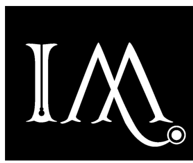


CLINIC

The Internal Medicine Clinic

Phone: (256)-715-9598
Fax: (256)-857-1257

www.imclinic.org

420 Lowell Dr. SE, Suite 105
Huntsville, AL 35801

Patient Registration Form

First Name | **Middle** Name | **Last** Name

Address

City | **State** | **Zip**

Home Phone | **Cell** Phone | **Work** Phone

Email Address | **SSN** | **Driver's License State & Number**

Date of Birth (mm/dd/yyyy) | **Sex** ☐Male ☐Female | **Marital Status** ☐S ☐M ☐D ☐W

Race ☐Black ☐White ☐Asian ☐Other | **Ethnicity** ☐Hispanic ☐Non-Hispanic

How did you hear about our office?

Preference for patient care summary: ☐Portal ☐Paper ☐Both

Next of Kin

Name | Relationship | Phone

Emergency Contact (if different from above)

Name | Relationship | Phone

Employer Information

Employer | Employer Phone | Occupation & Industry (current or most recent)

Insurance Information

Primary Insurance | **Contract #** | **Group #**

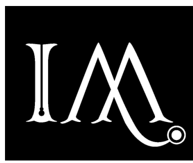
Name of Insured | Relationship to Patient | **Sex** ☐Male ☐Female | **SSN**(insured) | **DOB**(insured)

Secondary Insurance | **Contract #** | **Group #**

Name of Insured | Relationship to Patient | **Sex** ☐Male ☐Female | **SSN**(insured) | **DOB**(insured)

Signature | **Date**

Please turn in this form with your driver's license and insurance card to the receptionist.



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History and Physical

Name **Date of Birth** (mm/dd/yyyy) **Date**

Previous Primary Care Doctor (if transferring from another practice)

Doctor / Practice Name **Address** **Phone**
Fax

Pharmacy and Diagnostic Location Preference

Pharmacy preference

Lab
☐ Quest ☐LabCorp ☐HH
☐Crestwood ☐ Other
Specific which location:

Imaging
☐Outpatient Diagnostic
☐Huntsville Hospital / Med-Mall
☐ Crestwood
☐ Other:

Allergies to foods or medicines (indicate what happens)

☐No Known Food or Drug Allergies

Medications

Name	Dosage	Prescriber	Reason for taking

Vaccinations & Dates Given

Family History

My **mother** is ☐Living ☐Deceased
If deceased, cause of death?
☐Heart Disease, what age?
☐Cancer, what kind and what age?
☐Diabetes ☐High blood pressure ☐High cholesterol
☐Other:

My **father** is ☐Living ☐Deceased
If deceased, cause of death?
☐Heart Disease, what age?
☐Cancer, what kind and what age?
☐Diabetes ☐High blood pressure ☐High cholesterol
☐Other:

Other:

Social History

Smoking Status
☐Never Smoker ☐Former Smoker, age start to stop?
☐Current Smoker, Age started? How many PPD?

Live: ☐Alone ☐with others ☐Institution, which?

Hearing and Sight: ☐Deaf ☐Legally Blind

Alcohol intake: ☐None ☐Occasional ☐Moderate ☐Heavy

Advance Directive: ☐Yes ☐No

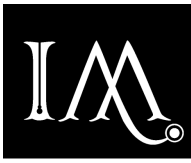
Occupation: Currently Employed ☐Yes ☐No

Able to care for self: ☐Yes ☐No

Exercise: ☐None ☐Occasional ☐Moderate ☐Heavy

Ambulatory Status:
☐Independent ☐Walker ☐Wheelchair ☐Bedbound

Signature **Date**



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Medical History

Other specialist you see:

Surgical & Procedural History

Prior hospitalizations (non-surgical)

Review of Symptoms
Circle all that apply recently.

Constitutional: Chills**,** Fevers
Eyes: change in vision, oculodynia
ENT: nasal congestion, sore throat, difficulty swallowing
Endocrine: excessive urination
GI: abdominal tenderness, hematochezia, melena
GU: dysuria, hematuria
Cardiac: heart racing or skipping beats, swelling, angina

MSK: joint effusion, muscular atrophy
Skin: rashes, changing or worrisome moles
Neuro: localized weakness, dizziness
Psych: hallucinations, mood swings
Heme/Lymph: easy bleeding, unexplained bruising
Allergy/Immunology: hay fever, runny nose
Respiratory: dyspnea, wheeze, cough

Other:

Signature **Date**

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Authorization to Release Medical Records

Patient Name	Date of Birth (mm/dd/yyyy)	SSN

Physician to provide records

Doctor / Practice Name	Address	Phone Fax

Records

The undersigned patient hereby authorizes the release of the following records:

- ☐ **All medical records**
- ☐ Most recent clinic or consult note
- ☐ History & Physical
- ☐ Discharge Summary
- ☐ Information specifically regarding
- ☐ Procedure reports
- ☐ Operative reports
- ☐ Pathology reports
- ☐ Laboratory test results
- ☐ Imaging reports
- ☐ Other

Consents

- I understand that I may change my mind and revoke this Authorization at any time in writing, except to the extent the releasing party has already relied upon this Authorization.
- I understand that protected health information disclosed based on this Authorization may be re-disclosed by the receiving person or entity and may no longer be protected from disclosure to others by federal or state law.
- I understand that protected health information disclosed based on this Authorization may include mental health treatment, alcohol or drug abuse treatment and/or sexual health treatment including HIV/AIDS related information. I authorize release of all medical information concerning these diagnoses and/or treatment of these conditions, to the extent included in the records identified above.
- I understand that neither IM Clinic LLC nor the releasing party may condition my treatment on my execution of this Authorization to Obtain Protected Health Information.
- I understand that this Authorization expires one year from the date of signature.
- I acknowledge that the party releasing my records will not receive payment or other remuneration from a third party in exchange for using or disclosing my protected health information.
- I acknowledge that a copy of this authorization may be utilized with the same effectiveness as an original.

Signature **Date**

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Patient Authorizations, Consents, and Notifications

Name **Date of Birth** (mm/dd/yyyy)

Assignment of Benefits

Initial I hereby authorize Omer Iqbal, D.O. (IM Clinic LLC) to apply benefits on my behalf for the covered services rendered by the office or by the office's order. I request that payment from my insurance company be made directly to Omer Iqbal, D.O. or to the party who accepts assignment. I certify that the information I have reported about my insurance coverage is correct.

No Show Policy

Initial I agree that if I do not call the office at least 24 hours prior to my scheduled appointment to cancel or reschedule that I may be charged a $25.00 no show fee which will not be covered by insurance. After 3 no show appointments, I may be discharged from the practice for non-compliance.

Financial & Office Policies

Initial I certify and agree that I have read and agree to the IM Clinic financial and office policies. I have been directed to the website location of the most up-to-date version of this document at https://imclinic.org/forms/ .

Profile Photo

Initial I hereby authorize IM Clinic LLC to have my photograph for the purpose of attaching it to my medical profile either in the electronic health record and on the paper chart should one be used.

Notice of Privacy Practices

Initial I acknowledge I am aware of the "Notice of Privacy Practices Form 7.2" for IM Clinic LLC. I acknowledge I have either been given a copy for my own reading and records or I have been directed to the website location of this form at https://imclinic.org/forms/ .

HIPAA Privacy and Release of Information Authorization

Initial I hereby authorize IM Clinic LLC and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws. I understand that I have a right to revoke this authorization by providing written notice to. However, this authorization may not be revoked if, it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services. I have been advised of this practice's Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority.

Communicating Your Health

Initial If family members call requesting information about your personal healthcare information, who may we release this information to? ☐**No, don't release** ☐**Yes, release to the following people:**

Name **Relationship** **Phone**

May we leave personal health messages on your home telephone: ☐**Yes** ☐**No**
May we leave personal health messages at your office number: ☐**Yes** ☐**No**

These agreements will remain in effect as long as you are a patient at IM Clinic LLC, unless we are advised in writing of the need to make a change.

Signature **Date**

Please turn in this form in to the receptionist.

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Welcome!

Thank you for choosing the Internal Medicine Clinic (IM Clinic) as your primary healthcare office.

IM Clinic is my vision for the ideal primary care clinic. I truly believe in person-focused (not disease-oriented) care over time.

We are in the midst of drastic changes in the landscape of healthcare in America. What the future holds, only time will tell. One thing is certain: my goal is to provide the highest level of care for my patients -- regardless of the changing landscape of healthcare.

I aspire to bring evidence-based medicine, care and compassion, and technology to the forefront of this medical practice.

As part of this practice, you will have access to a state-of-the art patient portal which gives you convenient, 24-hour access to your personal health information. I encourage you to complete your registration and utilize the patient portal to take full advantage of its many features. You can register anytime with the provided access instructions. Call our office anytime at 256-715-9598 if you need help.

The patient portal will allow you to:

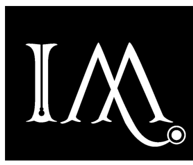
- Access lab results
- Request refills
- Send and receive secure messages with your physician and nurse
- Read and review alerts and health reading material

On your scheduled appointment day, arrive 10 to 15 minutes early. Please remember to bring all your medicine bottles (including over the counters) along with any logs (glucose, blood pressure, symptom, etc...) you may be keeping.

You can read more about the practice and find helpful information on our website: https://imclinic.org.

We look forward to being your partner in this journey of health!

Thanks,
Dr. Omer Iqbal



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Financial & Office Policies

Thank you for choosing us as your primary care provider. Please read this document carefully and ask us any questions you may have.

1. **Walk-ins.** We do see "work-ins" but discourage "walk-ins". Essentially this means we will be glad to see you, but please call first. This allows us to be better prepared to serve you and to keep our schedules on time.
2. **Insurance.** Knowing your insurance contract is your responsibility. You are responsible for knowing which laboratories, hospitals and providers participate with your insurance. Please contact your insurance company with questions regarding your coverage.
3. **Co-payments and Deductibles.** All co-payments and deductibles must be paid at the time of service; we do not bill for co-payments. This arrangement is part of your contract with your insurance company. A receipt of your co-payment will be provided. Returned check fee is $25.00 and we do not redeposit returned checks; returned check payment and fees are due within 10 days of notification.
4. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
5. **Proof of insurance—Identity Protection.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of a valid government issued picture ID and current valid insurance card. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. It is your responsibility to inform us of any address changes immediately. Please be prepared to show your insurance card at every visit. We may ask to see a valid government issued picture ID at any visit. Without the requested ID, you may not be seen.
6. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays your claim or not. Your insurance benefit is a contract between you and your insurance company, we are not party to that contract.
7. **Nonpayment.** If your account is over 90 days past due, please be aware that we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. In the event of default, you agree to pay a reasonable attorney's fee, plus any other costs of collection, in the event your account is turned over to an attorney for collection. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.
8. **Missed appointments.** You agree that if you do not call the office at least 24 hours prior to my scheduled appointment to cancel or reschedule that you may be charged a $25.00 no show fee which will not be covered by insurance. After 3 no show appointments, you may be discharged from the practice for non-compliance.
9. **Prescriptions.** Prescriptions will be provided at office visits. If you need prescriptions between visits, you are requested to call and schedule an appointment. We do not mail prescriptions as this presents a liability to both the patient and our practice. Please allow three (3) business days for prescription refills. Prescriptions may be picked up by the patient, guardian or specified person listed by the patient on the disclosure release form.
10. **Forms.** There will be a $20.00 charge for the completion of health forms. This fee also applies to requests for letters of documentation by our physicians to your work, school or other outside entity.
11. **Records.** Copies of medical records are available to you with a signed medical release form. We require three to five (3-5) business days to complete record releases.
12. **Worker's Comp and Motor Vehicle Injuries.** We do not see Worker's Comp or injuries sustained in motor vehicle accidents. We will be happy to supply you with information for practices who take worker's comp and motor vehicle accident injuries.

Our practice is committed to providing the best treatment to our patients. Thank you for understanding our office policies. Please let us know if you have any questions or concerns.

Last updated January 2nd, 2019.

Please keep this document for your reference.