-person.

Fax: 833.468.5230 **Address:** *Albertville Primary Care, 312 Sand Mountain Dr. E., Albertville, AL, 35950*

Office Policies

As a patient, you are ultimately responsible for your own care. This can be exhibited by knowing what medications you are taking and why, arriving on time for appointments, completing labs and tests that are ordered by your physician, and obtaining refills/completing paperwork in a timely manner. We will do our best to ensure we do our part by keeping you informed and complete your orders and prescriptions in a timely manner at your visit.

_____ Fees—Patients are expected to pay all co-pays at the time of your visit.

_____ Nurse calls and questions—Any non-scheduling questions will be routed to the nurse line. Please leave a message with the requested information and we will return your call within one business day.

_____ Appointment times—Please arrive on time or early for your scheduled appointment. If you are late, you may be asked to reschedule.

_____ Cancellations—Except under extenuating circumstances, we request you give at least 24 hours of notice when cancelling an appointment. Failure to do so will cause any missed appointments to be considered as a "no show".

_____ No show policy/Rescheduling—Patients that "no show" for 3 appointments are subject to dismissal from our practice for non-compliance. If you no show for your initial/new patient appointment, you will be charged a $150 fee. This will be collected before you are allowed to reschedule your appointment.

_____ Conduct—Verbal or physical abuse of our physician or staff will NOT be tolerated for any reason or under any circumstance.

_____ Form completion—There is a 5 business day turnaround time for FMLA or other forms needing completion. There is a $25 charge per form.

_____ Medication refills—refills need to be requested at least 3 days in advance. Ideally, these will be handled during your routine visits, but if you realize your medication needs to be refilled you may call and leave a message with the nurse requesting a refill.

I understand and agree to these policies:

Signature: _____ **Today's Date:** ____ / ____ / _____

Must be signed by patient or legal guardian if patient is a minor.

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FAMILY MEDICINE

Fabian Berru, MD

Office: 256-849-0440
Fax: 1-833-468-5230

New Patient Paperwork

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

□ **Male** □ **Female** **Race:** □ Non-Hispanic □ Hispanic **Language:** _____

Address: _____ **City:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Patient Employer: _____ **Patient Occupation:** _____

Email Address: _____

Pharmacy: _____ **City:** _____

Responsible Party *(if someone other than patient)*

Name: _____ **Relation to Patient:** _____

Address: _____ **City:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Emergency Contact *(Must have phone number different than patient)*

Name: _____ **Relationship:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Referred by: _____ **Previous Primary Care Physician:** _____

Reason for today's visit?

Allergies: *(check all that apply)*

Past Medical History: *(check all that apply)*

	Condition	*Did you see a specialist?* Y/N	Physician / Office
	Abnormal Menses		
	Anemia		
	Anxiety		
	Arthritis (unspecified)		
	Asthma		
	Breast Cancer		
	Cervical Cancer		
	Chronic Acid Reflux (GERD)		
	Colon Cancer		
	COPD		
	Coronary Artery Disease		
	Deep Vein Thrombosis		
	Depression		
	Diabetes Type 1		
	Diabetes Type 2		
	Emphysema		
	Endometriosis		

	Condition	*Did you see a specialist?* Y/N	Physician / Office
	Fibromyalgia		
	Hepatitis (A, B or C)		
	High Blood Pressure		
	High Cholesterol/Trig		
	Hyperthyroidism		
	Hypothyroidism		
	Kidney Disease		
	Kidney Stones		
	Liver Disease		
	Lung Cancer		
	Polyps (Colon)		
	Prostate Cancer		
	Rheumatoid Arthritis		
	Seasonal Allergies		
	Stroke		
	Autoimmune Disease		

Other (please list below)

Please list any medical issues not listed that you want us to be aware of:

Family History:

If known, please list age of diagnosis in relation to breast cancer, colon cancer, and coronary artery disease diagnoses.

	Mother's Side			Father's Side			Siblings / Other		
	Mother	Grandmother	Grandfather	Father	Grandmother	Grandfather	Brother	Sister	Other
Breast Cancer	_____	_____	_____	_____	_____	_____	_____	_____	_____
Colon Cancer	_____	_____	_____	_____	_____	_____	_____	_____	_____
Coronary Artery Disease	_____	_____	_____	_____	_____	_____	_____	_____	_____
Cystic Fibrosis	_____	_____	_____	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____	_____	_____	_____
Gout	_____	_____	_____	_____	_____	_____	_____	_____	_____
High Cholesterol	_____	_____	_____	_____	_____	_____	_____	_____	_____
Hunting's Disease	_____	_____	_____	_____	_____	_____	_____	_____	_____
Hypertension	_____	_____	_____	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____	_____	_____	_____
Liver Disease	_____	_____	_____	_____	_____	_____	_____	_____	_____
Lung Cancer	_____	_____	_____	_____	_____	_____	_____	_____	_____
Muscular Dystrophy	_____	_____	_____	_____	_____	_____	_____	_____	_____
Osteoarthritis	_____	_____	_____	_____	_____	_____	_____	_____	_____
Osteoporosis	_____	_____	_____	_____	_____	_____	_____	_____	_____
Prostate Cancer	_____	_____	_____	_____	_____	_____	_____	_____	_____
Rheumatoid Arthritis	_____	_____	_____	_____	_____	_____	_____	_____	_____
Sickle Cell Anemia	_____	_____	_____	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____	_____	_____	_____	_____	_____

Surgical History:

Surgery / Procedure	Approximate Date	Physician / Facility

Female Obstetric / Gynecological History:

Do you have a Gynecologist? (Y / N) _____ Who? _____

When was your last pap smear? _____ Results: (Normal / Abnormal)

When was your last mammogram? _____ Results: (Normal / Abnormal)

Have you ever been pregnant? (Y / N) _____ How many times? _____

How many children have you given birth to? _____

Have you ever had a miscarriage? (Y/N) _____

Date of last menstrual period: _____

Diagnostic Imaging:

Have you ever had any of the following diagnostic procedures?

Procedure	Y / N	Date Performed	Results	Provider / Office
Colonoscopy	_____	_____	_____	_____
Bone Density Study	_____	_____	_____	_____
Echocardiogram	_____	_____	_____	_____
MRI	_____	_____	_____	_____
CT	_____	_____	_____	_____
Ultrasound	_____	_____	_____	_____
Stress Test	_____	_____	_____	_____

If you are diabetic, when was your last…	**Provider / Office**
Foot Exam _____	_____
Eye Exam _____	_____

Immunizations:

Children / Adults unders 24, are you current on all "school" vaccinations? _____

If no, what vaccines are outstanding? _____

Name of Pediatrician: _____

Are you interested in the HPV Vaccine (Gardisil)? _____

Adults over 24, when was your last:

_____ TDaP (Tetanus, Diptheria and Pertussis)

_____ Pneumonia Vaccine

_____ Flu Vaccine

_____ Shingles Vaccine

Social History:

Have you ever smoked or used tobacco products (Y / N) _____

Do you currently smoke or use tobacco products (Y / N) _____

What kind? _____

When was the last time you smoked or used tobacco products? _____

Do you drink alcohol (Y / N) _____

How often? Occasionally _____ Several drinks per week _____ 1-2 drinks/day _____ >2 drinks/day _____

Current Medications:

Please list ALL medications you are currently taking. Please include all prescription and over the counter medications.

___ **CHECK HERE IF YOU TAKE NO PRESCRIPTION OR OVER THE COUNTER MEDICATIONS**

Medication Name	Strength	How Often?	Reason for Taking

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Integra Family Medicine's Notice of Privacy Practices or have had the opportunity to receive the Notice of Privacy Practices.

_____
Patient Name (Printed)

Signature: _____ Date: _____

RELEASE OF INFORMATION AUTHORIZATION:

Due to federal privacy guidelines (HIPAA), Integra Family Medicine is not allowed to divulge information to anyone other than the patient (or guardian of the patient) unless explicit written authorization is given to discuss personal medical information with someone other than you.

I, _____, give Integra Family Medicine permission to release / discuss personal medical information to include the pickup of prescriptions and / or financial information to:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

GUARANTEE OF ACCOUNT: <u>MUST BE 19 YEARS OF AGE TO SIGN</u>

I, the undersigned, directly assign to Integra Family Medicine all surgical and / or medical benefits, if any, otherwise payable to me for services rendered.

In consideration of services rendered or to be rendered, the undersigned agrees to pay all costs of collection and / or reasonable attorney fees, should the account be turned over to enforce collections of said charges. The undersigned hereby waivers all claims or rights of exemption allowed by the constitution of the state of Alabama or any other state of the United States.

I hereby authorize Integra Family Medicine to release any information necessary to secure payment of benefits to my account.

Signature: _____ Date: _____

May we leave voicemails on the numbers you've provided? ___ Yes ___No

Comments: _____

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FAMILY MEDICINE

Authorization to Release Protected Health Information

Phone: 256.849.0440
Fax: 833.468.5230

Please Print

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

Address: _____ **City:** _____ **Zip:** _____

Phone Number: _____

Release Information from Integra Family Medicine to:

Name / Facility: _____ **Attention:** _____

Address: _____ **City:** _____ **Zip:** _____

Phone Number: _____ **Fax Number:** _____

Purpose of Request: □ Personal □ Treatment □ Legal □ Insurance □ Transfer
□ Other: _____

Release Information to Integra Family Medicine from: Please Fax to 833.468.5230

Name / Facility: _____ **Fax Number:** _____

Date Range: _____

□ Progress Notes □ Radiology Reports □ Labs □ Operative Reports □ Injections

□ Physical Therapy □ EMG Report □ Work Status □Radiology Disk □ Billing Statement

□ Other: _____

Release Information to Integra Family Medicine from: Please Fax to 833.468.5230

I understand that: I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information. * _____ (Please Initial)

- ✓ I may refuse to sign this authorization and that it is strictly voluntary.
- ✓ My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
- ✓ I may revoke this authorization at any time in writing, but if I do, if will not have any effect on any actions taken prior to receiving the revocation.
- ✓ Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____.
  If I do not specify expiration this authorization will not expire.
- ✓ I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.
- ✓ I understand that I may see and obtain a copy of the information described in this form, for a reasonable copy fee, if I ask for it.
- ✓ I can request a copy of this form after I sign and date it.

Signature*: _____ **Today's Date:** ____ / ____ / _____

**For non-emancipated minors under the age of 19 years, a parent or guardian must sign release form. If patient is unable to sign a copy of the legal documentation for patient's representative must be supplied with a copy of this form.*