C.A.R.E.S.
CHEAHA AREA REGIONAL EMERGENCY SERVICES

CHEAHA AREA REGIONAL EMERGENCY SPECIALISTS
Immediate Family Care Occupational Medicine
Anniston Office Only

1325 Quintard Avenue
Anniston, Alabama 36201
Phone: (256) 741-1339

256 Oxford Exchange Blvd.
Oxford, Alabama 36203
Phone: (256) 835-0076

PATIENT INFORMATION SHEET

Patient Name: Last__________ First__________ Middle__________
Address:__________
City:__________ State:______ Zip:______ Phone:__________
Email Address:__________ Cell Phone:__________
Sex:______ Race:______ Marital Status:______ Birthdate: ___/___/___
Social Security #__________ Driver's License:__________
Retired:______ Employed:______ Full Time Student:______ Part Time Student:______
Employer:__________ Employer Phone:__________
Person responsible for account:__________
Social Security #__________ Driver's License:__________
Relationship:__________
Address__________
City__________ State______ Zip______ Phone:__________
Employer:__________ Phone:__________
Spouse's Name:__________ Phone:__________
Person to notify in case of emergency:__________ (Outside Your Home) Phone:__________ (Other than your number)
Relatives or friends who are patients:__________

INSURANCE POLICY INFORMATION

Insurance Company (Primary):__________
Policy Holder's Name:__________ Birthdate: ___/___/___
Employer:__________
Contract or Group:__________
Relationship of patient to policy Holder:__________
Insurance Company (Secondary):__________
Policy Holder's Name:__________ Birthdate: ___/___/___
Employer:__________
Contract or Group:__________
Relationship of patient to policy holder:__________
Referred by:__________

CONSENT FOR TREATMENT - I consent to necessary treatment, includng drug screen, medicine, performance of operations and conduct of X-ray, or other studies that may be used by the attending physician, his nurse or staff.

AUTHORIZATION FOR RELEASE OF INFORMATION - I authorized CARES to furnish my medical information requested by insurance companies with whom I have coverage, an public agency which may be assisting in payment of my care or my employer who is providing payment of my medical bills due to injury on the job.

ASSIGNMENT OF BENEFITS - I hereby authorize payment directly to CARES of benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits, but not to exceed the CARES charges for the services. I understand that I am financially responsible to CARES for charges not covered by this assignment. I authorize the refund of overpaid Insuranced benefits where my coverages are subject coordination of benefits.

GUARANTEE OF ACCOUNT - For services furnished by CARES I hereby guarantee the payment of all accounts for services rendered. For payment of said accounts for service I hereby waive all claims of exemption under the State of Alabama and agree to pay if necessary, all costs of collection, including attorney's fees that are not covered by insurance.

____
Patient Signature / Patient Representative

____
Date

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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:______________________________ Date of Birth:__________________

Patient Address:______________________________ SSN: __________________

By signing below, you hereby authorize us to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under Federal Law, for the sole purpose and time period described below. You may refuse to sign this authorization. Subject to certain exceptions, you have the right to inspect and copy the protected health information.

Information to be used or disclosed (must be identified in a specific and meaningful fashion); and purpose of the use and disclosure:

- ❑ ANY AND ALL MEDICAL INFORMATION
- ❑ PERSONAL INFORMATION
- ❑ TRANSFER OF MEDICAL RECORD FOR TREATMENT

Information that may not be used or disclosed:______________________________

____

Whom may we release your medical information to?

❑ Spouse Parent: ❑ Mother ❑ Father ❑ Sibling ❑ Significant Other: Name __________________

The name of other specific identification of the person(s), or class of persons, authorized to make the requested use of disclosure:

CARES MEDICAL CLINIC
1325 Quintard Avenue, Anniston, AL 36201
(256) 741-1339

The name of other specific identification of the person(s), or class of persons, to whom The Practice may make the requested use or disclosure: ______________________________

ARE WE PERMITTED TO LEAVE A MESSAGE ON HOME RECORDER OR CELL PHONE/VOICE MAIL?

❑ YES ❑ NO Cell / Home Phone #__________________

Expiration date or an expiration event (must relate to the individual or the purpose of the use or disclosure): __________________

This information about you is protected under Federal Law, and you have the right to revoke this authorization in writing. Please be advised, however that any revocation will be effective only to the extent we have not already taken action in reliance on your authorization. By signing below, you recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no long be protected under Federal Law. We will not condition treatment based on your authorization. You may refuse to sign the authorization.

______________________________ __________________

Patient Signature / Patient Representative Date

C. A. R. E. S.
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

I understand that CARES may share my health information for treatment, billing and healthcare operations. I have been given a copy of the organization's Notice of Healthcare Information Practices that describes how my health information is used and shared.
I understand the organized healthcare arrangement has the right to change this notice at any time. I may obtain a current copy by contacting CARES or by visiting caresinfo.com.

My signature below constitutes my acknowledgement that I have been provided with a copy of the Notice of Health Information Practices.

______________________________ ______________________________

Signature of Patient or Legal Representative | Date

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PATIENT PAST MEDICAL HISTORY FORM

CHART #________________

NAME: ____________________________ AGE: ______ DOB: _______ DATE: _________

PRIMARY PHYSICIAN: ____________________________________

REASON YOU ARE HERE: ____________________________________

Have you ever had any of the following health problems? Please check and give dates.

- ☐ Heart Attack ______
- ☐ Heart Failure ______
- ☐ Chest Pain related to heart disease ______
- ☐ High Blood Pressure ______
- ☐ Poor Circulation ______
- ☐ High Cholesterol ______
- ☐ Stroke ______
- ☐ Severe Headaches ______
- ☐ Seizures ______
- ☐ Blackout Spells ______
- ☐ Head Injury ______
- ☐ Meningitis ______
- ☐ Asthma ______
- ☐ Emphysema ______
- ☐ TB ______
- ☐ Pneumonia, severe ______
- ☐ Severe Heart Burn ______
- ☐ Hiatal Hernia ______
- ☐ Stomach Ulcers ______
- ☐ Hepatitis ______
- ☐ Jaundice ______
- ☐ Kidney Infection ______
- ☐ Other Kidney Problem ______
- ☐ Thyroid Problem ______
- ☐ Diabetes ______
- ☐ Arthritis ______
- ☐ Unplanned weight loss ______
- ☐ Enlarged lymphnodes ______
- ☐ Blood Thinner ______
- ☐ Cancer of what ______

ALLERGIES:

Are you allergic to any of the below, state your reactions.

- Penicillin ____________
- Sulfa ____________
- "Mycins" ____________
- Aspirin ____________
- Codeine ____________
- Tetanus ____________
- Demerol ____________
- Other ____________

Other problems not listed above:________________________

Please list surgeries or child births you have had:

Surgery	Date	Surgeon	Hospital

Social History: Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Smoke: ☐ Yes ☐ No Amount________ Yrs ________

Drink Alcohol? ☐ Yes ☐ No

Occupation

Family History: Please check and list family member.

☐ Heart Disease ☐ High Blood Pressure ☐ Stroke

☐ Diabetes ☐ Cancer

☐ Bleeding Problem ☐ TB

Is your mother alive? ☐ Yes ☐ No If not please list cause:________________

Is your father alive? ☐ Yes ☐ No If not please list cause:________________

Please list any medications you are now taking (include over the counter medications ie. aspirin) ________________

____

____

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Patient Bill of Rights and Responsibilities

We want to encourage you, as a patient of CARES, to communicate with your health care team; participate in your treatment choices, and promote your own safety by being well informed and actively involved in your care. Because we want you to think of yourself as a partner in your care, we want you to know your rights as well as your responsibilities during your stay here.

All patients are CARES shall have the right to:

1. To receive considerate, respectful and compassionate care regardless of your age, gender, race, national origin, religion, sexual orientation or disabilities.
2. To receive care in a safe environment free from all forms of abuse, neglect or harassment.
3. To be called by your proper name and to be told the names of the doctors, nurses and other healthcare team members.
4. To be told by your doctor about your diagnosis and possible prognosis, the benefits and risks of treatment, and expected outcome of treatment, including unanticipated outcomes. You have the right to give written informed consent before any non-emergency procedures begin.
5. To have your pain assessed, reassessed, and be involved in decisions about managing your pain.
6. To expect full consideration of your privacy and connfidentiality in care discussions, examinations, and treatments. You may ask for a chaperone during any type of examination.
7. To access protective and advocacy services in case of abuse or neglect. CARES will provide a list of protective and advocacy resources.
8. To participate in decisions about your care, treatment and services provided, including the right to refuse treatment to the extent permitted by law. If you leave CARES against the advice of your doctor, CARES will not be responsible for any medical consequences that may occur.
9. To sign language or foreign language interpreter services. You will be provided an interpreter if needed.
10. To receive detailed information about your physician charges.
11. To expect that all communications and records about your care are confidential, unless disclosure is allowed by law. You have the right to see or get a copy of your medical records and have the information explained, if needed. You may add information to your medical record by contacting the staff. Upon request, you have the right to receive a list of to whom your personal health information was disclosed.
12. To voice your concerns about the care you received. If you have a problem or complaint, you may talk with your doctor, nurse manager or department manager. If unresolved you may contact the Business Manager at 256-741-1339, file a complain with: The Alabama Department of Public Health, Division of Health Care Facilities, Complaint Unit, P. O. Box 303017, Montgomery, Alabama 36130-3017, and their number is 1-800-356-9596. The Joint Commission by calling 1-800-994-6610 and The Center of Medicare and Medicaid Services by calling 1-800-633-4227.

Patient Responsibilities

1. You are expected to provide complete and accurate information, including your full name, address, home telephone number, date of birth, insurance carrier and employer.
2. You should provide CARES with a copy of your advance directive if you have one.
3. You are expected to provide complete and accurate information about your health and medical history, including present condition, past illnesses, hospital stays, medicines, vitamins, herbal products, and any other matters that pertain to your health.
4. You are expected to ask questions when you do not understand information or instructions. If you believe you can't follow through with your treatment plan, you are responsible for telling your doctor. You are responsible for outcomes if you do not follow the care with your treatment plan, you are responsible for telling the doctor. You are responsible for outcomes if you do not follow the care.
5. You are expected to actively participate in your pain management plan and to keep your doctors and nurrses informed.
6. You are expected to treat all CARES staff, other patients and visitiors with courtesy and respect, abide by all CARES rules and safty regulations.
7. You are expected to provided complete and accurate information about your insurance coverage and pay your bills on time.