PLEASE READ THE FOLLOWING CAREFULLY

I, the undersigned, agree to the care and treatment by the attending physician, his/her associates, or assistants. The treatment may include but is not restricted to medications, immunizations, anesthesia, surgical and invasive procedures, laboratory tests, x-rays, or other studies that may be helpful in the provision of the patient's care. My medical records may be furnished to other physicians as needed for my treatment.

Receipt of Privacy Practices Notice: I acknowledge that I have received a copy of the Notice of Privacy Practices for Internal Medicine Specialists

Assignment of Benefits and Guarantee of Account: I acknowledge full financial responsibility for any services rendered, and I understand that the payment of charges incurred in this office is due at the time of service. I understand that a statement fee of $15.00 will be assessed on patient balances not paid at the time of service. I also understand that the charges not covered by insurance remain my responsibility, and I assign insurance benefits to IMS In the event an account is turned over to a collection agency, I agree to pay all cost of collection, including reasonable attorney's fees and hereby waive all rights of exemption under the Constitution of the State of Alabama. I understand that a $40.00 fee will be added to my account should I fail to give at least 24 hours cancellation notice. This includes same day appointments.

I authorize my health care provider to use an automated telephone system and/or email and/or text and to use my name, address, and phone number, the name of my scheduled treating physician, and the time and place of my scheduled appointments(s), and other limited information for the purpose of contacting me to notify me of a pending appointment, other healthcare related communication and for collection purposes. I also authorize my healthcare provider to disclose to third parties who answer my phone limited protected health information regarding pending appointments, account balances and to leave a reminder message on my voice mail system or answering machine. This also includes wireless methods of communication such as faxes and cell phones. I agree that my preferred method of communication for reminders from IMS is through secure messaging (except as stated above), and if I decline this method of communication, I will notify IMS in writing of my alternate communication method. I authorize and consent to have my protected health information exchanged through Alabama's Health Information Exchange and agree to notify IMS in writing if I elect to opt out of the exchange.

Medical/Billing information and/or test results may be given to PATIENT ONLY_____

Or to the following person(s) _____

DATE_____SIGNED_____

PRINT NAME_____Date of Birth _____

For patients who cannot sign or who have a personal representative present:

_____

Name of Authorized Representative Relation to Patient

Description of Personal Representative Authorizing Authority (*Examples: Parent for minor, legal guardian for minor, etc.)*

_____I refuse to sign acknowledgement that I have received a copy of your Notice of Privacy Practices.

_____A good faith effort has been made to obtain an acknowledgement receipt for our Notice of Privacy Practices.

Internal Medicine Specialists (IMS)

8/5/15

Office only - Chart Number: Physician:

Patient Information

Name (last, first, middle initial)_____

Address (including apt. number)_____

City, State, Zip Code_____

Home Phone_____Work Phone_____Cell Phone_____

E-mail Address_____Referring Physician_____

Date of Birth_____Social Security #_____Gender: M F

Employer's Name_____Marital Status: M S D W

Race_____Language Preference_____

Ethnicity Hispanic or Latino _____ Not Hispantic or Latino____ _____Other _____

Emergency Contact Person _____Relationship_____

Emergency #_____

Responsible Party or Person Responsible for Bill:

Name (last, first, middle initial)_____

Address (including apt. number)_____

City, State, Zip Code_____

Home Phone_____Work Phone_____Cell Phone_____

Date of Birth_____Social Security #_____Gender: M F

Signed by Patient_____

Insurance Information

Primary Insurance _____

Address_____

City, State, Zip Code_____

Policy #_____

Group #_____

Effective Date_____

Owner of Policy_____

Relationship to Patient_____

Birth Date of Policy Holder_____

Secondary Insurance_____

Address_____

City, State, Zip Code_____

Policy #_____

Group #_____

Effective Date_____

Owner of Policy_____

Relationship to Patient_____

Birth Date of Policy Holder_____