PLEASE READ THE FOLLOWING CAREFULLY

I, the undersigned, agree to the care and treatment by the attending physician, his/her associates, or assistants. The treatment may include but is not restricted to medications, immunizations, anesthesia, surgical and invasive procedures, laboratory tests, x-rays, or other studies that may be helpful in the provision of the patient's care. My medical records may be furnished to other physicians as needed for my treatment.

Receipt of Privacy Practices Notice: I acknowledge that I have received a copy of the Notice of Privacy Practices for Brookwood Internists, P.C.

Assignment of Benefits and Guarantee of Account: I acknowledge full financial responsibility for any services rendered, and I understand that the payment of charges incurred in this office is due at the time of service. I understand that a statement fee of $15.00 will be assessed on patient balances not paid at the time of service. I also understand that the charges not covered by insurance remain my responsibility, and I assign insurance benefits to Brookwood Internists, P.C. In the event an account is turned over to a collection agency, I agree to pay all cost of collection, including reasonable attorney's fees and hereby waive all rights of exemption under the Constitution of the State of Alabama. I understand that a $40.00 fee will be added to my account should I fail to give at least 24 hours cancellation notice. This includes same day appointments.

I authorize my health care provider to use an automated telephone system and/or email and/or text and to use my name, address, and phone number, the name of my scheduled treating physician, and the time and place of my scheduled appointments(s), and other limited information for the purpose of contacting me to notify me of a pending appointment or other healthcare related communication. I also authorize my healthcare provider to disclose to third parties who answer my phone limited protected health information regarding pending appointments, and to leave a reminder message on my voice mail system or answering machine. This also includes wireless methods of communication such as faxes and cell phones. I agree that my preferred method of communication for reminders from Brookwood Internists is through secure messaging (except as stated above), and if I decline this method of communication, I will notify Brookwood Internists in writing of my alternate communication method. I authorize and consent to have my protected health information exchanged through the Alabama Health Information Exchange and agree to notify Brookwood Internists in writing if I elect to opt out of the exchange.

Medical/Billing information and/or test results may be given to PATIENT ONLY______________________

Or to the following person(s) ____

DATE_____________SIGNED____

PRINT NAME_______________________________________Date of Birth ___________________________

For patients who cannot sign or who have a personal representative present:

____

Name of Authorized Representative   Relation to Patient

Description of Personal Representative Authorizing Authority (*Examples: Parent for minor, legal guardian for minor, etc.)*

____

_____________I refuse to sign acknowledgement that I have received a copy of your Notice of Privacy Practices.

_____________A good faith effort has been made to obtain an acknowledgement receipt for our Notice of Privacy Practices.

Brookwood Internists, P.C. Revised 08/20/2014

Office only -	Chart Number:	Physician:

Patient Information

Name (last, first, middle initial)____

Address (including apt. number)____

City, State, Zip Code____

Home Phone_______________Work Phone________________Cell Phone___________________

E-mail Address______________________________Referring Physician_____________________

Date of Birth_______________Social Security #______________________________Gender: M F

Employer's Name____Marital Status: M S D W

Race_____________________Language Preference___________________________________

Ethnicity Hispanic or Latino _____ Not Hispantic or Latino____ _____Other _____________________

Emergency Contact Person ________________________Relationship_______________________

Emergency #____

Responsible Party or Person Responsible for Bill:

Name (last, first, middle initial)____

Address (including apt. number)____

City, State, Zip Code____

Home Phone____________________Work Phone_____________Cell Phone___________________

Date of Birth____________________Social Security #__________________________Gender: M F

Signed by Patient____

Insurance Information

Primary Insurance ______________________

Address______________________________

City, State, Zip Code______________________

Policy #______________________________

Group #______________________________

Effective Date__________________________

Owner of Policy_________________________

Relationship to Patient____________________

Birth Date of Policy Holder________________

Secondary Insurance______________________

Address______________________________

City, State, Zip Code______________________

Policy #______________________________

Group #______________________________

Effective Date__________________________

Owner of Policy_________________________

Relationship to Patient____________________

Birth Date of Policy Holder________________