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

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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

Dr. Olaoluwa Mary Odofin, M.D.

Huntsville Internal Medicine
250 Chateau Drive Suite 220
Huntsville Al, 35801
Office: 256-881-1989
Fax: 256-319-1368 / 256-319-1907

Unfortunately, due to inadequate reimbursement from Insurance Companies and Medicare, we have to start charging for the following services:

1. $25.00 – For phone calls that require review of your complaints and medical history by a physician. (No charge for same complaint if seen in prior two weeks.)
2. $30.00 – For phone calls to physicians after hours, weekends, Holidays. (No charge if true emergency requiring transfer to hospital.)
3. $20.00- $100.00 – Forms completion by physician.
4. $40.00 – For missed appointments hat require review by a physician. All cancellations need to be made 24-48 hours prior to give us time to fill your appointment time.

Medicare and Insurance Companies will not pay these charges. They are non-covered charges; you will be billed separately for these.

Our primary goal in this is to make sure you get high quality healthcare.

Please let us know if you have a financial hardship.

Barbara McAnally
Business Manger
Huntsville Internal Medicine Associates

Please sign below; this letter will be placed in your Medical record.

PATIENT **DATE**

HUNTSVILLE INTERNAL MEDICINE ASSOCIATES
FINANCIAL POLICY

Our Physicians at HIMA believe that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy.

1. **PAYMENT:** is expected at the time of your visit. We will accept cash or debit/credit card (MC, VISA AND DISCOVER). Payment will include any unmet deductible, coinsurance, co-payment amount or non-covered with a (signed ABN form) charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of your visit. We do ask for a copy of an ID CARD along with your insurance card, complying with the Red Flag Rules. **(WE DO NOT BILL COPAY's)**

2. **INSURANCE:** We are participating providers with several insurance plans. We will file all of these insurance claims. A list of these insurance plans is available upon request. Please, remember that insurance is a contract between the patient and insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable time, you will be billed. If we later receive payment from your insurer, we will refund any overpayment to you.

If our doctors are not listed in your plans network, you may be responsible for partial or full payment. If you are insured by a plan with which we have no prior arrangement, we will prepare and send the claim for you on an unassigned basis. This means the insurer may send the payment directly to you and therefore, our charges for you are due at the time of service. Due to the many different insurance products out there, our staff cannot guarantee your eligibility and coverage. Be sure to check with your insurer's member benefits department about services and physicians before your appointment. You are responsible for obtaining a properly dated referral if required by your insurer and responsible for payment if your claim rejects for the lack of one.

Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered" you will be asked to sign an ABN form, before the service and at that time you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. All procedure billed in this office are considered covered unless limited by you specific insurance policy.

3. **RETURNED CHECKS: (DR. CHENNUPATI PTS ONLY)** Will incur a $30.00 service charge, PLUS a $6 bank fee. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus a $36 service charge to pay the balance prior to receiving services from our staff or the physicians. Stop payment constitutes a breach of payment and is subject to the $36 service fee and collection action. All bad checks written to this office are subject to collections and will be prosecuted in Madison County. **DR. ODOFIN NO LONGER ACCEPTS CHECKS.**

4. **ACCOUNTING PRINCIPALS:** Payments and credits are applied to the oldest charges first, except insurance payments which are applied to the corresponding dates of service.

5. **FORM FEES:** Completing insurance forms, copying medical records, etc... Requires office staff time away from patient care for our doctors. We require pre-payment for completing forms, copying medical records, notarizing, or for extra written communication by the doctor. The charge is determined by the complexity of the form, letter, or communication. Base form charges are $5 per occurrence plus $1.00/page up to 25 pages and then .50/ each additional page. HIMA will have 15buisness days in which to copy records before making them available for patient pick up, and those 15 days will commence after payment for copying has been received and after patient has signed this for authorizing records, release.

6. **ASSIGNMENT OF INSURANCE BENEFITS:** I hereby assign, transfer, and set over directly to HIMA sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the cost of the care and treatment rendered to

myself or my dependent in said clinic. I authorize HIMA to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan admin to release such information to HIMA. I authorize HIMA to release all medical information(including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare, other physicians or providers, and any third-party payers.

7. **INSURANCE WE WON'T BILL:** I am not currently eligible for; **MEDICAID, TRICARE PRIME, AETNA ADVANTAGE PROGRAM, HEALTHSPRING, ANY HMO (Dr. Lynn only, DOES NOT TAKE MEDICARE)** refer to office manager regarding Medicare contract. I will notify HIMA immediately if I become eligible for these payors, thus termination my care from HIMA or becoming a SELF PAY patient. We WILL NOT accept new patients with the above insurances nor bill these payors if patients switch after becoming established with HIMA.

8. **RELEASE OF INFORMATION:** I hereby, authorize and direct HIMA to release to government agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

9. **COLLECTION FEES:** I understand that in the event my account is placed in collection status, any additional fees incurred due to this, will be added to my outstanding balance. This includes, but not limited to late fees, collections, agency fees, court costs, interest and fines. I understand that these additional fees will be my personal responsibility to pay in full.

10. **DIVORCED PARENTS OF PATIENTS:** By signing below, the adult who signs a minor child into our practice on the day of service accepts responsibility for payment. This office does not promise to send bills or records to the other parent/guardian for issues of payment or communication. We will communicate about treatment and payment with the parent who signs in the day. Parents are responsible between themselves to communicate with each other about the treatment and payment issues

11. **RESPONSIBILTY FOR PAYMENT:** I understand that I, personally, am financially responsible to HIMA for charges not covered by the assignment of insurance benefits.

12. **BILLING OFFICE:** If you have any questions in regards to any of your billing statements, call our accounts receivable staff 256-881-1989 ext 4.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also, understand and agree that such terms may be amended by the practice from time to time.

_____ _____

Signature of Patient (or Guarantor) Date

_____

Please print the name of patient

Huntsville Internal Medicine Associates
250 Chateau Drive, Ste. 220
Huntsville, AL 3810.
Phone: (256) 880-1989, Fax (256) 319-1907

TODAY'S DATE:_____

Patient name				Date of birth		Age	Gender
Date of Last Wellness	(Medicare B eligibility date)			Race			Primary Language Spoken
BP	HR	RR	HT	BMI	WEIGHT		TEMP

SOCIAL HISTORY

TOBACCO?	Never	Current smoker	*No. years smoked?*	*Packs per day*	Year Quit	Other tobacco
ALCOHOL?	Never	Few times/year	1-2 per day	3 or more per day	Past history of abuse...Year quit:	
CAFFIENE?	Never	Occasional	Daily	DIET:		

DESCRIBE ANY HISTORY OF DRUG USE OR ABUSE	EXERCISE ROUTINE
Marital Status (Circle one) S M W D	Number of pregnancies: _____ Sexual partner preference: M F
Highest level of education completed	Current occupation
HOME ENVIRONMENT	Private home / Assisted Living / Nursing Home / Other

FUNCTIONAL / SAFETY SCREEN (*65 AND OVER*)

Do you need someone else to drive for you?	Yes	No	Do you have any difficulty feeding yourself?	Yes	No
Do have difficulty with mobility? (getting out of bed, walking, or getting in/out of a chair)	Yes	No	Do you have difficulty getting dressed?	Yes	No
Do you have difficulty with grooming? (combing hair, shaving, brushing teeth)	Yes	No	Do you need help with your shopping?	Yes	No
Do you need help with housekeeping?	Yes	No	Do you need help managing your money?	Yes	No
Do you need help managing your medications?	Yes	No	Do you need help using the telephone?	Yes	No
Do you have stairs in your home without handrails or with poor lighting?	Yes	No	Do you have difficulty with balance?	Yes	No
Have you noticed any hearing difficulties?	Yes	No	Does your bladder sometimes leak?	Yes	No
Do you have a living will or advanced directive?	Yes	No	Have you had days where you felt very little pleasure in Activities during the past 2 weeks Have you felt down, depressed or hopeless	I Yes I No I Yes I No	

Do you have regular or frequent pain?	None	Mild	Moderate or occasional	Continuous	Severe
Have you fallen DURING THE LAST 12 MONTHS?	No	Only once, no injury	Two or more times	Injury that required medical attention	

FAMILY HISTORY (Mark "X" if positive and list approx. age if known.)					
	Mother	Father	Sister	Brother	Child
Breast Cancer					
Ovarian Cancer					
Colon Cancer					
Prostate Cancer					
Heart Attack, stent, or bypass surgery					
Stroke					
High cholesterol					
High blood pressure					
Diabetes					
Dementia					
Aneurysm					
Sudden death or died in sleep <55 yrs old					

MEDICAL HISTORY

HAVE YOU EVER BEEN DIAGNOSED WITH OR TREATED FOR ANY OF THE FOLLOWING?

	High blood pressure		Reflux or esophageal strictures		Migraines
	High cholesterol		Ulcers		Seizures
	Heart attack / angina / stent/ bypass		Irritable Bowel / Spastic Colon		Brain or spinal cord abnormalities
	Heart failure		Crohn's Disease		Nerve condition of hands or feet
	Heart valve abnormality		Ulcerative Colitis		Skin disease
	Abnormal heart rhythm		Colon polyps		Peripheral artery disease (PAD)
	Diabetes		Diverticulosis / diverticulitis		Anxiety
	Thyroid problems		Liver problems		Depression
	Bleeding or anemia		Kidney or bladder problems		Drug or alcohol abuse or addiction
	Blood clots		Prostate problems		Dementia
	Blood transfusion		Autoimmune Disease		ADD
	Cancer		Fibromyalgia		Multiple Sclerosis
	COPD / Emphysema		Osteopenia / osteoporosis		Other Neurological or Psychiatric Condition
	Asthma		Stroke or TIA		Immune Deficiency
	Sleep apnea				

OTHER:

Hospital visits / Reason	Facility	Attending Physician	Dates	Previous Surgeries / Year

NAME _____ DATE _____

PROVIDER LIST (Please list all used /seen during past year)			
Physicians	**Reason**	**Other Physician / Therapist / Chiropractor**	**Reason**

Medical Supplier / DME company	**For**

Local Pharmacy	**Mail Order Pharmacy**

MEDICATION LIST (*List all prescription, non-prescription, supplements, herbals, other.*)

Name of Medication *Example: Ibuprofen*	**Strength or Dose** *200mg*	**Frequency and route** *2 tablets by mouth 3 times a day*

ALLERGY LIST

ALLERGY	**REACTION**	**ALLERGY**	**REACTION**

VACCINATIONS

	YEAR		*YEAR*		*YEAR*
Influenza (Flu Shot)		Pneumovax 23 (Pneumonia)		Tetanus / pertussis (TDaP)	
Shingles		Prevnar 13 (Pneumonia)		Tetanus / NO pertussis (dT)	
Hepatitis A		Hepatitis B		Gardasil	

SCREENING TESTS				
TEST	*NONE*	*DATE IF DONE*	*DR. OR FACILITY*	*(FOR OFFICE USE) RECOMMENDED*
Colonoscopy				
Stool test for blood				
Pap smear / pelvic exam				
Mammogram				
Bone Density				
Prostate cancer screen				
Electrocardiogram (EKG)				
Eye exam / Glaucoma screen				
Hearing evaluation				
Hepatitis C Screening				
Abdominal Aortic Screening (abdominal ultrasound)				

For office use:

COUNSELING:

X		Education	Recommended	Scheduled
	Diet / Nutrition			
	Advance Directive			
	Smoking Cessation			
	Alcohol Use			
	Home Safety			
	Exercise			
	Vaccines			
	Diabetic Education (DSMT)			
	Safe Sex Practices			
	Aspirin therapy			
	Calcium and / or vitamin D therapy			
	Cognitive evaluation			
	Driving assessment			
	Social Services			