Tarrant Medical, P.C.

Sidney R. Shah, M.D.
2038 Springdale Ln, Birmingham, AL 35217
(205) 841-7665

New Patient Intake Form

Today's Date: _____

Please complete the below information, to the best of your knowledge, and bring this form to your appointment.

NAME: _____ **BIRTHDATE** _____

ADDRESS: _____ CITY, STATE, ZIP: _____

PHONE: *HOME* ( ) _____ *WORK*: ( ) _____ *CELL*: ( ) _____

EMAIL ADDRESS: _____

Sex: _____ Race: _____ Ethnicity: _____ Social Security #: _____

Employer: _____ Occupation: _____

Retired: ☐ Yes ☐ No Disabled: ☐ Yes ☐ No Retirement Date: _____

Your Preferred Language: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse's Name: _____ Birthdate: _____

Spouse's Social Security #: _____ Spouse's Cell Phone #: _____

Person To Contact In Case of Emergency: _____

Relationship To You: _____ Phone #: _____

Billing Information

Primary Insurance:

Name of Insurance: _____

Contract #: _____ Group Name: _____ Group #: _____

Name of Policy Holder: _____ Policy Holder's Birthdate: _____

Relationship to Policy Holder: _____

Secondary Insurance:

Name of Insurance: _____

Contract #: _____ Group Name: _____ Group #: _____

Name of Policy Holder: _____ Policy Holder's Birthdate: _____

Relationship to Policy Holder: _____

LOCAL PHARMACY

NAME/ ADDRESS: _____

PHARMACY PHONE # ( ) _____ FAX # ( ) _____

MAIL ORDER PHARMACY

NAME/CITY/STATE: _____

PHARMACY PHONE # ( ) _____ FAX # ( ) _____

Medical History

PLEASE CIRCLE ANY ILLNESSES YOU HAVE HAD:

Anxiety	Thyroid Disease	COPD	Osteoporosis
Asthma	Gout	Kidney Disease	Lupus
Blood Clots	Heart Disease	Kidney Stones	Rheumatoid Arthritis
High Cholesterol	Heart Failure	Liver Disease	Seizures
Degenerative Arthritis	Hepatitis	Lung Disease	Sexually Transmitted Infection
Depression	High Blood Pressure	Migraine Headache	Tuberculosis
Glaucoma	HIV/AIDS	Neuropathy	Vein Trouble
Stroke	Fibromyalgia	A-Fib	IBS/Inflammatory Bowel Disease
BPH	Sleep Apnea	Neurological Disease	Anemia

DIABETES (if yes, how long, **last A1C** & **TYPE**) :

CANCER (if yes, location, type, date of diagnosis, treatment) :

Psychiatric Disorders (if yes, current treatment and treating doctor) :

Other Medical Conditions not listed above:

PREVIOUS SURGERIES/INJURIES (and date):

DRUG ALLERGIES (also list reactions): ☐ None

FAMILY HISTORY:

Father: Alive? Y or N Illnesses: _____ Age at Death _____ Cause _____

Mother: Alive? Y or N Illnesses: _____ Age at _____ _____

Number of Siblings/Health Issues: _____ Males: _____ Females: _____

Number of Children/Health Issues: _____ Males: _____ Females: _____

Other Relative Health Issues: _____

SOCIAL HISTORY: Single, Married, Divorced, Widowed, Living with: _____

Smoking: ☐ No ☐ Yes, Packs a day _____, How long _____ Circle Type: (pipe, cigar, cigarettes, vape, chew)
Recently quit _____, Wants to quit _____

Alcohol: ☐ No ☐ Yes, Drinks/day average _____ Circle Type: (beer, wine, liquor)

Substance Abuse: ☐ Y or ☐ N; List type of drug(s) used: _____

Occupation: _____

Caffeine: ☐ Y or ☐ N Drinks/day average _____ Circle Type: (tea, coffee, sodas, medicine, foods)

Diet: ☐ Y or ☐ N If yes, Circle Method of Diet: Low Carb, Low Calorie, Low Fat, Vegetarian, Other: _____

Exercise: ☐ Y or ☐ N Frequency _____ Duration _____ Type _____

HOSPITALIZATIONS THIS YEAR (list reason/date):

IMMUNIZATIONS AND DATES:

Gardasil _____ Hepatitis B _____ Influenza _____ Pneumovax _____ Measles _____

Meningococcal _____ Rubella _____ Tetanus _____ Shingles _____ COVID _____

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Reason for Visit: _____

Check any associated symptoms below

CONSTITUTIONAL: ☐ fevers/chills ☐ night-sweats ☐ anorexia ☐ weight loss ☐ weakness ☐ body aches ☐ sleep disorder ☐ weight gain

EYES: ☐ blurry vision ☐ double vision ☐ discharge ☐ eye pain ☐ light sensitivity ☐ eye irritation

EARS, NOSE, MOUTH & THROAT: ☐ decreased hearing ☐ runny nose ☐ mouth sores ☐ sore throat ☐ sinus congestion ☐ ringing in the ears ☐ nosebleeds ☐ difficulty swallowing ☐ hoarseness ☐ earache

CARDIOVASCULAR: ☐ chest pain ☐ palpitations ☐ decreased exercise tolerance ☐ lightheadedness ☐ shortness of breath ☐ swelling of hands or feet ☐ difficulty breathing while ☐ lying down ☐ fainting ☐ leg cramps with activity ☐ racing heart ☐ near fainting

RESPIRATORY: ☐ cough ☐ shortness of breath ☐ coughing up blood ☐ wheezing ☐ excessive ☐ sputum ☐ excessive snoring ☐ sleep disturbances due to breathing

GASTROINTESTINAL: ☐ nausea/vomiting ☐ difficulty swallowing ☐ heartburn ☐ diarrhea ☐ blood in stools ☐ abdominal pain ☐ regurgitation ☐ bloating ☐ constipation ☐ significant change in bowel habits ☐ hemorrhoid problems

GENITOURINARY: ☐ pain/burning with urination ☐ blood in urine ☐ frequency ☐ urgency ☐ unable to empty bladder ☐ trouble starting urinary stream ☐ nighttime urination ☐ foul urine odor ☐ kidney pain ☐ inability to control bladder ☐ genital sores ☐ lack of sexual drive ☐ missed period ☐ abnormal vaginal bleeding

MUSCULOSKELETAL: ☐ joint pain/swelling ☐ weakness ☐ stiffness ☐ arthritis ☐ gout ☐ loss of strength ☐fluid in joint

DERMATOLOGIC: ☐ rashes ☐ suspicious skin lesions

NEUROLOGICAL: ☐headaches ☐ poor balance ☐ numbness ☐ difficulty with coordination ☐ falling ☐sensation of room spinning ☐ tremors ☐ memory loss ☐ excessive daytime ☐sleeping ☐ weakness ☐ tingling in extremities

PSYCHIATRIC: ☐anxiety ☐ depression ☐ thoughts of suicide ☐ thoughts of violence ☐frightening visions or sounds ☐ sense of great danger ☐ other mental problems

ENDOCRINOLOGY: ☐cold intolerance heat intolerance ☐ excessive urination ☐ excessive thirst ☐significant weight change

HEMATOLOGY: ☐enlarged lymph nodes ☐ excessive bleeding ☐ abnormal bruising ☐ fevers without ☐other illness

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MEDICATIONS: See Below List Attached

NAME/DOSE/HOW IT'S TAKEN	NAME/DOSE/HOW IT'S TAKEN
1. _____	6. _____
2. _____	7. _____
3. _____	8. _____
4. _____	9. _____
5. _____	10. _____

HEALTH MAINTENANCE: (ENTER DATE OF YOUR LAST EXAM/STUDY)

Assisted Device: (Please circle one) None, Walker, Power Scooter, Manual Wheelchair, Power Wheelchair

Bone Density: Date _____ Findings: _____ Performed by _____

Colonoscopy: Date _____ Findings: _____ Performed by _____

Eye Exam: Date _____ Findings: _____ Performed by _____

Diabetic Foot Exam: Date _____ Findings: _____ Performed by _____

Mammogram: Date _____ Findings: _____ Performed by _____

OBGYN Care: Date _____ Findings: _____ Performed by _____

PSA (men): Date _____ Findings: _____ Performed by _____

Other Physicians seeing you currently and their specialty:

_____

_____

Authorization to Release Information:

I authorize the release of medical information and records concerning my treatment to Medicare, Medigap, and/or other insurance companies and assign my claim for medical benefits to the Practice to the extent permitted under applicable law or insurance agreements. I agree to allow the Practice to request and release mu medical records from the other physicians or medical institutions as it deems necessary for my medical care and I further authorize the release of my medical records by such parties for such purpose. I agree to allow the Practice to use my medical information and photography in an anonymous manner for the purpose of teaching or publication. I release the Practice from all legal responsibility or liability that may arise from above authorizations and agreements.

Appointment Reminder Policy:

I authorize this Practice and their agent to place appointment reminder phone calls to the phone I have listed on my patient form.

Consent to Treatment:

I authorize the physicians of the Practice, their associates, technical assistants, and other health care providers under their direction to provide diagnostic evaluation and treatment. I understand that no guarantee has or will be made to me regarding any possible result or cure based on my examination and/or treatment.

Patient Signature: _____

Date: _____

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Patient Name _____ Date of Birth _____ Patient ID # _____

Statement/Acknowledgment of Financial Responsibility

We appreciate you choosing us as your healthcare provider. Payment for services rendered is considered part of your overall treatment. Thus, your understanding of the following financial policies is important to our professional relationship.

Private Insurance Benefits and Coverage Disclosures

As a courtesy, Tarrant Medical, P.C. will assist in filing insurance claims as appropriate, but this in no way guarantees that any benefits will be paid by the patient's insurance company. Your insurance benefit is a contract between you and your insurance company. You are responsible for notifying Tarrant Medical, P.C. of any insurance coverage and any changes in your insurance coverage. Tarrant Medical, P.C. will assist with, but is not responsible for, obtaining any needed insurance referral(s) or prior authorization(s). Required insurance referral(s) or prior authorizations (s) are ultimately the responsibility of the patient. All efforts relating to the collection of the patient's insurance benefits are for the patient's convince and do not represent a guarantee of collection or a credit to the patient's account until such time as payment is received by Tarrant Medical, P.C..

The patient's insurance plan's eligible charges or maximum allowed amount(s) are the most the patient's insurance company is required to pay under the terms of the patient's insurance plan. These eligible charges or maximum allowed amounts are determined by the patient's specific insurance plan. Under many insurance plans, Tarrant Medical, P.C. is a non-contracted provider and may not have information about the patient's insurance plan's eligible charges or maximum allowed amount(s) until after a claim has been processed. As a non-contracted provider, Tarrant Medical, P.C. may bill the patient or his or her parents, guardians, or personal representative for any fees relating to care received at Tarrant Medical, P.C. that are not paid by the patient's insurance company even when the patient's insurance carrier has paid the plan's eligible charges or maximum amount(s) for those services.

If the patient no longer meets the plan's qualifications or if the criteria of the plan's benefit guidelines are not met (including but not limited to, referral or prior authorization procedures, benefit exclusion and/or eligibility, etc.), the patient or his or her parent, guardian, or personal representative will be responsible for payment of all non-covered claim charges relating to the care provided by Tarrant Medical, P.C.. If the patient is not able to provide proof of insurance at the time of appointment or if insurance is not able to be verified, the patient or his or her parent, guardian, or personal representative will be responsible for payment.

All services provided must be paid for, regardless of whether the patient's insurance company covers those services. The patient or his or her parent, guardian, or personal representative is ultimately financially responsible for all charges not covered by insurance payments.

Private Pay/Self-Pay Patients

If the patient does not have insurance coverage of any kind, the patient or his or her parent, guardian, or personal representative will solely be responsible for payment of all charges relating to the care provided by Tarrant Medical, P.C..

Payment Due Dates and Policies

Regardless of whether or not the patient has insurance coverage, the patient or his or her parent, guardian, or personal representative is ultimately responsible for payment for services rendered by Tarrant Medical, P.C.. It is the policy of

Tarrant Medical, P.C. to collect payment at the time the service is rendered, including co-pays, deductibles, payment for non-covered services, and payments by private pay patients. In addition for patients having an outstanding balance at the time of an appointment, payment of the outstanding balance is due prior to any additional services being rendered. Payment may be made by cash, check, or credit/debit card.

If the patient or his or her parent, guardian, or personal representative is unable to pay the amount due in full at the time of the appointment, the following procedures shall apply:

- Tarrant Medical, P.C. will accept payment of one-third (1/3) of the amount due at the time of the appointment. An additional one-third (1/3) is due thirty (30) days later, and the final one-third (1/3) is due thirty (30) days after that.
- If the patient is unable to pay one-third (1/3) of the amount due at the time of the appointment, established patients may be allowed to enter into a payment plan agreed to by Tarrant Medical, P.C..
- If the patient is unable to pay any of the amount due at the time of the appointment, in non-emergent situations, the patient will be asked to reschedule their appointment for a later date when payment can be made.

In the event that a filed insurance claim has not been paid within a reasonable amount of time, the patient or his or her parent, guardian, or personal representative will be billed and responsible for payment. If Tarrant Medical, P.C. later receives payment from the insurance company, the refund procedures discussed below will apply.

Any amounts due that are not paid timely may be turned over to an attorney or collection agency. The patient or his or her parent, guardian, or personal representative is responsible for all collection and attorney fees, as well as finance or interest charges, associated with such accounts.

Tarrant Medical, P.C. reserves the right to impose a charge for all returned checks. Tarrant Medical, P.C. reserves the right to impose finance charges on overdue balances. In the event that a check is returned making an account balance overdue, both a returned check charge and finance charge may apply.

In the event the patient or his or her parent, guardian, or personal representative has overpaid on an account, any credit balance will be applied towards an outstanding balance. In the event the patient does not have an outstanding balance, a refund will be made in accordance with Tarrant Medical, P.C.'s refund policy.

Acknowledgement

By signing below, I acknowledge the following:

- I have read and understand the information contained in this Statement/Acknowledgment of Financial Responsibility.
- I was provided with the opportunity to ask questions about the information contained herein. Any questions asked have been answered to my satisfaction.
- I understand that I am financially responsible for all charges for services rendered that are not covered by insurance.
- The decision to receive care from Tarrant Medical, P.C. was voluntary.

Patient Signature	Printed Name	Date
Parent/Guardian/Rep. Signature (If Applicable)	Printed Name	Date

Tarrant Medical, P.C.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND ABOUT HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

EFFECTIVE DATE: 09/03/2021

The policy of Tarrant Medical, P.C. is to protect the confidentiality, integrity and security of the protected health and personal information of our patients and to prevent unauthorized access to, or the use or disclosure of such information. We are required by law to maintain the privacy of your health information and provide you with this notice of our duties and obligations. This policy applies to patients who are current or former patients of Tarrant Medical, P.C.

Individually identifiable health and personal information are any information obtained by Tarrant Medical, P.C. in connection with providing healthcare treatment, obtaining payment and related health care operations. This relates to past, present or future information that Tarrant Medical, P.C. receives from you as our patient.

Tarrant Medical, P.C. collects personal information in order to learn about your medical history, medical conditions, render treatment and collect payment for our services. We gather this information from your patient forms, health questionnaires and other forms you will be asked to complete from time-to-time. In addition, we will assemble information based on our discussions and conversations with you, your personal representative and your family members. Your healthcare plan or insurance carrier may provide information to our office.

We will use this information to provide caring and quality medical care to you. Examples include diagnosis, treatment and communications such as follow up and appointment reminders, as well as treatment alternatives or other health-related benefits that may be of interest to you or your particular medical condition. As part of our standard treatment and healthcare operations, we may share information with a facility such as a hospital, laboratory, diagnostic service or healthcare provider to efficiently coordinate your treatment plan. We will obtain your written authorization before using your information for marketing purposes. For contracted insurers, your information will be used for claims management and to obtain payment from your insurance carrier. We will exchange paper and electronic data with your insurance carrier for activities such as eligibility, benefit and coverage determinations, precertification, utilization review and related activities. For worker's compensation, information about a work related condition can be exchanged with the employer.

Your information is maintained in our office in our computer system. We also maintain information about you in your medical chart. Tarrant Medical, P.C. limits the access to your protected health information to those employees and business associates who need to know that information. With some limitations, you have the right to inspect, amend, copy and receive an accounting of disclosures of your medical and billing records.

We do not disclose personal information to third parties unless one of the following exceptions applies:

- We will receive an explicit authorization from you to release individually identifiable information. This authorization must be in writing and give exact details regarding to whom the disclosure applies, the nature of the data to be released, the applicable dates and signed by the patient (or guardian). You may revoke this authorization by providing a written statement to Dr. Sidney Shah, Tarrant Medical, P.C., 2038 Springdale Ln, Birmingham, AL 35217.
- Federal, state or other applicable law requires us to share protected information or records. Your information may be disclosed to a health agency for purposes such as licensure, certification, audits, investigations and inspections. As required for law enforcement purposes or in response to a valid subpoena or court order, your information may be disclosed. Other disclosures could be required by law for military duty, national security activities or for coroners or funeral director to carry out their duties.
- We are obligated to abide by the terms of this notice. We will obtain a signed, written authorization from you for permission to use and disclose your information for reasons not described in this Notice of Privacy Practices. The authorization will have an expiration date and a description of the purpose or the event you are authorizing. You will be provided with a copy of the signed authorization. You have the right to revoke the authorization in writing, at any time, and mail to Dr. Sidney Shah, Tarrant Medical, P.C., 2038 Springdale Ln, Birmingham, AL 35217.

We will notify you in the event you are affected by an unsecured breach of information. We reserve the right to change the terms of this Notice of Privacy Practice and to make new notice provisions effective for all health information that we maintain. The revised notice will be made available on our website/portal and any new notices will be distributed to you upon your return to the practice.

With some exceptions, you have right to inspect, review or obtain a copy of your health information. This request must be in writing and there may be a reasonable charge to provide you with a copy of your information. You also have the right to request your records be amended, to request special accommodations and restrictions of your health information, including to your health plan, and to receive an accounting of the disclosures of your information. You have the right to request to receive communications of your information in a special manner or location. Tarrant Medical, P.C. is not obligated to agree to a requested restriction unless the disclosure to your health plan is for payment or health care operations and is not otherwise required by law and it pertains solely to a health care item or service has paid the health care provider/entity in full. We must receive a written request from you to administer these rights. Please ask to speak to the Privacy Officer or Office Manager for further information or to begin the process to exercise any of these rights.

If you have a complaint about the management of your health information or believe your privacy rights have been violated, please contact our Privacy/Security Officer, Dr. Sidney Shah at (205) 841-7665 or you may file a complaint in writing to our Privacy Officer, Dr. Sidney Shah, Tarrant Medical, P.C., 2038 Springdale Ln, Birmingham, AL 35217. You have the right to file a complaint with our office and the Office for Civil Rights (OCR) and there will be no retaliation for filing a complaint with either entity.

Other optional uses of PHI:

- ❑ Your medical information may be reviewed by our medical staff for possible inclusion and referral in research studies. You will be contacted prior the use of your information in a research study. You will be required to sign and complete a written authorization. The authorization will have an expiration date and a description of the purpose or the event you are authorizing. You have the right to revoke the authorization in writing and then mail to the Privacy Officer at Tarrant Medical, P.C., 2038 Springdale Ln, Birmingham, AL 35217, or this may be done at our office. You will be provided with a copy of the signed authorization.
- ❑ In order to coordinate your care or service your account, Tarrant Medical, P.C. and our agents may contact you by telephone at any telephone number you provide, including wireless telephone numbers, which could result in charges. Tarrant Medical, P.C. may also contact you by sending text messages or emails, using any e-mail address you provide. Methods of contacting may include prerecorded or artificial voice messages and or use of automatic dialing devices, as applicable.

Tarrant Medical, P.C.

Sidney R. Shah, M.D.
2038 Springdale Ln, Birmingham, AL 35217
(205) 841-7665

Acknowledgment of Receipt of Notice of Privacy Practices with Restrictions

Patient Name: _____ Patient Date of Birth: _____

I have been presented with a copy of Tarrant Medical, P.C.'s Notice of Privacy Practices, detailing how the above-named patient's information may be used and disclosed as permitted under federal and state law.

In the event of a medical emergency or if I am otherwise unavailable, I hereby allow Tarrant Medical, P.C. to discuss billing, appointments, treatment, diagnosis, test results, and other protected health information regarding the above-named patient with the following persons who are involved with the patient's health care and/or payment related to the patient's health care:

Name	**Relationship**	**Contact #**

Contact Methods:

May we leave information on your answering machine at home?	Yes	No
May we leave information on your voicemail at work?	Yes	No
May we leave information on your cell phone?	Yes	No

I understand the contents of the Notice of Privacy Practices, and I request the following restriction(s) concerning the use and/or disclosure of my personal medical information (*include type of information covered and the parties who should not receive the information*):

_____

_____

_____

I understand that Tarrant Medical, P.C. will carefully consider my request, but is not obligated to accept the request unless the request is to restrict the disclosure of information to a health plan for purposes of carrying out payment or other health care operations and the information pertains solely to a health care item or service for which Tarrant Medical, P.C. has been paid in full other than by the health plan.

The request stated herein ☐ **does or** ☐ **does not** restrict the disclosure of information to a health plan for purposes of carrying out payment or other health care operations with the information pertaining solely to a health care item or service for which Tarrant Medical, P.C. has been paid in full other than by the health plan

My signature below is acknowledgment that I have received a copy of Tarrant Medical P.C.'s Notice of Privacy Practices and that I agree to the conditions stated in the Notice of Privacy Practices and contained in this form.

_____ _____

Printed Name of Patient Date

_____

Signature of Patient

_____

Printed Name of Parent/Patient's Representative (If Applicable)

_____

Signature of Parent/Patient's Representative (If Applicable)

Tarrant Medical, P.C.

Sidney R. Shah, M.D.
2038 Springdale Ln Birmingham, AL 35217
Phone (205) 841-7665
Fax (205) 841-8366

Patient Name: _____ DOB:_____

1. I authorize Tarrant Medical, PC to Request, Use or Disclose the above named individual's health information as described below.

2. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

_____

_____

Specified Dates and Providers to be Included:

From (date) _____ to (date) _____

From (date) _____ to (date) _____

From (doctors' names)_____

Other: _____

3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

4. This information may be ☐ **Requested From** ☐ **Disclosed To and Used by** the following individual or organization:

Name: _____

Address: _____

For the purpose: _____

☐ At the request of the individual Phone number_____ Fax Number_____

5. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Privacy/Security Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that 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. Unless otherwise revoked, this authorization will expire on the following date, event, or condition_____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CRF 164.524 of the Federal Register Rules and Regulations. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure or my health information, I can contact Dr. Sidney R. Shah, Privacy Officer.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

If signed by Legal Representative, Relationship to Patient Signature of Witness

TARRANT MEDICAL STAFF MEMBER REQUESTING RECORDS: _____