Discovery Medical Center

502 Pratt Avenue NE Huntsville, Alabama 35801

Patient Name_____ Date: _____ Email: _____

SS #/SIN_____ DOB_____ ☐ Male ☐Female Home phone_____ Cell Phone _____

Check appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's Address _____City _____ State_____ Zip_____

Employer Name: _____

Spouse or Patient's Guardian name_____ Spouse's Employer_____

Whom may we thank for referring you? _____

Person to contact in case of an emergency_____ Phone_____

In case of a medical emergency, if the patient is of school age 15+, is ok to treat in my absence.

_____ _____

Parent or Guardian Date

Responsible Party

Name of The Person responsible for this account _____Relationship to Patient _____

Address _____Home Phone _____

E-Mail _____Cell Phone _____

Driver's License # _____ Date of Birth: _____

Is the person currently a patient at our office? ☐ Yes ☐ No

Do you have any Medical insurance? ☐ Yes ☐ No if yes, complete the following:

Name of the insured_____ Relationship to patient_____

Birthdate_____ SS#/SIN_____ Name of Employer_____ Work Phone _____

Address of Employer_____ State _____ Zip_____

Insurance Company_____ Group #_____ Union or local # _____

Ins. Co. Address _____ City _____ State _____ Zip_____

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN
APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **Discovery Medical Center, LLC, Dr. Elizabeth Owings, MD & Dr. Sam McGough, DC,** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been* or *will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider*. A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 20 ____. X_____ (SEAL)
(Patient signature)

X_____ X_____
(signature of Guardian if applicable) (please print patient name)

Health History

Patient Name: _____DOB: _____Date:_____

Chief Complaint: _____

History of Present illness:

Location: _____ (Where is the pain/problem?)

Quality: _____ (Example: normal vs abnormal color, activity, etc..)

Severity: _____ (How severe is the pain/problem on a scale of 1-10 with 10 being the most severe?)

Duration: _____ (How long have you had this pain/ problem? When did it start?)

Timing: _____ (Does the pain/problem occur at a specific time?)

Context: _____ (Where were you at the onset of this pain/problem?)

Associated Signs/Symptoms _____ (What other associated problems have you been having?)

Modifying Factors _____ (What makes the pain/problem worse or better? Have you had previous episodes?)

Past Medical History

(Have you ever had the following: (circle "yes" or "no"/ leave blank if you are uncertain.)

Measles……	NO	YES	Anemia……..NO	YES	Back Trouble……NO	YES	Hepatitis……NO	YES
Mumps……	NO	YES	Bladder Infection…….NO	YES	High Blood Pressure……NO	YES	Ulcer……NO	YES
Chicken Pox……	NO	YES	Epilepsy……NO	YES	Low Blood Pressure…….NO	YES	Kidney Disease……NO	YES
Whooping Cough…	NO	YES	Migraine Headaches. NO	YES	Hemorrhoids……NO	YES	Thyroid Disease……NO	YES
Scarlet Fever……	NO	YES	Tuberculosis……NO	YES	Date of Last Chest X-Ray_____		Bleeding Tendency…….NO	YES
Diphtheria……	NO	YES	Diabetes……NO	YES	Asthma……NO	YES	Any Other Disease…….NO	YES
Small pox……	NO	YES	Cancer……NO	YES	Hives of Eczema……NO	YES	(Please List):	
Pneumonia……	NO	YES	Polio……NO	YES	AIDS & HIV……NO	YES		
Rheumatic Fever…	NO	YES	Glaucoma……NO	YES	Infectious Mono……NO	YES	_____	
Arthritis……	NO	YES	Hernia……NO	YES	Bronchitis……NO	YES		
Venereal Disease…	NO	YES	Blood or Plasma Transfusion……NO	YES	Mitral Valve Prolepses….NO	YES	_____	
					Stroke……NO	YES		

Previous Hospitalizations/Surgeries/Serious Illnesses When? Hospital, City, State

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medication: (include nonprescription)

_____

_____

Have you ever taken Fen-Phen/Redux? NO YES

Are you taking any medications (prescription or over the counter) for acid indigestion?

O yes O no if yes what type: _____

Is this visit due to an accident?

Yes:_____ No:_____ It was: Automobile:_____ Fall: _____

Patient Social History:

Marital Status Single: _____ Married: _____ Separated: _____ Divorced: _____ Widowed: _____

Use of Alcohol Never: _____ Rarely: _____ Moderate: _____ Daily: _____

Use of Tobacco Never: _____ Rarely: _____ Moderate: _____ Daily: _____

Use of Drugs Never: _____ Type/Frequency: _____

Excessive Exposure

At home or at work to: Fumes: _____ Dust: _____ Solvents: _____ Airborne Particles: _____ Noise: _____

CLINICIAN SIGNATURE: _____ **DATE REVIEWED:**_____

PATIENT NAME: _____ **DATE:**_____

Name:_____ DOB _____ Date:_____

Family Medical History:

	Age	Disease	If Deceased, Cause Of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse:	_____	_____	_____
Children:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Indicate which of the below you have experienced in the last 1-2 months

1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Eyes/Ears/Nose/Throat/Respiratory		**Muscular/Skeletal**	
Asthma	1 2 3 4 5	Muscle Aches	1 2 3 4 5
Stuffy Nose	1 2 3 4 5	Fibromyalgia	1 2 3 4 5
Hay Fever	1 2 3 4 5	Arthritis	1 2 3 4 5
Sore throat	1 2 3 4 5	Joint Pain	1 2 3 4 5
Chronic Cough	1 2 3 4 5	Low Back Pain	1 2 3 4 5
Chest Congestion	1 2 3 4 5	Neck Pain	1 2 3 4 5
Frequent Sneezing	1 2 3 4 5	Wrist/Hand Pain	1 2 3 4 5
Itchy/Watery Eyes	1 2 3 4 5	Elbow Pain	1 2 3 4 5
Drainage	1 2 3 4 5	Shoulder Pain	1 2 3 4 5
Earache or Ear Infection	1 2 3 4 5	Hip Pain	1 2 3 4 5
Itching	1 2 3 4 5	Knee Pain	1 2 3 4 5
Hoarseness	1 2 3 4 5	Ankle/Foot Pain	1 2 3 4 5
Shortness of Breath	1 2 3 4 5	Pain b/t shoulder blades	1 2 3 4 5
Wheezing	1 2 3 4 5		

Neurological		**General**	
Headaches	1 2 3 4 5	Fatigue	1 2 3 4 5
Migraines	1 2 3 4 5	Malaise	1 2 3 4 5
Dizziness	1 2 3 4 5	Weakness, tiredness	1 2 3 4 5
Numbness	1 2 3 4 5	Lightheadedness	1 2 3 4 5
Tingling	1 2 3 4 5	Irritability	1 2 3 4 5
Pins/needles in hands or feet	1 2 3 4 5	Constipation	1 2 3 4 5
		Diarrhea	1 2 3 4 5
		Feeling foggy	1 2 3 4 5
		Forgetfulness	1 2 3 4 5

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of the Patient, Parent or Guardian Date

Doctor's Review

_____ _____

Signature of Doctor Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, [patient's name] acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Discovery Medical Center, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

_____ _____
Date Signature

_____
Print Name

FOR OFFICE USE ONLY IF NOTICE NOT PROVIDED TO PATIENT

The Practice has made a good-faith effort to obtain an acknowledgement of _____ [patient's name]'s receipt of our Notice of Privacy Practices. In spite of these efforts, the Practice has been unable to obtain a signed acknowledgement of receipt for the following reasons (check all that apply):

___ Patient Unavailable
___ Patient Physically Unable
___ Patient Unwilling

In an effort to obtain the patients acknowledgement, the Practice has attempted to provide patient with a Notice of Privacy Practices in the following manner (check all that apply):

___ Personally ___ Mail ___ Phone Follow Up
___ Other: _____

_____ _____
Date Signature

_____
Print Name of Physician

Discovery Medical Center
Name of Practice

Discovery Medical Center

Consent for Purposes of Treatment, Payment and Healthcare Operations

I, _____ [Name of Individual] consent to Discovery Medical Center use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I understand I have a right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has acted in reliance on this consent.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

INSURANCE FILING WAIVER

I understand that my insurance policy has limited Medical, Therapy, and/or Chiropractic benefits, and that I may exhaust these benefits for this year before completing treatment.

Although I understand that my insurance company may not cover my medical, therapy, and/or chiropractic services, I wish to have these treatments performed by the Doctor and his staff.

I understand the staff will inform me prior to receiving any treatments, exams, or x-rays, their corresponding charges.

I understand that I will be responsible for the cost of any treatment rendered in the event my insurance company denies payment. I understand that I will have the option to continue chiropractic treatment as a self-pay patient.

I understand that once my benefits are exhausted my visits will NOT be filed to my insurance company until my insurance anniversary date for the following year.

Patient Name: _____

Patient SSN: _____

Patient DOB: _____

Patient Signature: _____

Witness: _____

Date: _____