Obstetrics and Gynecology of West Alabama, PC.

Patient Medication List:
Pt Name: _____

Medication	Dosage	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Do you have any of these medical problems? (check all that apply)

General:
____ fatigue____ sleeplessness____ weight gain____ night sweats____ hot flashes____ weight loss
Breast:
_____breast lump _____nipple discharge _____tenderness
GI:
____ abdominal pain____ bloating____ diarrhea____ constipation____ blood/mucus in stool
____ heartburn____ cramping
GYN:
____heavy bleeding____ irregular bleeding ____ pain with cycle____ pain with intercourse____ pelvic pain
____ vaginal dryness____ vaginal discharge____ pain with urination _____frequent urination _____leaking of urine _____wake up at night to urinate _____vaginal burning _____vaginal irritation
ENDOCRINE:
_____cold intolerance _____heat intolerance
Psych:
____ depression____ anxiety____ irritability____ panic attacks____ crying spells

OBSTETRICS & GYNECOLOGY OF WEST ALABAMA, P.C.

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Harvey A. Edwards III, M.D., FACOG
Stephen E. Allen, M.D., FACOG
Myron S. Chwe, M.D., FACOG

Elizabeth C. Emig, M.D., FACOG
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PERMISSION TO RELEASE INFORMATION

It is a breach of patient confidentiality for a physician and/or their staff to release any information regarding you or your medical condition to anyone without your permission. This includes your medical condition, prognosis, appointment times, insurance information, billing or demographic information. Therefore, if you anticipate the need for anyone else to have access to this information, please complete the information below.

I, (we), the undersigned patient and/or responsible party hereby authorize Obstetrics and Gynecology of West Alabama, P.C., it's physicians, agents, employees or representatives to discuss or release any or all patient information about me including but not limited to past and current medical information, billing information, appointment scheduling, prescriptions, etc. to the person or persons indicated below:

_____Spouse Name_____

_____Parents Names_____

_____Children Names_____

_____Other Relationship Name

_____ _____

_____ _____

_____ _____

Patient Signature_____Date_____

2750 HOSPITAL DRIVE, NORTHPORT, ALABAMA 35476 (205) 339-3039 FAX (205) 339-9908

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☐ I am here today for a routine exam. (I have no medical complaint or problem.)

☐ I have a problem/complaint that I wish to have evaluated/treated by the doctor.
My chief complaint is _____.

☐ Other Medical Services:_____.

☐ Ultrasound

- We want to provide you with the best care possible. There are however, certain services necessary for the maintenance of good health that may not be covered by your insurance carrier. You will be expected to pay these services in full today. We will order only tests that we feel are necessary for your care.
- Some insurance companies require referrals for office visits. Any referral for a visit to our office must be obtained by the patient prior to services being rendered. If you do not obtain your referral, you must pay for your visit today.
- If you are not seen in our office over a period of 3 years, you will be considered a new patient. In order to schedule an appt, you will need to be accepted by one of our physicians as a new patient.

Assignment of insurance benefits: I hereby authorize direct payment of surgical/medical benefits to my physician, for services rendered by him/her in person under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

Authorization to release information to my insurance company: I hereby authorize my doctor to release any medical or incidental information that may be necessary for either care or in processing applications for financial benefit. A copy of these assignments shall be valid as the original.

Agreement to pay: I, the undersigned, accept the fee(s) charged as a legal and lawful debt. I understand the fee(s) charged are due at the time of service. Should it become necessary to forward my account for collection, I agree to pay all monies due, including a 33 1/3% collection fee, attorney fees, and/or court costs, if such be necessary. I waive now and forever, my right of exemption under the laws of the Constitution of the State of Alabama and any other state.

Express prior consent to contact consumer by cell phone: I the undersigned, give OB/GYN of West Alabama, P.C., it employees and/or agents "express prior consent" to contact me at any/all phone numbers, including cell phone numbers, for the purpose of treatment, insurance or payment.

Cancelation/No Show Policy: If an appointment is not cancelled at least 48 hours in advance you may be subject to a twenty five dollar ($25) fee; this will not be covered by your insurance company.

Signature:_____ Date:_____

Printed Name:_____ Witness:_____

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Provider Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and disclosures of health information

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes and to evaluate the quality of care that you receive. Continuity of care is part of treatment and your records may be shared with other providers to whom you are referred. Information may be shared by paper mail, electronic mail, FAX or other methods.

We may use or disclose identifiable health information about you without your authorization for several reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policies at any time. Before we make a significant change in our policy we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Individual rights

In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about you. If you request copies, we will charge you only normal photocopy fees. You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment or related administrative purposes and other than when you explicitly authorized it. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

Our legal duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practices that are described in this note and obtain your acknowledgement of receipt of this notice.

If you have any question in regard to this notice please contact our office manager Nacole McFerrin at the number provided below.

I acknowledge that I have received and read this Notice of Privacy Practices:

Signature:_____

Printed Name:_____

Date:_____

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