GRANDVIEW
MEDICAL GROUP

PATIENT INFORMATION

Patient Name: Last_____ First_____ Middle_____

Address: _____City_____ State_____ Zip Code_____

Home: _____ Work: _____ Cell: _____

Email: _____ Marital Status: _____ Birthdate: _____/_____/_____

Social Security #: _____ Race: _____ Sex: _____

Employer: _____ Employer Ph#: _____

Spouse's Name (if married): _____ Spouse's Employer: _____

Relatives/friends who are patients here?_____ Who referred you to us: _____

Pharmacy Name: _____ Pharmacy Phone #: _____

Emergency Contact and Number: _____ Relationship: _____

INSURANCE INFORMATION

Insurance Company (Primary): _____

Policy Holder's Name: _____ Birthdate _____/_____/_____

Contract Number: _____ Group Number: _____

Insurance Company (Secondary): _____

Policy Holder's Name: _____ Birthdate _____/_____/_____

Contract Number: _____ Group Number: _____

CONSENT FOR TREATMENT

I consent to necessary treatment, including drugs, medication, performance and operation of X-ray, or other studies that may be used by the attending physician, nurse, or staff.

CONSENT FOR ELECTRONIC COMMUNICATION

I consent to the use of electronic communication, including text messaging, email and Videoconferencing for Telehealth.

CONSENT FOR E-PRESCRIBING

I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

NON-COVERED SERVICE AGREEMENT

As your physician, I want to provide you with the best care possible. There may be certain routine services performed during your visit(s), such as dexa scans, pap smears, biopsies, ultrasounds/X-rays, lab work, injections, and/or other testing that I feel necessary for the maintenance of your good health that may not be covered by your insurance contract. By signing below, you agree that you will be responsible for costs not covered by your insurance.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I received a copy of the Notice of Privacy Practices.

SIGNATURE: _____ **DATE:** _____

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PATIENT HEALTH INFORMATION

Patient Name: _____ DOB: _____ Age: _____ Today's Date: _____
Height: _____ Weight: _____ Pain Scale: __/10
Chief Complaint: _____Date of accident/injury: _____
If this was an accident, how did id occur: _____
What makes your pain worse: _____
What makes your pain better: _____
Have you been treated for this condition? If so, please describe: _____
_____

FAMILY MEDICAL HISTORY:

Please list all medical illnesses affecting your mother and father or close relatives

☐ I have no known family medical history

Father:_____ Alive/Deceased _____
Mother:_____ Alive/Deceased _____
Other:_____ Alive/Deceased _____

SOCIAL HISTORY:

How many children?:_____Occupation: _____Do you exercise?:_____
Tobacco use?: _____ How much per day?: _____If not now, when did you quit?: _____
Alcohol use: Beer Wine Liquor How much per week?: _____If not now, when did you quit?: _____
Illegal Drugs: Marijuana Heroin Cocaine Other?: _____If not now, when did you quit?:_____

PAST SURGICAL HISTORY:

Please list all past surgeries and their approximate date

Surgery: _____Year: _____
Surgery: _____Year: _____
Surgery: _____Year: _____
Surgery: _____Year: _____
Surgery: _____Year: _____

PAST MEDICAL HISTORY:

Please circle any of the following you have been diagnosed with

Mitral valve prolapse	Seizure disorder	Cancer	Diabetes
Afib/Arrhythmia	Irritable Bowel Syndrome	Sleep Apnea	Anemia
Asthma	Osteoporosis	Anxiety/Depression	Lupus
Heart disease	Blood clots / DVT	Stroke	COPD
Heart attack	Thyroid disease	High blood pressure	Arthritis

Other: _____
Do you have a Pacemaker? _____ Year: _____
Do you have Heart Stents? _____ Year: _____

Signature: _____ **Date:** _____

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Patient Name: _____ **DOB** _____ **Today's Date:** _____

Pharmacy: _____ **Pharmacy Phone:** _____

☐ **I currently do NOT take any Medications**

Taking any blood thinners? ☐**No,** ☐**Asprin** ☐**Eliquis** ☐**Xarelto** ☐**Plavix** ☐**Coumadin** ☐**Lovenox**

Cardiologist: _____ **Phone#** _____

Medications you are currently taking:	Dose	Frequency

Medication allergies: _____

Last Vaccinations:

Influenza_____ Tetanus_____ Pneumonia_____ Shingles_____

Covid19 _____, Manufacturer Name_____

Signature: _____ **Date:** _____

GRANDVIEW
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PATIENT HISTORY INTAKE FORM

Patient Name: _____DOB/Age:_____ Today's Date: _____

Please circle any recent symptoms that you may be experiencing or may have experienced in the past year.

CONST
Weight gain/loss
Fever
Fatigue
Night Sweats
Hot/Cold Intolerance
Frequent Falls

EYES
Dry eyes
Vision Changes

ENT
Mouth Sores
Sore throat
Ringing in ears

RESP
Persistent cough
Wheezing

CV
Shortness of breath
Difficulty breathing
Chest pain
Rapid heartbeat
Swollen hands and feet

GI
Persistent diarrhea
Bloody stools
Nausea and vomiting
Constipation
Abdominal Pain

ALL
Hives, blisters
Red itchy eyes

KIDNEY
Pain or burning w/urination
Strain to urinate
Bladder infection

PSYCH
Depression
Mood swings
Anxiety

MSK
Joint or muscle pain
Muscle weakness

LYMPH
Swollen lymph nodes

NEURO
Seizures
Frequent headaches
Dizziness
Numbness

HEME
Easy Bleeding
Easy Bruising

ENDO
Night Sweats
Hot/cold Intolerance

SKIN
Rash
Easy Bleeding
Easy Bruising

OTHER _____

Signature: _____

Date: _____

GRANDVIEW
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AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

_____ **I DO NOT** wish to have test results or other medical information released to any person other than myself.

_____ **I DO** wish to have test results or other medical information released to the following person(s):

Name	Relationship	Phone #
Name	Relationship	Phone #
Name	Relationship	Phone #
Name	Relationship	Phone #

It is the responsibility of the patient to notify this office of any changes in the above information. If changes do occur, the patient must file another Authorization for Release of Patient Information with this clinic. Please understand that it may be necessary for us to disclose some or all of the Information contained in your medical records to other physicians, nurses, and/or healthcare providers (collectively referred to as "providers"). At times, other providers assist using assessing a patient's condition, screening for potential problems, or providing consultation under certain circumstances. All healthcare providers are required by law to maintain your patient confidentiality.

Also, due to the increased awareness of quality care and outcome measurements, it may be necessary to disclose information regarding your care to healthcare agencies (both private and governmental), your insurance company and/or your self-insured employer. Regarding the information going to your employer, other than information needed to verify your insurance coverage, the data released will consist of statistical information only.

_____ _____

Patient Signature Date

_____ _____

Printed Name SS#

GRANDVIEW
MEDICAL GROUP

NARCOTIC NOTICE TO PATIENTS

Grandview Medical Group will NOT provide prescriptions for hypnotic sedatives, stimulants and other controlled drugs to new patients, unless it is deemed necessary by the physician for situations that include severe illness or injury that has occurred within 24-48 hours for the date of the office visit. New patients are given this notice at the time of the appointment and patients should understand that if long term pain management is needed as part of their total medical care, an appointment with a chronic pain management facility is recommended and should be scheduled by the patient. Records from the treating physician will be requested as we may not be able to accept any records brought in by the patient. New patients should be aware that all patients, new and established, are subject to query at the State of Alabama Department of Public Health Prescription Drug Monitoring Website for verification of narcotic/analgesic use and/or random drug screening.

If a new patient should request a narcotic/analgesic prescription for a chronic/long term condition after they have read, understood and agreed by signature to this policy, the request will be denied and possible dismissal of medical services will be enacted at the physician's discretion. Also, if at any time, Grandview receives a report that a patient, new or established, is receiving inappropriate or duplicate prescriptions of narcotics/analgesics from other physicians, the patient will be immediately dismissed from receiving medical services from Grandview Medical Group indefinitely.

I have read and understood the Narcotics Policy for Grandview Medical Group and agree to follow this policy as a patient of Grandview Medical Group.

Signature:_____ **Date:** _____

Cancellation Policy/No Show Policy

We strive to promote the best quality healthcare for our patients. One of the ways we meet your healthcare needs is to provide appointments with our physicians in a timely manner, many times within the same day. In order to provide these appointments, we have the following No Show/Cancellation policy.

1. *Cancellation/ No Show Policy for Doctor Appointment*

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an Appointment, you may be preventing another patient from receiving much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment schedule.

If an appointment is not cancelled at least 24 hours in advance you may be subject to fees which are not covered by your insurance company. More than 3 no shows within a six month period will result in dismissal from the practice. Violators will receive a letter after the second no show as a reminder of the policy.

2. *Scheduled Appointments*

We understand that delays can happen however we must try to keep the other patients and our physicians on time.
If a patient is 10 minutes past their scheduled time, it may be necessary to reschedule your appointment.

3.*Cancellation/ No Show Policy for Surgery/Procedure*

Due to the large block of time needed for surgery and/or procedures, last minute cancellations can cause
problems and added expenses for the office.

If your are scheduled for a surgery/procedure is not cancelled at least 10 days in advance you may be subject to fees which are not covered by your insurance company.

4. Account balances

We will require that patients with self-pay balances do pay their account balances to zero (0) prior to receiving further services by our practice.
Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns.
Patients with balances over $100 must make payment arrangements prior to future appointments being made.

_____ _____ ____/____/____

Print Name Patient Signature Patient/Guardian Date

1. **ASSIGNMENT OF INSURANCE BENEFITS/PROMISE TO PAY:**
I hereby assign and authorize payment directly to the Physician Clinic all insurance benefits, sick benefits, injury benefits due because of responsibility of a third-party, or proceeds of all claims resulting from the responsibility of a third party, payable by any party, organization, et cetera, to or for the patient unless the account for this Physician Clinic, outpatient visit or series of outpatient visits is paid in full upon completion of the medical services. If eligible for Medicare, I request Medicare services and benefits. I further agree that this assignment will not be withdrawn or voided at any time until the account is paid in full. I understand I am responsible to pay any account balance for applicable coinsurance and deductible amounts and for those amounts not otherwise covered by my insurance company in accordance with the regular rates and terms of the Facility. I understand and acknowledge that I will be responsible for any co-payment or deductible amounts associated with treatment ordered by my physician.
I understand that I am obligated to pay the account of the Physician Clinic in accordance with the regular rates and terms of the Physician Clinic. If I fail to make payment when due and the account becomes delinquent or is turned over to a collection agency or an attorney for collection, I agree to pay all collection agency fees, court costs and attorney's fees. I also agree that any patient or guarantor overpayments on the above Physician Clinic visit may be applied directly to any delinquent account for which I or my guarantor is legally responsible at the time of the collection of the overpayment. I consent for the Physician Clinic to work with my insurance company/ companies on my behalf on authorization, appeal on my behalf any denial for reimbursement, coverage, or payment for services or care provided to me.

2. **PATIENT CONSENT FOR E-PRESCRIBING (ELECTRONIC PRESCRIBING):**
I understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

3. **CONSENT TO RELEASE HEALTH INFORMATION:**
I understand this Physician Clinic uses an electronic medical record. I understand that the electronic medical record contains information about my health from my past, current and future health care providers. I agree that this health information may be released through the Physician Clinic's electronic medical record or by other means (for example, fax, telephone, email, or hand delivery): (1) to the Physician Clinic; (2) to my past, current and future health care providers and other health care organizations that provide care to me; (3) to the health insurance company named in my medical record; and (4) to any other person named in my medical record or insurance payers who pay for my treatment . These people may use my health information: (1) to treat me; (2) to get paid for my treatment (for example, billing insurance companies), and (3) to do health care operations activities (for example, managing my care, providing quality care, patient safety activities, and other activities necessary to operate the Physician Clinic). I understand that these people will have access to all my health information in the medical record, including behavioral health and substance use disorder information (for example, drug and alcohol treatment), my medical history, diagnosis, hospital records, clinic and doctor visit information, medications, allergies, lab test results, radiology reports, sexual and reproductive health information, communicable disease related information (for example, sexually transmitted diseases), and HIV/AIDS related information. I understand that I may take back this consent at any time, except if my health information has already been released for these purposes. I also understand that I may request a list of the health care organizations that have received my substance use disorder information. This consent will not expire unless I revoke.

4. **NOTICE OF PRIVACY PRACTICES:**
Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I have received a copy of the Physician Clinic's Notice of Privacy Practices. I hereby consent to the use and disclosure of my protected health information, including information generated through use of virtual health or telemedicine services, as described in the Notice of Privacy Practices. This will include all of my protected health information generated during hospitalization and outpatient treatment at the Physician Clinic, including but not limited to treatment for mental health, drug and alcohol abuse, communicable diseases such as HIV/AIDS, developmental disabilities, genetic testing, and other types of treatment received.

5. **GENERAL CONSENT FOR TESTS, TREATMENT, AND SERVICES:**
I understand the provider will determine the treatment procedures considered necessary for me and that the treatments/ procedures will be directed by a physician or independent Advanced Practitioner, in accordance with state laws, scope of practice, and licensure of medical providers.

Patient Label

6. **CONSENT FOR VIRTUAL HEALTH/TELEMEDICINE SERVICES, & REMOTE PATIENT MONITORING:**
I hereby consent to engaging in virtual health/telemedicine services, & remote patient monitoring where available, as part of my treatment. I understand that "virtual health" or "telemedicine services" includes the practice of health care delivery, diagnosis, consultation, treatment, transfers of medical data, and education using interactive audio, video, or data communications when the health care provider and patient are not in the same physical location. Remote Patient Monitoring includes use of digital devices to collect health data from me where I am located and electronically transmit that information to providers in a different location for assessment and recommendations. This type of service allows a provider to continue to track my health status and data outside of the Physician Clinic. The interactive electronic systems used for these services will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption. I understand that the potential benefits of receiving care in this manner include improved access to care and the ability to obtain the expertise of a specialist. The potential risks include problems with information transmittal, including but not limited to poor data transfer which may include a poor video and data quality experience, technical problems with the information, transmission or equipment failures that could result in lost information or delays in treatment, or lack of access to my complete medical record by the remote provider. I understand that all information, including images, will be part of my medical record available to me if requested and with the same restrictions on dissemination without my consent. I understand that telehealth should not be used for emergency medical conditions. I understand I may withdraw my consent at any time.

7. **ADVANCE DIRECTIVE ACKNOWLEDGEMENT:**
Federal law requires that patients be provided information about their rights to make advanced health care decisions, including Living Will, Durable Medical Power of Attorney or designation of surrogate decision maker for health care decisions. By signing, you acknowledge awareness of these rights and understand the Physician Clinic can provide you with additional information and appropriate forms should you desire them.

8. **RESEARCH STUDIES:**
If you are currently participating in any research studies or clinical trials, we ask you please notify Registration and your Provider. You will be asked to provide a description of what is being studied (drug, medical device or other) and the Research Coordinator's contact information should your Provider have questions about the Study.

9. **CONSENT TO PHOTO/VIDEO:**
I consent to the photographing, videotaping and/or video monitoring, including appropriate portions of my body, for medical and medical record documentation purposes, provided said photographs or videotapes are maintained and released in accordance with protected health information regulations.

10. **CONSENT TO PHOTOGRAPH AT THE TIME OF REGISTRATION:**
I, hereby give consent to the medical practice to take my photograph at the time of registration. I understand this photograph will be stored in the medical practice's ambulatory medical record electronically as my photo identification.

11. **COMMUNICATIONS:**
I consent to this Physician Clinic, its successors or assignees contacting me via the methods I provide to the Physician Clinic. I understand the communications may occur in any manner, including phone calls to my cell phone or landline, voicemails on my cell phone or landline, use of automated telephone dialing systems, use of artificial or prerecorded voice messages, text messages to my cell phone, or email messages. I understand the communications may be about any matter, including, but not limited to, my medical treatment, prescriptions, insurance eligibility, insurance coverage, scheduling, billing or collection matters. I understand that these communications are not encrypted or secure, and I assume the risks of transmitting health information via unsecure means. If I incur any cost from being contacted at the telephone number(s) or email address(es) provided to the Physician Clinic, including but not limited to data, roaming, text messages, additional minutes or other fees, I understand that the Physician Clinic is not responsible for paying these charges. This consent also applies to any updated or additional contact information that I may provide. I understand that I will be able to change my preference at any time by contacting the Physician Clinic.

12. **VIDEOTAPING/RECORDING:**
I understand and agree not to photograph, videotape, audiotape, record or otherwise capture imaging or sound on any device. I also understand it is my responsibility to assure those accompanying me comply with this requirement.

The undersigned certifies that s/he has read (or have had read to me) the foregoing, understands it, accepts its terms, and has received a copy of. I hereby agree to all terms and conditions set forth above and understand that any sections of this consent that I do not consent to, I have struck through and initialed the section that does not have my consent or permission.

Patient's Signature or Legal Representative				Date	Time
Relationship to Patient			Interpreter, if Utilized	Date	Time
Witness Signature	Date	Time	If Telephone Consent, Second Witness Signature	Date	Time

Patient Label

All portions of this form ***must*** be completed to constitute a valid authorization for release of health information under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations.

Patient's Name	Date of Birth	Medical Record Number

Address	City	State	Zip	Telephone Number	Email Address

I authorize the use and disclosure of health information about me as described below:

Facility Authorized to Release my Health Information

Address	City	State	Zip	Telephone Number

Agency or Individual(s) Authorized to Receive my Health Information Bramlett Orthopedics

Address	City	State	Zip	Telephone Number
1021 Montgomery Hwy, Suite 201	Vestavia Hills	AL	35216	205·971·1925

Health Information that may be used / disclosed is limited to the following:

☐ Discharge Summary ☐ History and Physical ☐ Consultation(s) ☐ Progress Notes ☐ Emergency Room Record
☐ Operative Note(s) ☐ Imaging/X-Ray Films ☐ X-Ray Reports ☐ Lab ☐ Pathology Report
☐ Entire Record ☐ Fetal Heart Monitor Strips

Sensitive Information:

☐ Alcohol Abuse ☐ Drug Abuse ☐ Communicable diseases, including HIV status
☐ Genetic Testing ☐ Psychiatric/Behavioral Diagnoses
X Other *(specify)* Video | Picture for Patient testimonial

Health Information that may be used / disclosed is limited to the following periods of healthcare:

From (date): _____ To (date): _____ Account Number: _____
From (date): _____ To (date): _____ Account Number: _____

Health information to be released to the above named agency / individual is to be used / disclosed for the following purpose(s):

☐ Treatment/Consultation ☐ At Request of Patient X Research X Marketing ☐ Billing or Claims Payment
☐ At Request of Employer X Other Patient education
Form and Format of Disclosure Requested: _____

"Health Information" identifies you (the patient) by name, and includes other demographic information about you. "Health Information" may include, but is not limited to: medical records, X-Ray films, slides, tracings, strips, etc.

I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release of information authorized herein, including Sensitive Information as indicated above, which was compiled during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility.

Protected Health Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by this privacy rule. If research-related Health Information is used or disclosed for continued research purposes, an expiration date or event does not apply.

If no specific date or event is noted below, this authorization will automatically *expire 60 days* after the date of signature. I understand that I have a right to revoke this authorization at any time, in writing, as stated in the Notice of Privacy Practices, except where the facility has already made disclosures in reliance upon my prior authorization.

Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining an authorization if the HIPAA prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage.

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: This information is to be treated in accordance with (HIPAA) privacy regulations.

Patient's Signature or Legal Representative		Date	Time
Relationship to Patient / Authority to Act on Patient's Behalf	Interpreter, if Utilized	Date	Time
Witness Signature		Date	Time

Patient Label

Bramlett Orthopedics

Swaid Vestavia Medical Center

1021 Montgomery Highway, Suite 201

Vestavia Hills, Alabama 35216

Phone: 205-971-1925 Fax: 205-971-1927

FROM THE NORTH

Take I-65 SOUTH towards Birmingham

Follow I-65 SOUTH to Montgomery Highway NORTH/Hwy 31, Exit 252, on the right going SOUTH

From this exit, take a LEFT onto Montgomery Hwy NORTH/Hwy 31

Travel approximately 2.1 miles, then take a RIGHT into entrance to Vestavia Medical Center, crossing over a service road. Entrance is on the back side of the building once you have entered the parking lot. We are on the 2nd floor, suite 201

FROM THE SOUTH

Take I-65 NORTH towards Birmingham

Follow I-65 NORTH to Montgomery Highway NORTH/Hwy 31, Exit 252, on the right going NORTH

From this exit, take a RIGHT onto Montgomery Hwy NORTH/Hwy 31

Travel approximately 2.1 miles, then take a RIGHT into entrance to Vestavia Medical Center, crossing over a service road. Entrance is on the back side of the building once you have entered the parking lot. We are on the 2nd floor, suite 201

FROM THE EAST

From I-20/59 SOUTH, take I-459, exit 136, to Montgomery/Tuscaloosa (from I-20, merge toward left lane to access this exit)

From I-459, take I-65 NORTH to Birmingham, exit 15, stay in far RIGHT lane once on this exit to get on I-65 NORTH

Follow I-65 NORTH to Montgomery Highway NORTH/Hwy 31, Exit 252, on the right going NORTH

From this exit, take a RIGHT onto Montgomery Hwy NORTH/Hwy 31

Travel approximately 2.1 miles, then take a RIGHT into entrance to Vestavia Medical Center, crossing over a service road. Entrance is on the back side of the building once you have entered the parking lot. We are on the 2nd floor, suite 201

FROM THE WEST

From I-20/59 NORTH, take I-459, exit 106, to Birmingham/Gadsden

Take I-65 NORTH to Birmingham, exit 15, merge onto the far LEFT lane once on this exit to get on I-65 NORTH

Follow I-65 NORTH to Montgomery Highway NORTH/Hwy 31, Exit 252, on the right going NORTH

From this exit, take a RIGHT onto Montgomery Hwy NORTH/Hwy 31

Travel approximately 2.1 miles, then take a RIGHT into entrance to Vestavia Medical Center, crossing over a service road. Entrance is on the back side of the building once you have entered the parking lot. We are on the 2nd floor, suite 201