University Medical Center

Updated as of 7/19/16
Supersedes all prior versions

PATIENT INFORMATION

Patient Name ____ Chart # __________________

Mailing Address ________________________________ _________________ ______ ________
Street City State Zip

DOB _____/_____/_____ SEX: ☐ Male ☐ Female Social Security #: _____-_____-_____

☐ Home Phone ______________ ☐ Cell Phone _____________ ☐ Work Phone _____________

(Please check which number would be preferred number for contact)

Employer ____

Marital Status: ☐ single ☐ married ☐ divorced ☐ widowed RACE: _______________

Spouse's Name ______________________________ DOB ____/____/____ Last 4 digits of SSN _______

Spouse's Place of Employment ____

EMERGENCY CONTACT: _______________________________________ **PHONE:** ________________

INSURANCE & RESPONSIBLE PARTY INFORMATION

(This section *must* be filled out)

Primary ________________________________

Group #: ________________________________

Policy #: ________________________________

Responsible Party's Name (if other than patient)

____

☐ **Male** ☐ **Female**

DOB: ___/___/____ **Phone** _______________

Social Security #: _____-_____-______

Address ________________________________
Street

__________________ _______ __________
City *State* *Zip*

Secondary ________________________________

Group #: ________________________________

Policy #: ________________________________

Responsible Party's Name (if other than patient)

____

☐ **Male** ☐ **Female**

DOB: ___/___/____ **Phone** _______________

Social Security #: _____-_____-______

Address ________________________________
Street

__________________ _______ __________
City *State* *Zip*

I authorize and request my insurance company to pay directly to University Medical Center any health benefits resulting from care received in that facility. I understand that my insurance company may not cover all services rendered on behalf of me or my dependents and I agree to assume responsibility for any services, procedures, devices, or testing not covered. I consent to the release to my insurance company of any medical record (except psychiatric) necessary to resolve claims for services rendered. I understand that co-pays and any services not covered by an insurance company are DUE IN FULL AT THE TIME OF SERVICE. Patient/guarantor understands that any credit balance *on a date of service* may be applied to other outstanding balances *due on other dates of services* for their personal account and/or for accounts for which they are the guarantor.

***Signature** ____ ***DATE**_____________________

***Relation to Patient** ____

FOR OFFICE USE ONLY:

Suite _____________________________________ Doctor _________________________

New Patient _______ Update _______ OC _______ WC _______

University Medical Center

Revised Effective: 7/19/2016
Supersedes All Prior Copies

Patient Name ____________________

Date of Birth_____________________

UNIVERSITY MEDICAL CENTER

(Hereinafter referred to as UMC)

PATIENT COMMUNICATION CONSENT FORM

I agree to allow UMC to contact me in the following methods regarding my private health information, evaluation and treatment. I authorize UMC to leave messages for me when I am unavailable.

PREFERRED CONTACT NUMBER		NUMBER/ADDRESS	MESSAGES (YES OR NO)
____	Home Phone	(____) ____________________________	☐ Yes ☐ No
____	Cell Phone	(____) ____________________________	☐ Yes ☐ No
____	Work Phone	(____) ____________________________	☐ Yes ☐ No
____	Text Messages	(____)____________________________ **(Texting requires that you give us your cell number and for you to have a text enabled cell phone plan)**	☐ Yes ☐ No
____	Patient Portal	**Registration required** (Ask nurse to register you for this free service).	

____________________________________@_______________.__________

Email to be used for Patient Portal Registration Only

<u>Do not email patient except through Patient Portal</u>.

Security Questions: What is your mother's maiden name? ____________________________

What is the name of your childhood best friend? ________________________________

What is the brand of your first car? _________________________________

I authorize UMC and medical staff to discuss my healthcare information (which may include history, diagnosis, labs, test results, treatment and other health information) with the contacts listed below.

I understand that by leaving spaces blank I am indicating that I do not want any information released to anyone else.

NAME	RELATIONSHIP TO PATIENT	CONTACT INFO

I authorize the following person(s) to pick up prescriptions. (**Please check the Controlled Substance Form)**

____

____

EMERGENCY CONTACT ONLY -

NAME: ____________________________________ Phone: __________________________

By my signature below I acknowledge that I have read and understand the **<u>Guidelines to Patient Communication</u>** and information provided on this consent form. I understand the risk associated with the different methods of communication and consent to the conditions, restrictions and patient responsibilities outlined within the Guideline as well as any other instruction that UMC may impose.

____

Patient name printed   Date

____

Patient/Authorized Signature   Relationship to Patient

University Medical Center

UNIVERSITY MEDICAL CENTER

[hereinafter referred to as "UMC"]

Patient Name__________________________________

Chart Number_____________________________________

Acknowledgement of Notice of Health Information Practices

We have made available to you our Notice of Health Information Practices. PLEASE REVIEW THIS NOTICE CAREFULLY! You may have a personal copy of the Notice, or you may access the Notice on-line at http://umc.ua.edu/about/hipaa-notice/.

The Notice explains when we might use/disclose your health information, and includes some of the following examples:

- when you give us permission to disclose your health information
- to aid in your treatment or to persons involved in your health care or the payment for such
- to help us or other health care providers get paid for services provided to you
- to improve our health care operations
- for use by businesses with whom we contract to help provide administrative support, but only if they agree in writing to keep your information private
- to public health agencies, governmental agencies, or other entities or persons when required or authorized by law or when required or permitted to do so by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Notice also explains some of your rights under HIPAA, including but not limited to your:

- right to ask that information about you not be disclosed to certain persons
- right to restrict disclosures of PHI to your health plan when you pay out of pocket in full for a healthcare item or procedure
- right to ask that we communicate differently with you to ensure your privacy
- right to look at and get a copy of most of your health information in our records
- right to request that we correct health information in your record that is wrong or misleading
- right to be notified when a breach of your health information has occurred
- right to have us tell you to whom we have disclosed your health information
- right to make a complaint with our Privacy Officer or the Secretary of the U.S. Department of Health and Human Services.

I acknowledge that I have been given an opportunity to review this facility's Notice of Health Information Practices, that I understand what kind of information is contained in the Notice, that I am entitled to have my own personal copy of the Notice, and that a copy is available for me to have.

Signature of patient or patient's representative: ________________________________**Date:**____________

Printed Name of patient's representative:____

Relationship to the patient/description of authority to act for patient:_________________________________

FOR UMC USE ONLY:
Date Notice Made Available:__________ *Notice Delivered*: __in person__mail__electronic *Acknowledgement Signed?* __Yes__No
Why Acknowledgement Not Signed:__patient refused__patient failed to return__emergency__other______________________

Signed copy of Acknowledgement should be filed in Patient's Record

University Medical Center

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UNIVERSITY MEDICAL CENTER
[hereinafter referred to as "UMC"]

Chart Number: ______________

PATIENT'S RIGHTS AND RESPONSIBILITIES SIGNATURE FORM

We encourage you to take an active role in managing your health. We can work together most effectively if you understand what to expect from us and what we expect from you. Here is a summary of your rights and responsibilities as a user of UMC Health Services. If you would like more information about any of these points, please ask your provider or another UMC Staff.

I am signing that I have received and accept the University Medical Centers Patient Rights and Responsibilities.

Patient Printed Name ____
Patient Signature/Parent or Guardian ____
Relationship to Patient ____

Date: __________________________

University Medical Center

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Authorization to Disclose Health Information

I hereby authorize the use and/or disclosure of my individually identifiable protected health information ("PHI") as described below. Unless explicitly excluded, this authorization includes any information relating to drug and/or alcohol abuse/treatment, communications with psychiatrists or psychologists of records pertaining to sexually transmitted diseases, if they are part of my medical record. I understand that this authorization is voluntary. Once this information has been disclosed, it may be subject to re-disclosure and may no longer be protected by federal privacy regulations.

Patient Name: ______________________________________ Date of Birth: ____________________________ Medical Record # ____________

Patient Telephone #: _____________________________________ Social Security #: _____________________

Please request my medical records from: Name: ____

Address: ____

____

Phone #: _________________________ Fax #: ________________________

Please send my medical records to: Name: ____

Address: ____

Phone #: _________________________ Fax #: ________________________

Please send/request this information: Office Note: ______Lab: _____Medications: ______Immunizations: ______

Other: ________________Please specify: _____________________________ Entire record: _____________

From what time period do you want information released or obtained: ______________________________________

This information will be used by: self: _____ physician: ________ other: __________

Please send this information by: Mail: ( ) yes ( ) no Fax: ( ) yes ( ) no Telephone: ( ) yes ( ) no
Email ( ) yes ( ) no ( ) Encrypted ( ) unencrypted Patient has been informed of risk

This authorization will expire: ____
Note: After this date has passed, this authorization will no longer be valid. Unless otherwise specified this authorization will be valid for 6 months after the date it is signed. If the authorization is for research, the statement "end of the research study" or "none" or similar language will extend your permission beyond 6 months.

Unless explicitly excluded, this Authorization includes any information relating to drug and/or alcohol abuse/treatment, communications with psychiatrists or psychologists or records pertaining to sexually transmitted diseases, if they are a part of my medical record. I understand that this authorization is voluntary. Once this information has been disclosed, it may be subject to re-disclosure and may no longer be protected by federal privacy regulations.

If for marketing, will UMC receive payment/benefit from the third party receiving the PHI? __Yes __No __N/A

The patient or the patient's representative must read and initial the following statements:

Initials: _________ I understand that I may revoke this Authorization at any time by notifying UMC Privacy Officer in writing, UMC will not be liable for any protected health information released prior to me revoking this authorization.

Initials: _________ I understand that UMC may not condition the provision of treatment, payment, enrollment in a health plan, or eligibility for benefits on signing this Authorization, except under the following circumstances:

- **participating in research projects can be conditioned on my signing an Authorization to use and disclose PHI in the research**
- **initial enrollment in health plans can be conditioned on signing an Authorization for the health plan to review PHI to make eligibility determinations.**

If a third party request healthcare services for me, PHI will not be released without me signing an authorization.

Signature of patient or patient's representative: ____________________________________ Date: _________________

Printed name of patient's representative: ____

Relationship to patient/description of authority to act for patient: ____