University Medical Center

Patient Information

MR# _____

Patient Information

Patient Name _____

_____ _____ _____ _____ _____
Mailing Address: Street | Apt/Unit/Lot | City | State | Zip Code

DOB ___/ ___/_____ Sex: ☐ Male ☐ Female Social Security #: ____ - ____- _____
Month/Day/Year

☐ Home Phone _____ ☐Cell Phone _____ ☐ WorkPhone _____
(Please check which number would be preferred number for contact)

Employer_____

Marital Status: ☐ single ☐ married ☐ divorced ☐widowed

Race: ☐ White ☐ Black or African-American ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or other Pacific Islander

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Answer

Spouse's Name: _____ Spouse's Employer: _____

EMERGENCY CONTACT: _____ Phone: _____

Responsible Party

Responsible Party's Name (if other than patient) _____

_____ _____ _____ _____ _____
Mailing Address: Street | Apt/Unit/Lot | City | State | Zip Code

DOB (Month/Day/Year): ___/ ___/ _____ Social Security #: ____ - ____ - _____ Employer: _____

☐ Home Phone _____ ☐ Cell Phone _____ ☐ WorkPhone _____

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

Insurance Information

Primary: _____

Group #:_____

Policy #: _____

Subscriber's Name (if other than patient)

_____

☐ Male ☐ Female Phone: _____

DOB (Month/Day/Year): ____/ ____/ _____

Social Security # _____/ ____/_____

Address: _____ Apt./Unit/Lot # _____

_____ _____ _____
City | State | Zip Code

Secondary: _____

Group #:_____

Policy #: _____

Subscriber's Name (if other than patient)

_____

☐ Male ☐ Female Phone: _____

DOB (Month/Day/Year): ____/ ____/ _____

Social Security # _____/ ____/_____

Address: _____ Apt./Unit/Lot # _____

_____ _____ _____
City | State | Zip Code

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 _____

Suite _____ Doctor _____ New Patient _____ Update _____ OC _____ WC_____

University Medical Center

PATIENT COMMUNICATION CONSENT

University Medical Center (UMC)

Patient Name: _____

Patient DOB: _____

MR#: _____

Approved Contacts

I agree to allow University Medical Center 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 METHOD(S)	NUMBER	MESSAGES (YES OR NO)
☐ Home Phone	(_____) _____ - _____	☐ Yes ☐ No
☐ Cell Phone	(_____) _____ - _____	☐ Yes ☐ No
☐ Work Phone	(_____) _____ - _____	☐ Yes ☐ No
☐ Text Messages	(_____) _____ - _____	☐ Yes ☐ No

Patient Health Information Identifying Questions

If I am not able to come to UMC, I agree to answer the following questions before information can be provided to me.

Security Questions:

1. What is your mother's maiden name? _____
2. What is the name of your childhood best friend? _____
3. What is the brand of your first car? _____

Healthcare Information

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
_____	_____	(_____) ____-_____
_____	_____	(_____) ____-_____

Medication

I authorize the following person(s) to pick up prescriptions. An additional form is needed for Controlled Substance(s).

Name	Relationship to Patient	Contact Info
_____	_____	(_____) ____-_____
_____	_____	(_____) ____-_____

Emergency Contact

My emergency contact is:

Name: _____ Phone: (_____) _____ - _____

_____ _____

Patient Name (printed) Date

_____ _____

Patient/Authorized Signature Relationship to Patient

University Medical Center

Acknowledgement of Notice of Health Information Practices

University Medical Center
(also referred to as "UMC")

Patient Name: _____

Patient DOB: _____

Medical Record #: _____

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/abouthipaa-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 of 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 you 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 Halth 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 reacord 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 Nocitce, 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

PATIENT'S RIGHTS AND RESPONSIBILITIES SIGNATURE FORM

University Medical Center
(hereinafter referred to as "UMC")

Patient Name: _____

Patient DOB: _____

Medical Record #:_____

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 Center's Patient Rights and Responsibilities.

Patient Printed Name _____

Patient Signature/Parent or Guardian _____

Relationship to Patient _____

Date: _____