Alpha Medical Center

Austin Ogwu, M.D.

Information below is for the patient being seen today

Name: _____ Today's Date: _____
Address: _____ City: _____
State: _____ Zip: _____ Home Telephone: _____
Work Number: _____ Cell Number: _____
Date of Birth: _____ Age: _____ Circle One: Male /Female
Social Security Number: _____ Drivers License: _____
Employer: _____
Circle One: Married / Single / Divorced / Widowed Number of Children: _____

Emergency Contact: _____ Telephone: _____

Responsible Party - If patient is a minor, the adult with the patient today is:

Name: _____ Social Security Number: _____
Driver's License: _____ Circle One: Mother / Father / Guardian

Address (if different from above): _____
City: _____ State: _____ Zip: _____
Home Telephone: _____ Cell Number: _____
Employer: _____ Work number: _____

Insured - Circle One: Mother / Father / Spouse / Self (skip below)

Name of Insured (if not the patient): _____
Date of birth: _____ Social Security # _____
Home Telephone: _____ Cell Number: _____
Employer: _____ Work number: _____

Address (if different from above): _____
City: _____ State: _____ Zip: _____

We will make a copy of your insurance card(s) for our records. Please advise us of any changes to your personal information in the future so that we may update our records.

I request that payment under my medical insurance program be made to the provider named above for services rendered to me (or my dependent child). I also authorize the above named provider to release to my insurance company any medical information needed for the claim. Further, I permit a copy of the authorization to be used in place of the original. I understand that I am financially responsible for all charges not covered by my insurance plan.

_____ _____
Patient or Responsible Party Signature Date

ALPHA MEDICAL CENTER
PATIENT FINANCIAL POLICY SHEET

To reduce confusion and misunderstanding between our patients and practice, we have added the following financial polices. If you have any questions regarding these polices, please discuss them with our office manager. We are dedicated to providing the best possible care service to you and regard your complete understanding of your financial responsibilities as essential elements of you care and treatment.

Unless other arrangements have been made on advance by either you or your health insurance carrier, full payment is due at the time of service.

Your Insurance

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment at the time of service. This office's policy is to collect this co-payment when you arrive for your appointment.
- If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of the services.
- In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- We will bill you health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.

Minor Patients

- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

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

_____ _____

Print name of patient **Date**

_____

Signature of patient of responsible of party of minor

Alpha Medical Center
Practice of Privacy Practices

I have reviewed this office's Notice of Privacy Practice, which explains how may medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____
Signature of Patient or Personal Representative

_____
Date

_____
Name of Patient or Personal Representative

_____
Descriptions of Personal Representative's Authority

PATIENT CONSENT FORM

Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

I understand that as part of my Healthcare, **Alpha Medical Center** ("PHYSICIAN") originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare information such as assessing quality and reviewing competence of healthcare professionals.

The PHYSICIANS *Notice of Privacy Practices* provides specific information and complete description of how my personal health information may be used and disclosed. I have been provided a copy of or access to the *Notice of Privacy Practices* and understand that I have the right to review the notice prior to signing this consent. I understand that the PHYSICIAN reserves the right to change the *Notice of Privacy Practices* Prior to implementation of the revised *Notice of Privacy Practices*, the revised Notice will be mailed to me if I provide my address below. I understand that I have the right to restrict the use and/ or disclose of my personal health information for treatment, payment, or Healthcare operations and that the PHYSICIAN is not required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that the PHYSICIAN has already taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

I request the following restrictions on the use and/ or disclosure of my personal health information.

_____

_____

_____

I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise written by law.

I have been provided and have reviewed the PHYSICIAN'S *Notice of Privacy Practices* dated _____.

_____ _____

Signature of patient or Legal Representative **Date**

_____

Print name of patient or Legal Representative

* I request that changes to the *Notice of Privacy Practices* be sent to me at this

Address: _____

_____

ALPHA MEDICAL CENTER
PATIENT PERSONAL HISTORY

Name: _____ Sex: ___ Age: _____ Date: _____
(Last name, First name)
Reason for office visit: _____

PERSONAL HISTORY (please check all that apply)

- ❑ Acid Reflux/ heart burn
- ❑ Aids / HIV
- ❑ Allergies _____
- ❑ Anemia
- ❑ Asthma
- ❑ Attention Deficit Disorder (ADD)
- ❑ Back Pain
- ❑ Blood Disease
- ❑ Bronchitis
- ❑ Cancer
- ❑ Chest Pain
- ❑ Cough
- ❑ Circulatory Problems
- ❑ Chronic Obstructive Pulmonary Disease (COPD)
- ❑ Congestive Heart Failure (CHF)
- ❑ Constipation
- ❑ Crohn's
- ❑ Depression
- ❑ Diabetes Mellitus Type_____
- ❑ Diarrhea
- ❑ Difficulty Urination
- ❑ Ear Problem
- ❑ Fever
- ❑ Frequent Urination
- ❑ Glaucoma
- ❑ Gout
- ❑ Hand Pain
- ❑ Heart Problems
- ❑ Hypertension
- ❑ IBS (Irritable Bowel Sydm.)
- ❑ Joint Pain
- ❑ Leaking of Urine (Incontin.)
- ❑ Leg Pain
- ❑ Liver Disease
- ❑ Kidney Disease
- ❑ Knee Pain
- ❑ Migraine Headache
- ❑ Nervous Problems
- ❑ Numbness or Tingling in the legs/Hands
- ❑ Obesity
- ❑ Pacemaker
- ❑ Psychiatric Care
- ❑ Rheumatic Fever
- ❑ Seizure
- ❑ Sexual Transmitted Disease
- ❑ Shortness of Breath
- ❑ Sickle Cell Anemia
- ❑ Sinusitis
- ❑ Sore Throat
- ❑ Stroke
- ❑ Swelling of feet or hands
- ❑ Suicide Considered
- ❑ Thyroid (Hyper or Hypo)
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Urinary Tract Infection (UTI)
- ❑ Vomiting
- ❑ Other _____

Last menstrual period _____ (female only)

Have you had any surgeries? (Please list what type of surgery and what year)

_____

_____

Medications- (Please list any medications currently taking including the dosage and how often taking medication)

Name of Medication	Dosage amount (mg)	How many per day

(Please list additional medications on back of this form)

Are you allergic to any medications? [] Yes [] No If yes, please list: _____

Family History- (Please list any diseases above that your immediate family member have below)

Mother-
Father-
Grandparent(s)-
Siblings-

Do you smoke tobacco? [] Yes [] No How many packs per week _____. Do you dip snuff? [] Yes [] No
Do you drink alcohol? [] Yes [] No [] Occasionally. How many per week? _____
Do you exercise? [] Yes [] No. How many times per week? _____
Social History- Marital Status: M S W D No. of Children: _____