HUNTSVILLE INTERNAL MEDICINE ASSOCIATES

R. BRIAN ROBERTS, M.D
KELLY LYNN, M.D.
BALA CHENNUPATI, M.D.
MARY ODOFIN, M.D.

PATIENT INFORMATION

PLEASE PRINT: DATE: _____

Patient's Name: _____ Referred By: _____

LAST FIRST MI

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____)_____ Cell Phone: (____)_____ Work Phone: (____)_____

SS# ____-____-____ Sex: M F D.O.B. ____/____/____

☐ Married ☐ Divorced ☐ Widowed ☐ Single

Patient's Occupation : _____ Employer_____

Employer's Address _____ Employer's Phone (____)_____

Spouse's Name: _____ Spouse's D.O.B. _____

Spouse's Occupation: _____ Spouse's Employer _____

Employer's Address _____ Employer's Phone (____)_____

Notify in case of emergency: _____ Relationship: _____

City: _____ State: _____ Phone: (____) _____

PRIMARY INSURANCE

Policy #	Group #
Insurer's Name:	Relationship to Patient
Insurer's Social Security # or ID #	
Insurance Company Name:	

SECONDARY INSURANCE

2nd Policy #	2nd Group #
2nd Insurer's Name:	2nd Relationship to Patient
2nd Insurer's Social Security # or ID #	
2nd Insurance Company Name:	

PERSON RESPONSIBLE FOR THIS ACCOUNT: _____ PHONE: (____)_____

Payment is required for all services at the time they are rendered. In the event of financial hardship, our office will attempt to negotiate a payment plan or file the appropriate insurance when hospitalization or major procedures are required. However, before such claims are filed, coverage will be pre-certified, and you will be asked to pay any unmet deductible, non-covered services and co-payments. Your signature below signifies your understanding and willingness to comply with this policy.

I authorize all physicians, medical professionals, hospitals and other medical care institutions, insurers, prepaid health plans, employers, group policy holders, contract holders, and benefit plan administrators to provide insurer with information concerning medical care, advice, treatment or supplies provided to the patient.

Signature: _____ Date: _____

HUNTSVILLE INTERNAL MEDICINE ASSOCIATES, INC.

250 CHATEAU DRIVE, SUITE 220
HUNTSVILLE, ALABAMA 35801
(256) 881-1989 FAX (256) 319-1368

R. BRIAN ROBERTS, M.D., P.C.
KELLY LYNN, M.D., P.C.

BALA CHENNUPATI, M.D., P.C.
MARY ODOFIN, M.D., P.C.

Due to recent federal privacy guidelines (HIPAA), Huntsville Internal Medicine Associates, Inc. is not allowed to divulge medical or billing information to **anyone** other than the patient (or guardian in the case of a minor) unless explicit authorization is given.

To authorize Huntsville Internal Medicine Associates, Inc. to discuss your medical information with someone other than yourself, please fill in below:

I, _____ (patient name), give HUNTSVILLE INTERNAL MEDICINE ASSOCIATES, INC. permission to release/discuss personal medical and/or billing information to/with:

_____	_____	_____
Person we can release info to	Relationship to Patient	Phone #,
_____	_____	_____
Person we can release info to	Relationship to Patient	Phone #
_____	_____	
Signature of Patient	Date	

I, _____ (name of patient) do not wish to give Huntsville Internal Medicine Associates, Inc. permission to release/discuss my personal medical and/or billing information to/with anyone other than myself.

_____	_____
Signature of Patient	Date
_____	_____
WITNESS	Date