MADISON FAMILY CARE
AND WELLNESS CENTER

PATIENT INFORMATION

Date: _____ /_____ /_____ SS#:_____-_____-_____

E-mail:_____

Name: _____
Last Name First Name MI

Sex (please circle): Male or Female

Date of Birth: _____ /_____ /_____

Are you a minor: Yes or No

Home: (_____)_____-_____ Cell: (_____)_____-_____

Address: _____

City:_____ State: _____ Zip:_____

Please Circle: Single - Married - Divorced - Separated - Widowed - Partnered for _____Years

Employer/School: _____

Employer/School Address: _____

_____

Employer/School Phone: (_____)_____-_____

How did you hear about us?: _____

ADDITIONAL INFORMATION

Spouse's Name: _____

DOB: _____ /_____ /_____ SS#: _____-_____-_____

Employer: _____

Cell: (_____)_____-_____ Work: (_____)_____-_____

EMERGENCY INFORMATION

Contact Name: _____

Relationship: _____

Cell: (_____)_____-_____ Work: (_____)_____-_____

INSURANCE INFORMATION

Who is responsible for this account:_____

PRIMARY MEDICAL INSURANCE

Subscriber's Name: _____

DOB:_____/_____/_____ SS#:_____-_____-_____

Insurance Company: _____

Policy #: _____

SECONDARY MEDICAL INSURANCE

Subscriber's Name:_____

DOB:_____/_____/_____ SS#:_____-_____-_____

Relationship to Patient: _____

Insurance Company: _____

Policy #: _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with:

_____
Name of Insurance Company(ies)

and assign directly to:

Southeastern Medical Group dba Madison Family Care

All insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature for each and every claim to be submitted for myself and/or dependents and that I am bound by this signature as though the undersigned had personally signed the particular claim. The above-named practitioners may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ Date:____/____/_____
Print name of Patient, Parent / Guardian or Representative

_____ Date:____/____/_____
Signature of Patient. Parent / Guardian or Representative

***** *SELF-PAY-PATIENT* - I understand that I am responsible for charges incurred at the time of my visit(s). (Initial _____)

PATIENT CONDITION

Reason for Visit: _____

_____

When did your symptoms appear?: _____

Is the condition getting progressively worse? Yes No

How often do you have this pain?: _____

Is it constant or does it come and go?: _____

Type of Pain: Sharp Dull Throbbing Numbness Aching
Shooting Burning Tingling Cramps Stiffness
Swelling Other: _____

Docs it interfere with: Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform:
Sitting Standing Walking Bending Lying down

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What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Care ☐ None

☐ **Other**: _____

Name and address of other doctor(s) who have treated you for your condition:_____

Date of Last:

Physical Exam:_____ Blood Test:_____ Urine Test:_____

Bone Density:_____ EKG:_____ ECHO:_____

Pap Smear:_____ Mammogram:_____ Prostate/PSA:_____

Colonoscopy:_____ Eve Exam:_____ Foot Exam:_____

Mark "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
		Glaucoma	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Falls	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Polio	☐ Yes ☐ No	_____	
Bleeding Disorders	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	_____	
		Herpes	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No	Head Injuries	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	_____	
Bronchitis	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No	_____	
Bulimia	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No	Broken Bones	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Sexually Transmitted Disease	☐ Yes ☐ No	_____	
Cataracts	☐ Yes ☐ No	Measles	☐ Yes ☐ No			_____	
Chemical Dependency	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Stroke	☐ Yes ☐ No	Dislocations	☐ Yes ☐ No
		Diabetes	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No	_____	
Chicken Pox	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No	_____	

Are you pregnant? ☐ Yes ☐ No Due Date: _____ Any complications? ☐ Yes ☐ No _____

EXERCISE

☐ None

☐ Moderate

☐ Daily

☐ Heavy

WORK ACTIVITY

☐ Sitting

☐ Standing

☐ Light Labor

☐ Heavy Labor

HABITS

☐ Tobacco

☐ Alcohol

☐ Coffee/Caffeine Drinks

☐ High Stress Level

Packs/Cans/Day:_____

Drinks/Week:_____

Cups/Day:_____

Reason:_____

Surgeries (Description and Date):_____

_____

MEDICATIONS

_____

_____

_____

_____

ALLERGIES

_____

_____

_____

_____

VITAMINS/HERBS/MINERALS

_____

_____

_____

_____

MADISON FAMILY CARE
AND WELLNESS CENTER

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

1. This is to inform you that Madison Family Care & Wellness Center may use and disclose your health information that identifies you, and that consist of your past, present, or future physical or mental health condition. The provision of your healthcare: and the past, present or future payment for the provision of your healthcare (this health information is referred to herein as "PROTECTED HEALTH INFORMATION").
2. The use and disclosure of your protected health information will be to carry out treatment, payment and healthcare operations for Madison Family Care & Wellness Center.
3. You have the right to request that Madison Family Care & Wellness Center be restricted from using or disclosing your protected health information in carrying out treatment, payment or healthcare operations; however, Madison Family Care & Wellness Center is not required to agree to your requested restrictions. If Madison Family Care & Wellness Center does agree to your requested restrictions, then it will comply with your request.
4. You have the right to revoke this consent. This revocation must be made in writing to Madison Family Care & Wellness Center. This revocation will be valid except to the extent that Madison Family Care & Wellness Center has taken action in reliance on this consent.

Further, I hereby authorize and give my consent to Madison Family Care & Wellness Center to communicate any of my protected health information to the following persons:

Name:	Relationship:
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

_____ I acknowledge receipt of this notice of privacy practices from which details how protected health information may be used and disclosed, and how I may access that information.

_____ _____
Patient Name (Please print) Authorized Representative

_____
Patient Signature & Date

MADISON FAMILY CARE
AND WELLNESS CENTER

CONSENT AGREEMENT CONCERNING PATIENT ASSESSMENT & NUTRITIONAL THERAPY

Madison Family Care & Wellness Center offers medical evaluative and treatment services for the purpose of nutritional assessment of the patient. Since a nutritional deficiency may or may not be associated with a specific disease, or it may be the cause of the disease, or it may occur as a result of the disease, it is important for you to understand that our sole concern in your case will be your nutritional program and your ability to metabolize and utilize the nutrients that you consume.

We will not diagnose, treat or cure any specific disease, and the nutritional recommendations we make based on lab tests, physical and clinical findings, history and symptoms does not constitute treatment for any disease or affliction, real or imagined by you. In the event that any vitamin, mineral, food, or other nutritional substance is prescribed or administered in your case, we want you to understand that its purpose will be for the following: Improvement of your overall nutritional status, improvement in your metabolism, improvement of your sense of well-being, improvement of your appetite, gain or reduction in weight or possible remission or reduction of pain where present.

However, you must understand that you may not receive any of these benefits because they do not occur predictably with every patient and in some cases may not occur at all. Also understand that this office may choose to use not only oral routes of administrations of nutritional products, but we may also use injectable routes (IM, Sub-Q, IV) or Nebulizers.

According to the Federal Food, Drug and Cosmetic Act, as amended Section 201 (g) (1), the term “DRUG” is defined to mean, “Articles intended for use in Diagnosis, Cure, Mitigation, Treatment or Prevention of Disease.” A vitamin is not a drug; neither is a mineral, trace element, amino acid, herb or homeopathic remedy. Although a vitamin, a mineral, trace element, amino acid, herb or homeopathic remedy may have an effect in any disease process or symptoms, this does not mean that it can be misrepresented or be classified as a drug by anyone. Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as primary treatment and or therapy for any disease or particular bodily symptom. Nutritional counseling, vitamin recommendations nutritional advice and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and biochemical processes of the human body. Nutritional advice and nutritional intake may also enhance the stabilization of body functions.

I have read and understand the above:

Signature:_____ Date:_____

CONSENT AGREEMENT CONCERNING PATIENT PRESCRIPTIONS

Madison Family Care requires that every patient follow his/her plan of care regarding blood work and follow up appointments to receive his/her prescriptions. If a patient misses his/her appointment for blood work and/or follow up, then the patient may request a 30 (thirty) day supply of prescription medication. The patient will incur a $25 charge for this service. No additional prescriptions will be provided until the patient completes blood work and/or follow up appointment.

I have read and understand the above:

Signature:_____ Date:_____

MADISON FAMILY CARE
AND WELLNESS CENTER

CONFIDENTIAL

REQUEST FOR RELEASE OF MEDICAL RECORDS

Date:_____

Requested from:

_____

_____

_____

I hereby authorize you to release medical records on:

_____
(Patient Name and Date of Birth)

_____
(Address of Patient)

INFORMATION NEEDED:
_____ All Records
_____ Hospital Stay
_____ Hospital Discharge Summary
_____ Immunization Only
_____ Laboratory/X-ray Reports
_____ Operative Report
_____ Pathology Report
_____ Sexually Transmitted Disease/HIV
_____ Psychiatric History

_____
(Patient Signature and Date)

PLEASE REMIT RECORDS BY FAX OR BY MAIL TO:
1230 Slaughter Road, Suite C
Madison, AL 35758
Fax: 256-830-5135

CONSENT DISCLOSURES:

As your business partner, Holloway Credit Solutions, LLC is committed to sharing the important information that may affect your ability to recover unpaid account balances. The collection industry is constantly being challenged by consumers who do not intend to pay their legal and lawful debts voluntarily. In many cases the consumer seeks legal remedies to avoid payment.

Through the American Collectors Association, and many other resources, we are monitoring litigation across the United States that may change or alter your ability to enforce the collection of past due account balances. From time to time the Courts make findings that set new interpretations of existing laws. These rulings in turn require the provider to add, delete, or change their office policies to circumvent future losses. The following consent disclosures are the results of just such litigations.

Adding Collection Fees To Account Balances:

AGREEMENT TO PAY: I, the undersigned, 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.

Consent To Contact Debtors On Their Cell Phones:

EXPRESS PRIOR CONSENT TO CONTACT CONSUMER BY CELL PHONES:
You agree, in order for us to service your account or to collect monies you may owe, Madison Family Care and Wellness Center and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial dialing device, as applicable.

I/We have read this disclosure and agree that Madison Family Care and Wellness Center, its employees and/or agents may contact me/us as described above.

_____ _____

Responsible Party Signature Date

MADISON FAMILY CARE
AND WELLNESS CENTER

March 25, 2016

Thank you in advance for respecting our policies. The policies are in place to help us serve you better by keeping our office running efficiently.

There will be a $30.00 fee for all “no shows” or missed appointments. This includes cancellations with less than a 24 hour notice. Everyone is sent an email reminder, text reminder and a call 2 days prior to an appointment. We schedule this time just for you!

If you missed a scheduled appointment or cancelled your appointment and then need refills, there will be an additional $25.00 fee imposed. You will only be given a 30 day supply and there will be no additional refills until you have been seen by the doctor.

Invoices are sent out monthly. After 2 invoices have been sent, the balance will be forwarded on to collections.

_____

PRINTED NAME

_____

SIGNATURE DATE

MADISON FAMILY CARE
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BHRT Checklist For Women

Name: _____ **Date:** _____

Email: _____

Symptom *(please check mark)*	Never	Mild	Moderate	Severe
Depressive mood				
Fatigue				
Memory Loss				
Mental confusion				
Decreased sex drive/libido				
Sleep problems				
Mood changes/Irritability				
Tension				
Migraine/severe headaches				
Difficult to climax sexually				
Bloating				
Weight gain				
Breast tenderness				
Vaginal dryness				
Hot flashes				
Night sweats				
Dry and Wrinkled Skin				
Hair is Falling Out				
Cold all the time				
Swelling all over the body				
Joint Pain				

Family History

	NO	YES
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		
Breast Cancer		

MADISON FAMILY CARE
AND WELLNESS CENTER

bioTE MEDICAL

BHRT Checklist For Men

Name: _____ **Date:** _____

Email: _____

Symptom *(please check mark)*

Symptom	Never	Mild	Moderate	Severe
Decline in general well being				
Joint pain/muscle ache				
Excessive sweating				
Sleep problems				
Increased need for sleep				
Irritability				
Nervousness				
Anxiety				
Depressed mood				
Exhaustion/lacking vitality				
Declining Mental Ability/Focus/Concentration				
Feeling you have passed your peak				
Feeling burned out/hit rock bottom				
Decreased muscle strength				
Weight Gain/Belly Fat/Inability to Lose Weight				
Breast Development				
Shrinking Testicles				
Rapid Hair Loss				
Decrease in beard growth				
New Migraine Headaches				
Decreased desire/libido				
Decreased morning erections				
Decreased ability to perform sexually				
Infrequent or Absent Ejaculations				
No Results from E.D. Medications				

Family History

	NO	YES
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		