PHONE: 334-654-5080

ANDERSON FAMILY CARE

FAX: 334-654-5081

Patient Request for Health Information

Patient Information

First Name _____ Middle Name _____ Last Name _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Phone _____

_____ **I request that the following organization provide my health information to Anderson Family Care:**

Name _____

Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____

Release records from the following dates: _____ to _____

_____ **I request that Anderson Family Care provide my health information to:**

Name _____

Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____

Release records from the following dates: _____ to _____

Release the following records:

_____ Entire Record/All _____ Labs _____ Immunizations _____ Images _____ Office Notes

_____ Other (specify): _____

Signature of Patient: _____ Date: _____

Signature of Representative: _____ Relationship to Patient: _____

A processing fee may be applied.

ADULT NEW PATIENT FORM

Please fill out completely.

Last Name _____ First Name_____ Middle Name _____

Date of Birth _____ Gender _____ SSN _____-_____-_____

Preferred Contact ☐Home Phone ☐Work Phone ☐Cell Phone ☐Email ☐Postal Mail

Marital Status _____ Spouse Name _____

Street Address _____ City _____ State _____ Zip _____

Primary Language _____ Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race ☐Black or African American ☐White ☐Asian ☐Other _____

Home Phone (_____) _____ Cell Phone (_____) _____

Work Phone (_____) _____ Email Address _____

Emergency Contact_____ Phone (____) _____ Relationship _____

Pharmacy: _____ Pharmacy City: _____

Responsible Party (if other than patient)

Name _____ Phone (____) _____

Date of Birth _____ Gender _____ SSN _____-_____-_____

Street Address _____ City _____ State _____ Zip _____

Primary Insurance
Company _____ ID/Policy # _____ Group # _____

Insurance Phone (_____) _____ Is this policy through your employer? Y / N Spouse's employer? Y / N

Employer _____ Phone (_____) _____

Secondary Insurance
Company _____ ID/Policy # _____ Group # _____

Insurance Phone (_____) _____ Is this policy through your employer? Y / N Spouse's employer? Y / N

Employer _____ Phone (_____) _____

Patient's Signature _____ Date _____

Insured's Signature _____ Date _____

ANDERSON FAMILY CARE
Health History ADULT

Name: _____ DOB _____

Phone: _____

How did you find out about our office? _____

PERSONAL HISTORY

Birthplace: _____

Marital Status: *Single Married Separated Divorced Widowed*

Children/Ages: _____

Occupation: _____ Youy

Religion: _____

CURRENT SPECIALTY PHYSICIANS NONE

Specialty	Physician Name
Cardiology	
Endocrine	
Gastroenterology (GI)	
Nephrology (Kidney)	
Surgery	
Urology	
Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization

SURGERIES

Year	Surgery	Reason for Surgery

DATE OF LAST:

Menstrual Period: _____

PAP Smear: _____

Mammogram: _____

Colonoscopy: _____

DEXA Scan: _____

Tetanus Vaccine: _____

Pneumonia Vaccine: _____

Flu Vaccine: _____

Shingles Vaccine: _____

COVID Vaccine: _____

HEALTH HABITS / SOCIAL HISTORY

	Currently		How Much?	Quit Date
Caffeine:	YES	NO	_____	_____
Tobacco:	YES	NO	_____	_____
Alcohol:	YES	NO	_____	_____
Any Drugs:	YES	NO	_____	_____

Have you ever felt you should cut down on your drinking? YES NO

Are you sexually active? YES NO

PERSONAL & FAMILY HEALTH HISTORY

Check (√) if you or your blood relatives have ever had any of the following. Include details on the right.

You	Disease	Family	Details If you, what year? If family, what relation?
	ADD/ADHD		
	Alcohol/Drug dependency		
	Anemia		
	Anxiety or depression		
	Arthritis or Lupus		
	Asthma/ Lung Disease		
	Blood Clots		
	Blood Transfusions		
	Breast Disease or Cancer		
	Cancer (list type)		
	Dementia		
	Diabetes		
	Genetic disease or Birth defects		
	Heart problems		
	Hepatitis		
	High Blood Pressure		
	HIV		
	Kidney disease		
	Liver disease		
	Migraines		
	Neurological disease		
	Pap smear ever abnormal		
	Sexual infections (Gonorrhea, Chlamydia, Herpes, Syphilis)		
	Seizures		
	Stomach problems		
	Stroke		
	Thyroid disease		
	Tuberculosis		
Other Medical Problems			

ADVANCE DIRECTIVE / LIVING WILL

_____ I have executed an Advanced Healthcare Directive, Living Will, or Durable Power of Attorney.
_____ I would like to fill out an Advanced Directive.
_____ I would like to talk about my options.
_____ I do not wish to fill out an Advanced Directive at this time.

ANDERSON
FAMILY CARE

MEDICATION LIST

*****Please list ALL medications, dosage, and instructions. This includes over the counter medications.*****

Name:	Date of Birth:
Allergies/ Reaction:	

Medication	Dosage	Directions	Prescribed By:
Example: **Metformin**	**500mg**	**Twice a day**	**Dr. Anderson**

ANDERSON FAMILY CARE

PATIENT CONTACT RECORD

Patient Name: _____

The HIPAA Privacy Rule gives individuals the right to restrict release of their Private Health Information (PHI). A copy of Anderson Family Care, LLC's Notice of Privacy Practices is included in this packet.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

WRITTEN ACKNOWLEDGEMENT OF FORM

I, _____, have received a copy of Anderson Family Care, LLC's Notice of Privacy Practices.

Signature _____ Date _____

AUTHORIZATION TO RELEASE MEDICAL HISTORY TO ANOTHER INDIVIDUAL

Please list the individual(s) you will allow Anderson Family Care, LLC to release or discuss your PHI with.
Do not list other physicians.

Name	Relationship	Phone Number

AUTHORIZATION TO OBTAIN MEDICATION HISTORY

I, _____, hereby authorize Anderson Family Care, LLC to obtain/download my medication history from Pharmacies and/or Pharmacy Benefit Managers. This authorization will allow my physician to check drug-to-drug interactions for any new prescriptions he/she may prescribe and to facilitate electronic pharmacy prescriptions. I understand this authorization will remain in effect until revoked by me in writing.

AUTHORIZATION TO LEAVE RECORDED MESSAGES

I give Anderson Family Care permission to leave protected health information on an answering machine or voicemail.

(Circle Yes or No) YES NO

AUTHORIZATION OF ELECTRONIC CORRESPONDENCE

I give Anderson Family Care permission to communicate protected health information with me via email, text message and other electronic mechanisms. I understand the potential risks associated with electronic correspondence.

(Circle Yes or No) YES NO

Signature _____ Date _____

ANDERSON
FAMILY CARE

ASSIGNMENT OF BENEFITS

Your signature is necessary for us to process any insurance claims and to ensure payment of services rendered.

I request that payment of authorized insurance benefits, including Medicare if I am a Medicare beneficiary, be made on my behalf to Anderson Family Care, LLC for any equipment or services provided to me by its physicians or clinical staff.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to Anderson Family Care, LLC, my insurance carrier, or other medical entity. A copy of this authorization will be sent to my insurance company or other entity if requested. The original authorization will be kept on file by Anderson Family Care, LLC.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for services rendered.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I have read and I understand the information above. I agree to be financially responsible for all charges as discussed above.

Patient Signature _____

Date_____

ANDERSON
FAMILY CARE

CONSENT TO USE AI SCRIBE DURING CLINICAL VISITS

At Anderson Family Care, we are committed to providing the best possible care for our patients. As part of this commitment, we are continuously looking for innovate ways to enhance our services.

We would like to inform you about a new technology that we are using called AI Scribe. AI Scribe is an artificial intelligence (AI) tool that assits us during patient visits by generating clinical notes based on our conversations. This tool allows our providers to focus more on you during the visit and less on computer documentation. This tool will allow the entire staff to better serve patients in and outside of the clinic.

There is nothing that you or the provider will do differently during your visit. The AI Scribe does not interact with you directly, it simply listens to the conversation and creates a clinical summary. The clinical summary will be reviewed for accuracy and signed by the provider before it enters your clinical chart. There will be no video recording of your visit.

Be assured that your privacy is our priority. The AI tool adheres strictly to Health Information Portability and Accountability Act (HIPAA) compliance guidelines to ensure that your data is secure and protected. Only the healthcare professionals involved in your care will have access to your clinical notes.

Your participation is voluntary and your consent is required for this service to be using during your visits. If you agree to the use of the AI Scribe during your visits, please sign and date the form below. You may withdraw your consent at any time. If you have any questions, please feel free to discuss them with us before signing this document.

I, _____, consent to the use of AI Scribe during my clinical visits at Anderson Family Care.

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if under age 18): _____ Date: _____

ANDERSON
FAMILY CARE

CLINIC POLICIES

Cancellations
If you are ever unable to keep your appointment, please call our office at 334-654-5080 to reschedule. Promptly rescheduling will help our clinic flow and will help other patients who may need to schedule an appointment during the time that would be made available by your cancellation.

Late to Appointments
Because there is only one physician in clinic each day, efficient scheduling is important. If you are more than 15 minutes late to your scheduled appointment, you will not be seen. We will do our best to reschedule you to the next available appointment, which may not be that same day. If you know in advance that you will be late, please kindly call our office, and we will make arrangements that do not disrupt our clinic flow.

Missed Appointments
It is imperative that you show up for your scheduled appointments or cancel in advance if you are not able to attend. Anderson Family Care reserves the right to charge a fee in the case of repeated missed appointments. In the case of children who repeatedly miss scheduled appointments (especially well-child/developmental/immunization appointments), Anderson Family Care reserves the right to request assistance from local agencies to ensure that any issues hindering the child from getting to clinic are addressed.

Calls During Business Hours
Please review our clinic hours. We will do our best to answer each phone call as it comes in to the office. We understand that there may be times when you will be given the option to leave a voicemail and we ask, if it is not urgent, that you leave a message. All voicemails left before 2pm on Monday-Thursday and before 12pm on Friday will be checked and returned before the end of that day. Voicemails left after these times will be checked and returned on the following day. Weekend voicemails will be returned on the next business day.

After-Hours Calls
You may call our office after hours if there is an urgent matter requiring you to speak to a member of our staff. You will be routed to an answering service who can page the physician on call. Please note that no refill requests will be filled after hours or on weekends; we ask that you keep track of your medication counts and make these requests during office hours. No appointments will be made after hours or on weekends; we ask that you schedule appointments during office hours. If you have an after-hours emergency, we ask that you go to the emergency room! Do not call our office as there will be a delay in our getting back to you—please seek medical attention right away! Please note that overuse of the after-hours line for non-urgent matters may result in a fee.

Medication Refills
All appropriate medication refill requests will be filled within 24 hours of the request. Controlled medications will not be refilled without a visit to the office. Medications will not be refilled if you have not been seen at Anderson Family Care within the past 6 months. If you request an appropriate refill, you can assume that it will be sent to your pharmacy; you do not need to call our office to confirm, and we will not call you to say that it has been sent. We ask that you check the status of the prescription with your pharmacy before re-calling our office.

Controlled Substances
We adhere to state and national regulatory guidelines regarding the writing of prescriptions for controlled substances. As a board-certified physician, Dr. Anderson reserves the right to refuse to prescribe any medication or combination of medications that can be harmful or are not medically necessary. Patients prescribed controlled medications will be asked to sign and adhere to a controlled substance policy which includes urine drug testing.

Notification of Test Results
An attempt will be made to notify you within 24 hours of our receipt of your test results. Please give us time to review your results and call you. If your preferred communication is by phone, please ensure that we have an accurate number on file for you and if this number changes, please let us know. If your results are normal and you have elected to receive voicemails from our office, this information will be left in a message. If results require discussion, you will be asked to call our office. After 3 attempts, we will send a letter to the address on file, and you are then responsible for contacting our office. If you do not have test results within one week of the test, please call our office.

Account Balances
If you have an outstanding balance, you will receive written notification by mail or you can view this information on the Patient Portal. It is important that you clear your balances in a timely manner. We accept cash, personal checks, and all major credit cards. If you are unable to pay your balance, please call our office so payment arrangements can be made. Payment arrangements that are not adhered to are subject to fines and past due accounts may be turned over to our collection agency.

Returned Checks
If our bank returns your check for insufficient funds, we will ask that you come in to our office to pay the amount of the check plus a $35 fee, and the total must be paid by cash or card. We will not re-deposit returned checks through the bank. Returned checks that are not resolved within 2 weeks will be turned over to our collection agency.

Insurance
If you are insured, please be prepared to present your card at each visit. Insurance co-pays are due at the time of your appointment. Please inform our office immediately if your insurance changes.

Forms/Special Letters
Forms and requests for special letters should be presented to the clinic in a timely fashion. Please do not bring forms to clinic on the day they are due. In order to efficiently serve all patients, we will not stop clinic to complete forms. Please allow 5 days for all forms to be completed.

Use of Phones in Office
We do kindly ask that you refrain from talking/interacting on your phone in the exam room during the clinic visit. Our staff will give you our full attention during the visit and we ask the same from our patients.

Use of Photography and Recording Devices
Recording of the clinical visit and taking photographs during the visit are not permitted, unless explicitly discussed and approved by a member of the staff beforehand.

Clinic Behavior
As much as we want Anderson Family Care to be a happy place, we understand that sometimes visits to the doctor can be stressful. We will always strive to be kind, courteous, and understanding, and we ask the same from you. Patients who disrupt our environment, either verbally or physically, will be promptly dismissed from our practice and local authorities may be called.

Received by: _____ _____ _____
(print name) (signature) (date)