Patient Information:

Last Name_____ First Name_____ Middle_____

Male/Female_____ SS#_____ Marital Status_____ Date of Birth_____

Race_____ Ethnic Group_____ Primary Language Spoken_____

Street Address_____ City/State_____ Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

Email Address_____ Preferred Reminder Method ____ Text ____Email

Preferred Pharmacy_____

Emergency Contact:

Name_____ Relationship_____ Phone_____

Responsible Party Information (If not Self)

Full Name_____

Street Address_____ City/ State_____ Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

Date of Birth_____ Marital Status_____ SS#_____ Relationship_____

*** How did you hear about us? ____ Source Magazine _____ Facebook _____ Instagram**

_____ Internet____ Billboard_____ Family/ Friend:_____

____ Other:_____

I hereby authorize and direct payment to better weighs to better health for medical benefits. I understand that I am financially responsible for the charges of services. I understand that checks returned for non-payment will result in a $30.00 fee. I Understand that regardless of my insurance status I am solely responsible for payment of any services rendered to me, or on my behalf.

Patient/ Responsible Party Signature: _____

Date: _____

Inclement Weather Policy

In the event of inclement weather, please call our office to confirm we are open.

Appointment No Show Policy

It is the policy of better weighs to better health to monitor and manage appointment no shows. Any patient who fails to arrive for a scheduled appointment without cancelling the appointment less than 24 hours prior to the scheduled time is considered a "no show." The no-show patient fee is $50.00, as set by better weighs to better health, for failure to show.

_____ Please Initial Here

Medication Refill Policy

It is the responsibility of each patient to bring all their medications, in the original bottle, to each visit.

Lists of medication are not acceptable due to possible error and lack of information.

It is imperative to notify the nurse if there is a need for any refills at the time of each visit. Calling at a later time for refills may cause a delay in receiving your medications.

Please allow at least 24-48 hours for medication refills that are requested by call in.

_____ Please Initial Here

Forms Requests

There will be a $30.00 charge for certain forms that require the doctor to complete. Please Allow 5-7 business days to complete.

Patient Signature **Date**

HIPPA Notice of Privacy Practices

Better Weighs to Better Health

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

This notice of Privacy Practices describes how we may use and dislose your protected health information(PHI) to carry out treatment, payment of health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and relates health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For Example, your protected health information may be provided to a physician whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support he business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required uses and Disclosures: Under the law we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with YOUR consent, Authorization or opportunity to object unless required law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Patient Signature **Date**

725 W. Market Street Suite B

Athens, AL 35611

Phone: 256-777-4965 Fax: 833-714-2128

DUE TO THE PRIVACY CONFIDENTIAL ACT, please list the people that you approve to have access to your information as stated below:

Billing Information: _____ Relationship:_____

_____ Relationship:_____

Medical Information: _____ Relationship:_____

_____ Relationship:_____

Authorization to Leave Messages:

I hereby authorize **better weighs to better health** staff to leave messages regarding my medical condition, such as lab reports, other test results, medications, and appointment reminders on my home answering machine. This authorization will be in effect until I have given written notice to **better weighs to better health.**

Check one of the following:

Agree _____ Disagree_____

We are required by law to maintain privacy of and provide individuals with a notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our Office Manager.

Signature below is acknowledgement that you have received this Notice of our Privacy Practices and agree to all the information listed above. Signature below also indicates that you have received a copy of the HIPPA agreement.

Print Patients Name:_____

Patients Date of Birth:_____

_____ _____

Signature of Patient or Patient's Representative **Date**

Better Weighs to Better Health

Name_____

Patient Health Assessment

Telephone_____

D.O.B_____

Life Habits:

Yes	No	
_____	_____	Do you live alone? If no, with whom do you live?_____
_____	_____	Have you ever used nicotine? (Circle Cigarettes, Cigar, Pipe) How much per day?_____
		For how many years?_____
_____	_____	Do you currently use nicotine? If yes, what do you use?(Cigarettes, Cigar, Pipe, Smokeless tobacco)
		How much per day?_____ For how many years?_____
_____	_____	Do you currently use alcohol? If yes how much per day?_____ How often?_____
		Past use?_____
_____	_____	Do you currently use any illicit drugs? If yes, How often?_____
		Past use?_____
_____	_____	Do you have problems sleeping?_____
		If yes, explain_____

Domestic Violence:

Yes	No	
_____	_____	Are you being abused, injured or frightened by anyone at home or in another area of your life?

Beliefs, Rights, & Values

Yes	No	
_____	_____	Do you have ethnic, religious, spiritual, or cultural practices that need to be a part of your care?
		_____
_____	_____	Do you have financial concerns related to your medical care? Please List:_____
_____	_____	Do you have children? How Many? Adult_____ Minor_____
_____	_____	Do you have a guardian? If yes, whom?_____
_____	_____	Do you have an Advanced Directive (e.g living will or durable power of attorney) If yes, bring a copy with you to the office upon your admission. If not, information is available upon request.
_____	_____	Are you an organ/tissue donor?

Better Weighs to Better Health

Name:_____

Date of Birth:_____

Check the box if the condition pertains to you and write comments if necessary.

Respiratory

	Comment
_____ Asthma	_____
_____ COPD	_____
_____ Emphysema	_____
_____ Sinus Problems	_____
_____ Sleep Apnea	_____
_____ TB	_____
_____ Other	_____

Gastrointestinal

	Comment
_____ Constipation	_____
_____ Diarrhea	_____
_____ Diverticulitis	_____
_____ GERD	_____
_____ Heartburn	_____
_____ Hepatitis	_____
_____ Hiatal Hernia	_____
_____ Jaundice	_____
_____ Other	_____

Genitourinary

	Comment
_____ Kidney Disease	_____
_____ Kidney Stone	_____
_____ Prostate Disease	_____
_____ UTI	_____
_____ Other	_____

Other Conditions

	Comment
_____ Anxiety	_____
_____ AIDS/HIV	_____
_____ Cancer	_____
_____ Cataracts	_____
_____ Depression	_____
_____ Diabetes	_____
_____ Eye Problems	_____
_____ Glaucoma	_____
_____ Hearing Problems	_____
_____ Peripheral Artery DZ	_____
_____ Rheumatic Fever	_____
_____ STD	_____
_____ Thyroid Disease	_____
_____ Other	_____

Neurological

	Comment
_____ Dementia	_____
_____ Fibromyalgia	_____
_____ Osteoarthritis	_____
_____ Osteopenia	_____
_____ Osteoporosis	_____
_____ Other	_____

Musculoskeletal

	Comment
_____ Arthritis	_____
_____ Chronic Headaches	_____
_____ Faint/Dizziness	_____
_____ Migraines	_____
_____ Numbness/Weakness	_____
_____ Seizures	_____
_____ Stroke	_____
_____ Other	_____

Previous Surgeries

DATE Reason

_____
_____
_____
_____
_____
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_____
_____
_____

Cardiovascular

	Comment
_____ Anemia	_____
_____ Angina	_____
_____ Heart DZ	_____
_____ CHF	_____
_____ Heart Attack	_____
_____ High Blood Pressure	_____
_____ High Cholesterol	_____
_____ Pacemaker	_____
_____ Valve Problem	_____
_____ Other	_____

Are there any other Medical Conditions not listed above? Please list them on the back of form.

Patient's Name: _____ **Date of Birth:** _____

Family History (Complete Health Information about your family)

Disease	Family Member (Circle One)				
Alzheimer's/ Dementia	Father	Mother	Sibling	Grandparent	Other:_____
Asthma, hay Fever	Father	Mother	Sibling	Grandparent	Other:_____
Cancer, Type_____	Father	Mother	Sibling	Grandparent	Other:_____
Cataracts	Father	Mother	Sibling	Grandparent	Other:_____
CHF	Father	Mother	Sibling	Grandparent	Other:_____
CVA/Stroke	Father	Mother	Sibling	Grandparent	Other:_____
COPD	Father	Mother	Sibling	Grandparent	Other:_____
Diabetes	Father	Mother	Sibling	Grandparent	Other:_____
GI Problems	Father	Mother	Sibling	Grandparent	Other:_____
Glaucoma	Father	Mother	Sibling	Grandparent	Other:_____
Heart Disease	Father	Mother	Sibling	Grandparent	Other:_____
Hyperlipidemia	Father	Mother	Sibling	Grandparent	Other:_____
Hypertension	Father	Mother	Sibling	Grandparent	Other:_____
Kidney Problems	Father	Mother	Sibling	Grandparent	Other:_____
Seizure Disorder	Father	Mother	Sibling	Grandparent	Other:_____
Thyroid Disease	Father	Mother	Sibling	Grandparent	Other:_____
Other:_____	Father	Mother	Sibling	Grandparent	Other:_____
Other:_____	Father	Mother	Sibling	Grandparent	Other:_____

MEDICATIONS CURRENTLY IN USE

Medication Name	Dose	Frequency

ALLERGIES

- **NO KNOWN DRUG ALLERGIES**
- **FOOD:** _____
- **MEDICATIONS**: _____
- **OTHER:** _____