DOTHAN MEDICAL ASSOCIATES, P.C.

Doctor's Building • 1118 Ross Clark Circle, Suite 100 • Dothan, Al 36301 • (334) 794-1148

Welcome to Dothan Medical Associates, PC

You have been scheduled for an appointment to see one of our physicians or a nurse practitioner here at Dothan Medical Associates, PC.

Your appointment time is enclosed along with the **forms and information needed for your visit with us.**

You must complete the enclosed paperwork prior to being seen in our office.

IMPORTANT**:** Arrival time is 30 minutes before your scheduled appointment. This will allow our staff ample time to complete all the necessary paperwork.

BRING ALL MEDICATIONS OR A COMPLETE WRITTEN LIST OF CURRENT MEDICATIONS.

If you are a diabetic and have a meter, please bring your meter and log book.

LOCATION: We are located in the **"Doctor's Building"** on the **1st floor** at **Southeast Health**, formerly Southeast Alabama Medical Center.

Please feel free to contact us if you have any questions or concerns at (334)794-1148.

Dothan Medical Associates, PC **334-794-1148**
1118 Ross Clark Circle, Suite 100 **Dothan, AL 36301**

IMPORTANT NOTICE

All co-pays, deductibles, patient balances, or "collection" balances are collected at the time of check-in. Please be prepared to pay amount due upon arrival. If you are unable to pay, it may be necessary to reschedule your appointment until payment can be made.

We ask that you arrive 30 minutes prior to your appointment time to complete registration. We will need to get copies of your insurance cards. Driver's License (if applicable), and collect any co-pays or balances. Our goal is to have your registration complete prior to your appointment time.

Thank you.

GW#_____

Dothan Medical Associates, PC
Financial Policy

Thank you for choosing Dothan Medical Associates, PC as your healthcare provider. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment in our office.

All co-payments and deductibles are due at time of service. Full payment is due at time of service for all non-covered services. Our contract with your insurance company requires us to collect these from you. With rising cost of medical care, paying at the time of service is essential in keeping these costs at a minimum. Payment in full is required without proof of insurance coverage.

It is your responsibility to check with your insurance company prior to your appointment for verification of benefits such as preventive services, lab and x-ray procedures, etc. Many insurance plans now require you to go to specific labs, x-ray facilities, pharmacies, etc.

It is your responsibility to give us accurate and updated insurance information at each visit. Failure to do so may result in you being responsible for a balance that your insurance company may have otherwise paid. Many managed care insurance plans have strict guidelines regarding timely filing which makes accurate information a necessity. If you are covered under more than one insurance plan, please remember to give us information on all plans at the time of service.

It is important for you to respond to your insurance company when any information is request from you. Often they will send questionnaires regarding other coverage and will not process your claim until you respond. Some insurance companies require this with your first claim each calendar year. Do not make the mistake of thinking you have already given them this information and it is not necessary for you to respond. When your insurance notifies us they have requested information from you, the balance then becomes your responsibility and remains your responsibility until the claim is paid.

We understand unforeseen circumstances such as hospitalization, uncovered services, and unplanned emergencies occur. In these situations when you incur a balance, someone in our billing department will discuss options with you. You may also be asked for a credit card to keep on file for payment if necessary.

If monthly payments are not received regularly, your account will automatically move into our collection process. We are willing to work with you on the balance but communication with our billing office is essential. If you have questions regarding your bill you may contact our office at 334-794-1148 and ask for the billing department.

Never ignore a bill simply because you feel it is not your obligation or you think your insurance company should pay it. You cannot expect your insurance company will cover any balance once we have transferred the responsibility of that balance to you. We only transfer responsibility to you after we have had response from your insurance company.

If you have questions regarding coverage of your charges, questions about your bill, or wish to set up payment arrangements, please contact our billing office at 334-794-1148.

_____ _____

Signature of Responsible Party Date

1118 Ross Clark Circle, Suite 100
Dothan, AL 36301
(334)794-1148

DOTHAN MEDICAL ASSOCIATES, P.C.
NEW PATIENT INFORMATION
Please Complete In Full

GW#_____
(office use only)

NAME:_____ **Date of Birth**:_____ Sex: ☐ M ☐ F

Occupation: _____Marital Status:_____

Do you smoke? ☐ No ☐Yes, packs per day? _____ ☐ Former smoker-how long?_____

Do you drink alcohol? ☐ No ☐ Yes - how much and how often? _____

Do you drink caffeinated beverages? ☐ No ☐ Yes - cups/glasses per day? _____

Do you have a history of illegal drug use? ☐ No ☐ Yes If yes, name of drug_____

MEDICAL HISTORY

Have you had or do you have any of the following? (check box if applicable)

☐ Abdominal Aortic Aneurysm
☐ Acid reflux
☐ Allergic Rhinitis
☐ Alzheimer's
☐ Anemia
☐ Anxiety disorder
☐ Arthritis
☐ Arrhythmias
☐ Asthma
☐ Atrial Fibrillation
☐ Bipolar disorder
☐ Cancer: Location _____
☐ Carpal Tunnel Syndrome
☐ Cataracts
☐ Cirrhosis
☐ CHF (Congestive Heart Failure)
☐ COPD (Chronic Obstructive Pulmonary Disease)
☐ Coronary Artery Disease
☐ Dementia
☐ Depression
☐ Diabetes ____Type I ____Type II
☐ Diverticulitis
☐ DVT (Blood Clot)
☐ Emphysema
☐ Enlarged prostate
☐ Erectile Dysfunction
☐ Fatty Liver
☐ Fibromyalgia
☐ GERD (Gastro-esophageal Reflux Disorder)
☐ Glaucoma
☐ Goiter
☐ Gout
☐ Heart attack
☐ Hepatitis A____ B____ C____
☐ High blood pressure
☐ High cholesterol
☐ HIV/AIDS
☐ Jaundice
☐ Kidney disease
☐ Kidney stones
☐ Leukemia
☐ Lupus
☐ Menopause
☐ Migraine headaches
☐ Mitral Valve Prolapse
☐ Nervous breakdown
☐ Neuropathy
☐ Osteoporosis
☐ Parkinson's Disease
☐ Pneumonia
☐ Psoriasis
☐ PVD (Peripheral Vascular Disease)
☐ Raynaud's
☐ Rosacea
☐ Schizophrenia
☐ Seizure disorder
☐ Sleep apnea
☐ Stomach ulcers
☐ Stroke
☐ Thyroid abnormality (overactive or underactive)
☐ TIA (Mini Stroke)
☐ Tuberculosis
☐ Other significant illness: (please list)____
_____
_____
_____
_____
_____

PAST SURGICAL HISTORY
List All Surgeries

Type of Surgery	Year	Surgeon
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Any previous fractures? ☐ No ☐ Yes Describe: _____

Any other serious injuries? ☐ No ☐ Yes Describe: _____

FAMILY MEDICAL HISTORY

	IF LIVING		IF DECEASED	
	Age	Health	Age at Death	Cause
Father	_____		_____	
Mother	_____		_____	

Number of siblings _____Number living _____Number deceased _____

Number of children _____Number living _____Number deceased _____Ages of each _____

Health of children: _____

_____

Do you know of any blood relative who has or had: (check and give relationship)

☐ Cancer _____	☐ Heart disease _____	☐ Asthma _____
☐ Diabetes _____	☐ High blood pressure _____	☐ Leukemia _____
☐ Stroke _____	☐ Bleeding tendency _____	☐ Epilepsy _____
☐ Psoriasis _____	☐ Rheumatic fever _____	☐ Goiter _____
☐ Colitis_____	☐ Rheumatoid Arthritis _____	☐ Alcoholism _____
☐ Lupus_____	☐ Tuberculosis _____	☐ Auto Immune Disease? Explain:
☐ Scleroderma _____		_____

CURRENT MEDICATION LIST

(Include any vitamins or non-prescription medicines)

NAME OF MEDICATION	**DOSAGE (ex. mg, mcg)**	**DIRECTIONS**

ALLERGIES: _____

_____

DOTHAN MEDICAL ASSOCIATES, P.C.
SYSTEMS REVIEW

As you review the following list, please check any of those problems that you are currently having at time of visit.

Date of last mammogram _____ Date of last eye exam _____ Date of last chest x–ray _____

Date of last tuberculosis test _____ Date of last bone densitometry _____ Date of last foot exam _____

Constitutional
- ☐ Recent weight gain
- ☐ Recent weight loss
- ☐ Fatigue
- ☐ Fever

Eyes
- ☐ Pain
- ☐ Double or blurred vision
- ☐ Dryness

Ears–Nose–Mouth–Throat
- ☐ Ringing in ears
- ☐ Dryness of mouth
- ☐ Bad teeth
- ☐ Hoarseness
- ☐ Difficulty swallowing

Cardiovascular
- ☐ Chest pain
- ☐ Palpitations

Respiratory
- ☐ Shortness of breath
- ☐ Cough
- ☐ Swollen legs or feet
- ☐ Loud snoring

Gastrointestinal
- ☐ Vomiting
- ☐ Constipation
- ☐ Reflux/Indigestion
- ☐ Persistent diarrhea
- ☐ Blood in stools

Genitourinary
- ☐ Difficult urination
- ☐ Frequent urination
- ☐ Pain or burning on urination
- ☐ Blood in urine

For Women Only:
Number of pregnancies? _____
Number of miscarriages? _____
☐ Menopausal: Age: _____
Bleeding after menopause? ☐Yes ☐No

Musculoskeletal
- ☐ Morning stiffness
  Lasting how long?
  _____minutes _____hours
- ☐ Joint pain
- ☐ Joint swelling

List joints affected in the last 6 mos.
_____
_____
_____
_____

Integumentary (skin and/or breast)
- ☐ Easy bruising
- ☐ New skin lesions
- ☐ Rash
- ☐ Color changes of hands or feet in the cold

Neurological System
- ☐ Headaches
- ☐ Dizziness
- ☐ Muscle weakness
- ☐ Memory loss
- ☐ Night sweats
- ☐ Numbness/tingling in hands___ feet___
- ☐ Tremors

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Difficulty sleeping

Endocrine
- ☐ Excessive thirst
- ☐ Hot/Cold Intolerance
- ☐ Difficulty swallowing

Hematologic/Lymphatic
- ☐ Swollen glands
- ☐ Tender glands _____
- ☐ Anemia
- ☐ Enlarged lymph nodes

Other symptoms: _____
_____
_____
_____
_____

Patients Name:_____ Date:_____ Physician's Initials: _____

DOTHAN MEDICAL ASSOCIATES, P.C.

PATIENT CONSENT FOR USE / DISCLOSURE OF HEALTH CARE INFORMATION

I, _____ , give permission to my physician(s) at **Dothan Medical Associates, P.C.** to use and disclose my personal health information to carry out treatment, payment, and other health care operations. I understand that **Dothan Medical Associates, P.C.** works hard to protect my privacy and preserve the confidentiality of my personal health information. I realize that employees who work for **Dothan Medical Associates, P.C.** may use and see my information, but they may use it only as permitted in this form.

This information can include spoken or written facts about my health or payment benefits as permitted under the law. It can include copies of records from my health care providers or health plans about my health care. It also gives permission for any listed persons I designate below to have access to my medical information.

This disclosure becomes effective April 14, 2003 and will continue unless it is cancelled, changed or amended by my appointed legal representative, or myself. I realize I may stop or change the names listed below by notifying my doctor in writing that I do not want them to know or share my private information. If I decide to revoke this consent, I understand that **Dothan Medical Associates, P.C.** does not have to provide any further care services to me depending on the circumstances.

I know that my private healthcare information will be protected by **Dothan Medical Associates, P.C.** and every safety precaution will be taken to ensure that my personal health information is kept private and confidential. My signature below indicates that I agree to allow Dothan Medical Associates, P.C. to use and disclose my personal health information to carry out treatment, payment, and health care operations.

_____ _____ _____

Signature of Patient or Authorized Person **Date of Birth (Patient)** **DATE**

_____ _____

Printed Name of Above **Relation to Patient**

PLEASE CHECK ANY/ALL OF THE FOLLOWING WAYS WE ARE PERMITTED TO LEAVE PATIENT INFORMATION FOR YOU:

❑ Information regarding tests results may be left on my_____home phone_____work phone_____other_____
❑ Information regarding appointments may be left on my_____home phone_____work phone_____other_____
❑ I do not wish for any of my private information to be left on my home phone, work phone, or other phone.

*** The names listed below are permitted to share and know my health information.**

_____ RELATION:_____ PHONE:_____
_____ RELATION:_____ PHONE:_____
_____ RELATION:_____ PHONE:_____
_____ RELATION:_____ PHONE:_____
_____ RELATION:_____ PHONE:_____

* **The names given above mean we can discuss results of ordered tests, labs, medication changes, appointments, or other things pertaining to your health care. For example, if your daughter is usually the contact person for you, please be sure to list her.**

Dothan Medical Associates, P.C.
Patient Registration

FOR OFFICE USE ONLY
ID# _____

REASON FOR VISIT: _____ PREFERRED PHARMACY: _____

WHAT DOCTOR REFERRED YOU TO US: _____ DATE _____

NAME		SEX ❑ M ❑ F	AGE	BIRTHDATE	MARITAL STATUS M S D W
MAILING ADDRESS		SOCIAL SECURITY #		DRIVER'S LICENSE #	
CITY	STATE ZIP	❑ EMPLOYED	❑ RETIRED	❑ DISABLED	❑ STUDENT
EMAIL ADDRESS		EMPLOYER OR SCHOOL		OCCUPATION	
HOME PHONE	CELL	WORK		PRIMARY NUMBER	

WHICH ONE OF THE ABOVE NUMBERS CAN WE USE TO LEAVE MESSAGES REGARDING APPOINTMENT REMINDERS:

SPOUSE OR GUARDIAN INFORMATION:

NAME		RELATIONSHIP TO PATIENT	SSN #	BIRTHDATE
ADDRESS		OCCUPATION		
CITY		EMPLOYER		
HOME PHONE	WORK OR CELL PHONE	CITY	STATE	ZIP

EMERGENCY CONTACT OTHER THAN SPOUSE (REQUIRED):
Name Relationship Phone

FINANCIAL POLICY:

COMMERCIAL INSURANCE:
Payment is expected at the time of service unless we are a provider for your insurance company. We currently have provider contracts with Medicare, BCBS PMD/PPC, Heathsource PPN (formerly Provident PPN), Perdue, Beechstreet, CCN, TriCare, and OneSource MedNet. It is our policy that all co-pays and/or deductible amounts are due and expected at the time of service.

Credit Cards accepted: VISA MASTERCARD

INSURANCE INFORMATION:

Primary _____ Secondary _____

Please present the following information to the Receptionist to make a photocopy for your chart:

All Insurance Cards Your Driver's License

AUTHORIZATIONS:

I authorize **Dothan Medical Associates, P.C.** to release any medical information requested by my health insurance carrier, Medicare or any other third-party payers. **Dothan Medical Associates, P.C.** may contact my insurance company or health plan administrator to obtain pertinent financial information concerning coverage and payments under my policy. I hereby authorize payment of insurance benefits be made on my behalf to **Dothan Medical Associates, P.C.** and assign benefits to the physician indicated on the claim.

I understand that I am responsible for any co-pays or deductibles as defined by my insurance policy, and for any "non-covered" services of my consent if deemed necessary. I accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees (33.33%), attorney fees, and/or court costs, if such be necessary.

I agree, in order for you to service my account or to collect monies I may owe, **Dothan Medical Associates, P.C.** and/or its agents may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. **Dothan Medical Associates, P.C.** may also contact me by sending text messages or emails, using any email address I provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

I hereby give authorization for treatment to my physician(s) at **Dothan Medical Associates, P.C.,** and give permission to disclose my protected health information in order to carry out treatment, payment, and other healthcare operations. I also authorize **Dothan Medical Associates, P.C.** to release all information to my referring physician and/or primary care physician.

DATE_____ **SIGNATURE** _____
(PATIENT OR RESPONSIBLE PARTY)

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PATIENT AUTHORIZATION FOR MEDICAL RECORDS RELEASE OF PROTECTED HEALTH INFORMATION

_____ I authorize Dothan Medical Associates, P, C, to disclose certain protected health information (PHI) about me to the entity/party listed below:

_____ I authorize Dothan Medical Associates, P. C. to request my personal health information (PHI) from the entity/party listed below:

Physician: _____

Address: _____

City/St Zip: _____

Phone: _____ Fax : _____

✻ The following protected health information is requested: (*office use only*)

_____

_____

_____

_____

Send records to the attention of: _____

✻ **PLEASE MAIL RECORDS IF OVER 20 PAGES**

I understand that private health information that is used or disclosed in pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule.

_____ _____

Signature of Patient or Legal Guardian Patient 's Date of Birth

_____ _____

Relationship to Patient Date

_____

Clearly Print Name of Patient

Fax Numbers:

Internal Medicine: 334-793-7592 **Endocrinology: 334-793-1954**

Rheumatology: 334-671-9764

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PHARMACY INFORMATION SHEET

DATE: _____

PATIENT NAME: _____

DATE OF BIRTH: _____

LOCAL PHARMACY NAME

PHARMACY NAME: _____

CITY OR LOCATION: _____

PHONE NUMBER: _____

FAX NUMBER: _____

MAIL ORDER

PHARMACY NAME: _____

PHONE NUMBER: _____

FAX NUMBER: _____

Please Circle One :

30 day supply or 90 day supply

PHARMACY INSURANCE INFORMATION

INSURANCE COMPANY NAME: _____

CONTRACT NUMBER OR SSN: _____

PHONE NUMBER: _____

Dothan Medical Associates, PC

Important News!

Our New Secure Patient Portal

As a valued patient, we hope you will enjoy the convenience of online access to our office. We invite you to join our Secure Patient Portal called **Medfusion.**

To register for an account, please go to our Website, www.dothanmedical.com. Click on the "Secure Patient Portal" button.

To register for an account, you will need to answer some basic information to verify your identity. Once you are signed up, you will be able to communicate with us through our secure portal to request an appointment, ask a clinical question, make a payment online, and even view your health information.

Thank you for trying us out. I hope you will find it a helpful tool in improving our communication with our patients.

IMPORTANT NOTICE

"NO SHOW" POLICY

AT DOTHAN MEDICAL ASSOCIATES, PC, WE STRIVE TO MAKE EVERY EFFORT TO NOTIFY YOU OF ANY SCHEDULED APPOINTMENTS. OUR REMINDER SERVICE WILL ATTEMPT TO CONTACT YOU *TWO* DAYS PRIOR TO YOUR APPOINTMENT AT THE PRIMARY PHONE NUMBER YOU HAVE LISTED WITH US TO REMIND YOU OF YOUR SCHEDULED DATE AND TIME.

WE REALIZE THERE MAY BE TIMES WHEN YOU NEED TO RESCHEDULE YOUR APPOINTMENT. WE ASK YOU TO SHOW CONSIDERATION BY NOTIFYING OUR OFFICE AT LEAST 24 HOURS IN ADVANCE IF YOU ARE UNABLE TO KEEP AN APPOINTMENT. WE WOULD LIKE TO HAVE THE OPTION TO OFFER THAT APPOINTMENT TO ANOTHER PATIENT WHO NEEDS TO SEE THE DOCTOR.

THIS SERVES AS NOTICE THAT IF YOU FAIL TO GIVE AT LEAST 24-HOUR NOTICE OF CANCELLATION IN THE FUTURE, THERE WILL BE A $35 CANCELLATION FEE FOR "NO-SHOW" RETURN APPOINTMENTS, AND A $50 FEE FOR "NO SHOW" NEW PATIENT APPOINTMENTS.

REPEATED MISSED APPOINTMENTS MAY RESULT IN DISMISSAL FROM OUR PRACTICE.