PANACEA
O'NEILL MEDICAL GROUP

104 SPENRYN DRIVE
MADISON, AL 35758
(256) 772-4300

**Patient Information**

Last Name _____ First _____ Middle _____

Address _____ City _____ State _____ Zip _____

Home Phone # _____ Cell Phone # _____ Work Phone # _____

Sex _____ Date of Birth _____ Social Security Number _____ Employer _____

**Person Responsible for Charges (if different than above)**

Last Name _____ First _____ Middle _____

Address _____ City _____ State _____ Zip _____

Home Phone # _____ Cell Phone # _____ Work Phone # _____

Date of Birth _____ Relationship _____ Social Security Number _____ Employer _____

**Insurance Coverage**

Primary _____ Policy Number _____ Group Number _____ Subscriber _____

Secondary _____ Policy Number _____ Group Number _____ Subscriber _____

List all people we may talk to about your general health and test results:

_____

_____

Emergency Contact Name _____ Phone Number _____ Relationship _____

I provide consent to Panacea O'Neill Medical Group using my cell phone number for automatic calls (ATDS) in order to provide courtesy appointment reminders and future recall reminders. I also understand I am not required to provide such consent in virtue of being a patient and may revoke this cell phone consent at any time in the future.

Attestation that all above information is true, correct and up to date

Patient Signature _____ Date _____

Guardian Signature _____ Date _____

**PANACEA O'NEILL MEDICAL GROUP**
104 SPENRYN DRIVE
MADISON, AL 35758
(256) 772-4300

**Medical History Form**

Last Name _____ First _____ Middle _____

Today's Date _____ Date of Birth _____

Please list all known allergies, including drug allergies:

_____ _____ _____

_____ _____ _____

List all medications, with strengths, you are currently taking:

_____ _____ _____

_____ _____ _____

Do you have a family history of any of the following diseases:

Arthritis, Gout _____ Asthma, Hay Fever _____ Cancer _____ Chemical Dependency _____

Diabetes _____ Heart Disease, Strokes _____ High Blood Pressure _____ Kidney Disease _____

Tuberculosis _____ Other _____

Which of the following problems are you currently experiencing:

☐ Decreased Hearing
☐ Ringing in Ear
☐ Ear Infections - Frequent
☐ Dizzy Spells
☐ Failing Vision
☐ Double or Blurred Vision
☐ Eye Pain
☐ Eye Infections - Frequent
☐ Nose Bleeds - Recurrent
☐ Sinus Trouble
☐ Sore Throats - Frequent
☐ Hayfever / Allergies
☐ Hoarseness - Prolonged
☐ Pneumonia / Pleurisy
☐ Bronchitis / Chronic Cough
☐ Asthma / Wheezing
Shortness of Breath:
☐ On Exertion ☐ Lying Flat
☐ Chest Pain
☐ High Blood Pressure
☐ Heart Murmur
☐ Palpitations
☐ Irregular Pulse
☐ Swollen Ankles
☐ Fainting Spells

☐ Leg Pain when Walking
☐ Varicose Veins / Phlebitis
☐ Loss of Appetite - Recent
☐ Difficulty Swallowing
☐ Indigestion or Heartburn
☐ Persistent Nausea / Vomiting
☐ Peptic Ulcers
☐ Abdominal Pain - Chronic
☐ Change in Bowel Habits - Recent
☐ Diarrhea ☐ Constipation
☐ Diverticulosis
☐ Bloody or Tarry Stools
☐ Hemorrhoids
☐ Gall Bladder Trouble
☐ Jaundice / Hepatitis
☐ Hernia
☐ Urine Infections - Frequent
☐ Painful Urination
☐ Blood in Urine
☐ Overnight Urination - More than 2
☐ Control in Urination
☐ Decrease in Force of Urination
☐ Kidney Stones
☐ Venereal Disease
☐ Urethral Discharge

☐ Chronic Fatigue
☐ Weight Loss - Recent
☐ Anemia ☐ Bruise Easily
☐ Cancer
☐ Diabetes
☐ Thyroid Disease
☐ Convulsions / Seizures
☐ Stroke
☐ Tremor / Hands Shaking
☐ Muscle Weakness
☐ Numbness / Tingling Sensations
☐ Headaches / Frequent
☐ Arthritis / Rheumatism
☐ Back Pain - Recurrent
☐ Bone Fracture / Joint Injury
☐ Gout
☐ Foot Pain ☐ Cold Numb Feet
☐ Rashes ☐ Hives
☐ Psoriasis ☐ Eczema
☐ Sleeping - Difficulty
☐ Nervousness ☐ Depression
☐ Memory Loss
☐ Moodiness - Excessive
☐ Phobias
☐ Mental Illness

☐ Chicken Pox ☐ Polio
☐ Measles ☐ Germ. Measles
☐ Rheumatic ☐ Scarlet Fever
☐ Mumps ☐ Tuberculosis
☐ Alcohol ☐ oz. per week
☐ Smoking ☐ cig. per day
☐ Coffee / Tea ☐ cups per day

**Females - Menstrual History**
☐ Age of Onset ____ ☐ Reg. ☐ Irreg.
Flow ☐ Heavy ☐ Mod. ☐ Light
☐ Pain / Cramps with Mens. Flow
☐ Days of flow
☐ Length of Cycle
☐ Pain / Bleeding After Sex
No. of Pregnancies _____
No. of Live Births _____
No. of Miscarriages _____
Birth Control Method _____
B.C. Pill (Name) _____
☐ Flushing / Menopause

Other Symptoms or Diseases
☐ _____
☐ _____
☐ _____

List any surgeries (with the dates) you may have had in the past:

_____

_____

Approximate date of your last injection/immunizations: _____

Attestation that all above information is true, correct and up to date:

Patient Signature _____ Date _____

Guardian Signature _____ Date _____


# New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Panacea O'Neill Medical Group originates and maintains paper and/or electronic 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 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 can be 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 healthcare operations.

I understand that Panacea O'Neill Medical Group 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 taken 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 wish to have the following people granted access to 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 understand/agree that Panacea O'Neill Medical Group has the right to communicate with my insurance plan and various pharmacies regarding my prescription filling profile.

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

_____
Patient's Signature

_____
Date

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FOR OFFICE USE ONLY

- ❑ Consent received by _____ on _____.
- ❑ Consent refused by patient and treatment refused as permitted.
- ❑ Consent added to the patient's medical record on _____.

PANACEA
O'NEILL MEDICAL GROUP

# AUTHORIZATION TO RELEASE OR RECEIVE MEDICAL INFORMATION
# and
# AUTHORIZATION OF ASSIGNMENT OF BENEFITS

**We strongly feel that all patients deserve from us the very best medical care that we can provide. Further, we feel that everyone benefits when definitive financial arrangements are agreed upon. Accordingly, we have prepared this material to acquaint you with our policy.**

***Our professional services are rendered to you, not the insurance company. Therefore, payment for treatment is your responsibility.***

**Please read and sign the following:**

1) **I authorize this office to release or receive any information necessary to expedite insurance claims.**
2) **I hereby authorize this office to bill my insurance company directly for their services.**
3) **I authorize payment directly to this physician of any insurance benefits otherwise payable to me.**
4) **In the event I receive payment from my insurance carrier, I agree to endorse any payment I receive over to my physician for which these fees are payable.**

**I understand that I am directly and fully financially responsible to this physician for charges not covered by my insurance. I further understand that such payment is not contingent on any settlement, judgment, or insurance payment by which I eventually recover for said fee. I realize that if my insurance company fails to pay my balance in full, or there is no payment made within 60 days, it is my responsibility to pay my doctor's bill directly.**

**You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs and expenses, including reasonable attorneys' fees, we incur in such collection efforts.**

There will be a $30.00 charge on all returned checks in addition to the amount of the check.

***A photostatic copy of these authorizations and agreements shall be as valid as the original.***

Signature _____

Date _____

Witness _____

**PLEASE PRESENT BOTH YOUR INSURANCE CARD AND YOUR DRIVER'S LICENSE SO WE MAY MAKE A COPY FOR YOUR RECORDS.**

PANACEA
O'NEILL MEDICAL GROUP

**Panacea – O'Neill Medical Group**

**Office Policies and Code of Conduct**

***Patient Code of Conduct***

You must treat all members of our staff (providers, medical assistants, receptionists and managers) with appropriate and civil respect. Vulgar language, belligerent or abusive behavior will not be tolerated. The same rule applies in our dealings with patients for all staff members. Patients or even staff who do not follow this expectation will be dismissed from this practice upon report.

***Patient Compliancy***

Panacea O'Neill Medical Group providers strive to provide the best medical care possible. This is especially applicable to acute care, disease management and preventative care. To this end, providers may require and hold the right to expect their patients to be compliant to their orders. Patients need to accept this includes not only following through with orders, but as well any requirements for follow-up appointments. Many disease conditions and medications require routine testing of various system processes or simply seeing the doctor. Providers reserve the right to decide on their prescription habits and the way in which they hold their medical license, not failing to mention administer the best medical care possible they see fit.

***Front Office Policies and Various Charges***

In order to provide the best medical care possible and continue our operations we must not neglect there are necessary additional fees and various policies we have set in place to insure our viability. From your requests or visits there may be certain additional charges or limitations that apply; **a complete list can be provided upon request.** We follow many industry standards in respect to these measures but have made our best efforts to keep these costs as low as possible. These fees and or processes are non-negotiable and must be paid at time of service, along with and including payment of co-pays, co-insurances and deductibles. Furthermore, all requests will be met in a timely fashion as determined by the office but can never be expected in an unreasonable time frame; thus you must allow 48 hours for all requests to be met. Patients are responsible for managing their medications/requests appropriately and allow time for requests to be met.

*We thank you for your understanding and co-operation on the above. As a patient we understand and respect the right of choice you have for selecting a primary care physician. In order to fulfill your expectations of the best medical care possible you need to be familiar with our policies and standards.*

_____ _____ _____

Date Patient Name Signature

PANACEA
O'NEILL MEDICAL GROUP

104 Spenryn Drive
Madison, AL 35758
(256) 772-4300
Fax (256) 772-4302

# Patient Authorization to Release Medical Information

Patient Name (First, M, Last): _____

Address/City/State/Zip: _____

Phone Number: _____ Date of Birth: _____

**This Authorization applies to the following information:**

☐ All Records.
I understand that the information may contain psychiatric/psychological, alcohol /drug abuse, and/or AIDS/HIV information and I expressly consent to the release of the information.

☐ Only the following records or types of information: _____

**The identified information will be used for the following purpose:**

☐ Changing Doctor
☐ Moving
☐ Individual Request
☐ Physician Request

**I consent for my medical records to go:**

TO:
Practice Name: Panacea O'Neill Medical Group
Address:104 Spenryn Drive
City/State/Zip:Madison, AL 35758
Phone: 256-772-4300
Fax: 256-772-4302

FROM:
Practice Name: _____
Address: _____
City/State/Zip: _____
Phone: _____
Fax: _____

**OR**

**I consent for my medical records to go:**

TO:
Practice Name: _____
Address: _____
City/State/Zip: _____
Phone: _____
Fax: _____

FROM:
Practice Name: Panacea O'Neill Medical Group
Address:104 Spenryn Drive
City/State/Zip:Madison, AL 35758
Phone: 256-772-4300
Fax: 256-772-4302

I understand once the information below is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

This authorization will expire on (insert date or event): _____
If I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

_____ / / _____
Patient Signature (or Signature of Person Completing Form if Not Patient*) Date

*Relationship to patient: ☐ Parent ☐ Legal Guardian ☐ Physician ☐ Other: _____