Dr. Bernice R. Swain | Family Medicine
2424 Danville RD Suite L
Decatur, AL. 35603
Phone: 256-341-0043
Fax: 256-341-0095

## Patient Information

Patient Name:_____ Marital Status:_____ Date of Birth:_____

Street Address:_____ City, State, Zip:_____

Home Phone:_____ Cell Phone:_____ Social Security #:_____

Patient Employer:_____ Occupation:_____

Employer Address:_____ Employer Phone:_____

Spouse/Parent:_____ Home Phone:_____ Cell Phone:_____

Emergency Contact (other than spouse):_____ Relation:_____

Address:_____ Home Phone:_____ Cell Phone:_____

*Billing information & responsible party (Payment required at the time of service unless other arrangements have been made.)*

Billing Name (if different from patient):_____ Relation to patient:_____

Billing Address:_____ City, State, Zip:_____

## Insurance Information

**Primary Insurance:**_____ Phone Number:_____ Effective Date:_____

Address:_____ Group Number:_____

Name of Insured:_____ Relationship to patient:_____

**Additional Insurance:**_____ Phone Number:_____ Effective Date:_____

Address:_____ Group Number:_____

Name of Insured:_____ Relationship to patient:_____

**Additional Insurance:**_____ Phone Number:_____ Effective Date:_____

Address:_____ Group Number:_____

Name of Insured:_____ Relationship to patient:_____

**Signature:**_____ Date:_____

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# Patient Consent

**Consent for treatment:**

I hereby authorize the performance of any medical procedure which may be advised and/or recommended by Dr. Bernice R. Swain while I am under her care.

**Authorization for release of medical information:**

I authorize Dr. Bernice R. Swain and/or authorized employee to furnish any medical information requested by insurance companies with whom I have coverage or any public agency which may be assisting in payment for my care

**Financial Policy:**

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees. Financial Policy, or your responsibility. All patients must complete our *"Patient Information form"* Before receiving treatment.

I understand that I will be responsible for all charges incurred during my course of treatment in this office regardless of insurance coverage.

Adult patients: Are responsible for full payment.

Minors Accompanied by an Adult: The adult accompanying a minor, and his/her parents (or Guardian), are responsible for full payment.

Unaccompanied Minors: The parents (or guardians) are responsible for full payment. Non-emergency treatment may be denied unless charges have been pre-authorized to an approved method of payment (cash, or check).

**Insurance:**

If you have insurance, we will help you receive maximum benefits. If we accept your insurance, you will be responsible for your estimated co-payment amount and any unmet deductible at the time of service.

**Insurance is a contract between you and your insurance company.**

We are NOT a party to this contract. We file insurance claims as a COURTESY to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual, customary & reasonable" charges, etc. other than to supply factual information as necessary. You are responsible for the timely payment of your account.

Any account that we receive no payment on for 90 days will be turned over to a collection agency for collection. At that time, you will be responsible (or the balance on your account, and an additional charge of 40% of your total balance to cover the collection agency fees. Therefore, please do not let your account reach this point without trying to make satisfactory arrangements with us to keep your account current.

**Missed Appointments**

If you cannot make your appointment, please call at least two hours in advance to cancel. We reserve the right to charge for any non-cancelled appointment. It is our policy that three consecutive "NO SHOW" for two scheduled appointments, or a total of six cancellations and/or no shows constitute discontinuation of treatment.

Patient (Responsible Party) Signature _____ Date _____

Witness _____ Date _____

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# Authorization to Release Medical Information

Dr. Bernice R. Swain is authorized to discuss my medical information or needs with the following individuals:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Patient or Representative Signature:_____ Date:_____

(14 and Over)

By circling yes on this form you authorize Dr. Swain and staff to leave detailed messages regarding personal health care information on your voicemail. (Please Circle One) Yes / No

If yes, please list numbers where you may be contacted:

Cell: (___)_____

Work: (___)_____

Home: (___)_____

Parent or Guardian Signature:_____ Date:_____

(14 and Over)

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# HEALTH HISTORY

(Confidential)

Name:_____ Date:_____

Age:_____ Birth Date:_____ Date of last physical examination _____

What is your reason for visit?_____

SYMPTOMS (Check all that apply)

### GENERAL

☐ Chills
☐ Depression
☐ Dizziness
☐ Fainting
☐ Fever
☐ Forgetfulness
☐ Headache
☐ Loss of sleep
☐ Loss of weight
☐ Nervousness
☐ Numbness
☐ Sweats

### MUSCLE/JOINT/BONE

Pain, Weakness, Numbness in:

☐ Arms ☐ Hips
☐ Back ☐ Legs
☐ Feet ☐ Neck
☐ Hands ☐ Shoulders

### GENITOURINARY

☐ Blood in urine
☐ Frequent urination
☐ Lack of bladder control
☐ Painful urination

### GASTROINTESTINAL

☐ Appetite poor
☐ Bloating
☐ Bowel changes
☐ Constipation
☐ Diarrhea
☐ Excessive hunger
☐ Excessive thirst
☐ Gas
☐ Hemorrhoids
☐ Indigestion
☐ Nausea
☐ Rectal bleeding
☐ Stomach pain
☐ Vomiting
☐ Vomiting blood

### CARDIOVASCULAR

☐ Chest pain
☐ High blood pressure
☐ Irregular heart beat
☐ Low blood pressure
☐ Poor circulation
☐ Rapid heart beat
☐ Swelling of ankles
☐ Varicose veins

### EYE, EAR, NOSE, THROAT

☐ Bleeding gums
☐ Blurred vision
☐ Crossed vision
☐ Difficulty swallowing
☐ Double vision
☐ Earache
☐ Ear discharge
☐ Hay fever
☐ Hoarseness
☐ Loss of hearing
☐ Nosebleeds
☐ Persistent cough
☐ Ringing in ears
☐ Sinus problems
☐ Vision-Flashes
☐ Vision-Halos

### SKIN

☐ Bruise easily
☐ Hives
☐ Itching
☐ Change in moles
☐ Rash
☐ Scars
☐ Sore that won't heal

### MEN ONLY

☐ Breast lump
☐ Erection difficulties
☐ Lump in testicles
☐ Sore on penis
☐ Other

### WOMEN ONLY

☐ Abnormal Pap Smear
☐ Bleeding between periods
☐ Breast lump
☐ Extreme menstrual pain
☐ Hot flashes
☐ Nipple discharge
☐ Painful intercourse
☐ Vaginal discharge
☐ Other

Date of last menstrual period_____
Date of last Pap smear_____
Have you had a mammogram? _____
Are you pregnant?_____
Number of children_____

CONDITIONS (Check all that apply)

☐ AIDS
☐ Alcoholism
☐ Anemia
☐ Anorexia
☐ Appendicitis
☐ Arthritis
☐ Asthma
☐ Bleeding disorder
☐ Chemical Dependency
☐ Chicken Pox
☐ Diabetes
☐ Emphysema
☐ Epilepsy
☐ Glaucoma
☐ High Cholesterol
☐ HIV Positive
☐ Kidney Disease
☐ Measles
☐ Migraine Headaches
☐ Miscarriage
☐ Prostate Problems
☐ Psychiatric Care
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Stroke
☐ Suicide Attempt

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| | | | |
|---|---|---|---|
| ☐ Breast lump<br>☐ Bronchitis<br>☐ Bulimia<br>☐ Cancer<br>☐ Cataracts | ☐ Golter<br>☐ Gonorrhea<br>☐ Gout<br>☐ Heart Disease<br>☐ Hepatitis<br>☐ Hernia<br>☐ Herpes | ☐ Mononucleosis<br>☐ Multiple Sclerosis<br>☐ Mumps<br>☐ Pacemaker<br>☐ Pneumonia<br>☐ Polio | ☐ Thyroid Problems<br>☐ Tonsillitis<br>☐ Tuberculosis<br>☐ Typhoid Fever<br>☐ Ulcers<br>☐ Vaginal Infections<br>☐ Venereal Disease |

| MEDICATIONS (List all medications you are currently taking) | ALLERGIES (List any medicines you are allergic too) |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

FAMILY HISTORY (Fill in health information about your family)

| Relation | Age | State of Health | Age at Death | Cause of Death | | | |
|---|---|---|---|---|---|---|---|
| Father | | | | | | | |
| Mother | | | | | | | |
| Brothers | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| Sisters | | | | | | | |
| | | | | | | | |
| | | | | | | | |

| HOSPITALIZATIONS | | | PREGNANCY HISTORY | | |
|---|---|---|---|---|---|
| Year | Hospital | Reason for Hospitalization and Outcome | Year | Sex | Complications |
| | | | | | |
| | | | | | |

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| | | | | | |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

| Have you ever had a blood transfusion? Yes □ No □ | | | | | |
|---|---|---|---|---|---|
| SERIOUS ILLNESS/INJURIES | DATE | OUTCOME | SOCIAL HISTORY | | |
| | | | Type | Yes/No | How long? |
| | | | Do you use tobacco? | | |
| | | | Do you use alcohol? | | |
| | | | Do you drink caffeine? | | |
| | | | Do you use illegal drugs? | | |
| | | | OCCUPATIONAL CONCERNS<br>Check if your work exposes you to the following:<br>□ Stress<br>□ Hazardous Substances<br>□ Heavy Lifting<br>□ Other | | |
| | | | | | |
| | | | | | |
| | | | Your occupation: | | |

I certify that the information is correct to the best of my knowledge. I will not hold my Dr. Swain or any members of her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature:_____ Date:_____

Reviewed By:_____ Date:_____

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Consent for Purposes of Treatment. Payment and Health Care Operations

I, _____, understand that as part of my health care; Dr. Bernice Swain originates and maintains paper and/or electronic records describing my health history, symptoms, examination, test results, diagnoses, treatment, and any plans for future care or treatment I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Dr. Bernice Swain is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Dr. Bernice Swain reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Dr. Bernice R Swain change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to allow the following persons to have access to, use of, or disclosure of my health information:

_____
_____

I wish to have the following restrictions to the use or disclosure of my health information:

_____
_____
_____

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / disclose the terms of this consent.

_____

Patient’s Signature

_____

Date

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# Receipt of Notice of Privacy Practices Written Acknowledgement Form

I am patient of Dr. Bernice R. Swain. I hereby acknowledge receipt of Dr. Bernice R. Swain's Notice of privacy Practices.

Name:_____

Signature:_____

Date:_____

or

I am a parent of legal guardian of _____ [Patient Name]. I hereby acknowledge receipt of Dr. Bernice R. Swain's Notice of privacy Practices with respect to the patient.

Name:_____

Relationship to Patient:_____ Parent_____ Legal Guardian_____

Signature:_____

Date:_____