Thank you for choosing The Waddell Center for your medical needs. Please complete the enclosed paperwork and return it to our office as soon as possible. We will then request your medical records from your previous physician(s). After your records have been reviewed by the physician of your choice here at The Waddell Center, our office will contact you regarding your request for an appointment.

Dr. Samantha Ross, M.D. **Dr. William Woodall, M.D.**
Neha Patel, CRNP **Jaclyn Collie, CRNP**
Dr. Phillip Ingram

If you already have an appointment scheduled at The Waddell Center, please arrive 30 minutes before your scheduled appointment and bring your drivers license and insurance cards. If you are taking any medication (prescription or over the counter), always bring the actual bottles with you. Do not bring a list. Please bring the bottles with you. It is very important that you always bring your medication bottles with you to every visit.

We look forward to seeing you.

NOTE: If you use GPS to find out office, please enter the address as
209 Fitness Way, Athens, AL.
We are located directly across from The Wellness Center.

WADDELLCENTER FamilyMedicine

902 West Washington Street
Athens, AL 35611
Phone (256) 216-9777 Fax (256) 216-9776

WELCOME TO OUR PRACTICE!

Your appointment has been scheduled with one of our physicians. We are pleased that you have selected our clinic as your health care provider. Please complete the enclosed forms with your signature where indicated and return them on your appointment day.

APPOINTMENTS: Your initial visit with the doctor will consist of routine checking of your vital signs, weight, etc. and complete discussion of your medical history, medications you are taking, and health issues you may currently be experiencing. An actual "physical examination" or "gynecological exam" will be scheduled for 1-2 weeks later with appropriate time allowed to focus on the actual examination by request. If you are sick, and seen on an urgent, work-in basis, only your acute problem will be addressed. You will need to schedule another appointment for any other medical questions or issues you may have. If your doctor schedules lab work or x-rays for you, a letter will be sent to you advising you of the results or requesting that you return to the office to discuss the results directly with the physician.

INSURANCE: Our office participates in most insurance plans. If you are unsure about your insurance coverage, please call your insurance provider for clarification. Remember that your health coverage is a contract between you and your insurance company. We will assist you in getting full benefits from your insurance carrier. **Your co-payment will be collected at the time of the visit.** If you accrue an unpaid balance with no effort to pay, you will be denied medical treatment from our office. We accept cash, checks (payable to WCFM), Master Card, Visa, American Express, Money Orders and debit cards.

BILLING: Payment is expected at the time of service. If you do not have insurance coverage, please discuss financial options with the office staff prior to your visit. As a courtesy, if we accept your insurance, a statement will not be issued until after your insurance carrier has paid your allotted benefits. If your insurance carrier reimbursement is delinquent for 90 days, you may be asked to contact your insurance carrier. Please remember that any balance not covered by your insurance company is your responsibility.

MEDICATIONS: In order to maintain a harmonious flow within the office, we ask that you always ask for and obtain your medication refills at your visit with the physician. If you call for refills, always allow at least 3 business days for your medication to be sent to your pharmacy of choice.

HOURS: Our normal business hours are Monday through Thursday, 8:00 a.m. until 4:30 p.m. and Friday 8:00 a.m. till 12:00., excluding 12:00 to 1:00 for lunch. Our office telephone number is **256-216-9777**. Please feel free to contact us with any questions or problems.

Athens-Limestone Health Services

PATIENT RIGHTS

Welcome to Waddell Center Family Medicine. Our goal is to make your hospital stay as pleasant as possible. We want to ensure that each patient at our clinic receives information regarding patient rights. We are committed to provide a standard of care that ensures our patients are safe from accidental injury. These rights are stated to publish our commitment that each patient will receive the best possible care that we can offer.

As a patient at Waddell Center Family Medicine your rights include the following:

- The right of access to treatment regardless of race, age, creed, sex or national origin in a safe setting, free from abuse or harassment.
- The right to reasonable access to care and acceptance for treatment within the clinic's capacity or referral to another facility when medically appropriate.
- The right to care that is considerate and respectful of your personal values, culture and beliefs.
- The right to personal privacy and confidentiality of your personal health
- The right to appropriate assessment and management of pain.
- The right to access information contained in your clinical record within a reasonable time frame.
- The right to participate in decisions regarding your care, to be involved in planning your care and treatment, and to receive information necessary to give informed consent.
- The right to accept medical care and refuse medical treatment, as permitted by law, and to be informed of the medical consequences if refused.
- The right to formulate an Advance Directive, such as a Living Will. Information will be provided to you upon your request.
- The right to legally designate a representative decision maker in the event you are incapable of understanding a proposed treatment or procedure or are unable to communicate your wishes regarding your care and to have effective communication.
- The right to receive an itemized, detailed explanation of your bill for services and explanation of benefits paid by insurance.
- The right to voice complaints concerning the quality of care you receive without fear of reprisal, to have those complaints reviewed, according to our Patient Grievance Resolution Policy, and, when possible, resolved.

If you have any concerns about the care you receive while you are a patient please ask to speak to the Office Manager at any time. If you have a patient safety or quality care concern you may also contact any one of the following:

1. **Joint Commission on Accreditation of Healthcare Organizations**
   Office of Quality Monitoring
   One Renaissance Boulevard
   Oakbrook Terrace, IL 60181
   (Fax) 630-792-5636
   (Email) complaint@jcaho.org

2. **State of Alabama Dept of Public Health Hotline**
   1-800-356-9595 Monday-Friday 8 a.m. to 5 p.m.

3. **Athens-Limestone Hospital Patient Safety Officer**
   Administration Telephone: 256-233-9119.

4. **Centers for Medicare and Medicaid Services**
   7500 Security Blvd., Mail Stop S2-12-25
   Baltimore, MD 21244-1850

PATIENT RESPONSIBILITIES

As a patient of Waddell Center Family Medicine, your responsibilities include:

- To provide, to the best of your knowledge, complete and accurate information about your present condition, past illnesses, hospitalizations, medications, and other matters relating to your health.
- To report unexpected changes in your condition.
- To follow instructions and adhere to your plan of care.
- To review all educational materials given to you.
- To report the presence of pain to your physicians and nurses.
- To ask appropriate questions when you don't understand.
- To cooperate with nurses, physicians, and others who participate in administering your care.
- To recognize that your own behavior and actions influence treatment outcomes.
- To recognize that other patients and clinic personnel also have rights.
- To act with consideration and respect toward other patients and clinic personnel.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint.
We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before **April 14, 2003.**

HIPAA Notice of Privacy Practices

WADDELL CENTER FAMILY MEDICINE

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

WADDELLCENTER FamilyMedicine

902 West Washington Street
Athens, AL 35611
Phone (256) 216-9777 Fax (256) 216-9776

PATIENT INFORMATION:

Last Name_____ First Name_____ Middle_____

Male/Female_____ SS#_____ Marital Status_____ Date of Birth_____

Race_____ Ethnic Group_____ Primary Language Spoken _____

Street Address_____ City/State_____ Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

Email Address_____ Preferred Reminder Method_____

Preferred Pharmacy_____

EMERGENCY CONTACT:

Name_____ Phone_____ Relationship_____

RESPONSIBLE PARTY INFORMATION (If Not Self)

Full Name_____

Street Address_____ City/State_____ Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

Date of Birth_____ Marital Status_____SS#_____ Relationship_____

Type of Insurance _____ Contract # _____ Group # _____

Secondary Insurance _____ Contract # _____ Group # _____

***How did you hear about us? ___Source Magazine ___Facebook ___Friend/Family**

___Internet search ___Hospital Inpatient ___Billboard ___Postcard ___Radio ___Other

I hereby authorize and direct payment to Waddell Center Family Medicine for medical benefits, if any, otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for the charges not covered by this authorization. I understand that checks returned for non-payment will incur a $30.00 fee. I hereby authorize Waddell Center Family Medicine to release any information acquired in the course of my examination or treatment to my insurance company for the purpose of processing claims for medical services. I understand that regardless of my insurance status, I am solely responsible for payment of any services rendered to me, or on my behalf, whether or not paid by my insurance company.

Patient/Responsible Party Signature_____ **Date**_____

Inclement Weather Policy

In the event of inclement weather, please call our office to confirm if we are open or closed.

Appointment No-Show Policy

Effective August 1st, 2012

It is the policy of Waddell Center Family Medicine to monitor and manage appointment no shows. Any patient who fails to arrive for a scheduled appointment without canceling the appointment less than twenty-four (24) hours prior to the scheduled time is considered a "no show." The first time a patient is a no show; they will be reminded of the no-show policy with a letter. Once the patient has been a no show for the second time, the no-show fee will be charged and another letter will be sent. The no-show patient fee is $25.00, as set by Waddell Center Family Medicine, for failure to show. A patient who consistently fails to present themselves more than five (5) times can be dismissed from Waddell Center Family Medicine.

_____**Please initial here**

Medication Refill Policy

Effective January 23rd, 2013

It is the responsibility of each patient to bring all of their medications, in the original bottles, to each visit. Lists of medicines are not acceptable due to possible error and lack of information.

It is imperative to notify the nurse if there is a need for any refills at the time of each visit. Calling at a later time for refills may cause a delay in receiving your medications.

Please allow at least 3 business days for medication refills that are requested by call in.

_____**Please initial here**

Forms Requests

There will be a $30.00 charge for certain forms that require that require the doctor to complete. Please allow 5-7 business days to complete.

_____

Patient's Signature **Date**

Waddell Center Family Medicine

Patient Health Assessment

Please use ink pen and fill in all applicable areas. If you have any questions, please discuss with doctor or nurse at your initial visit

Name_____

Telephone_____

Date of Birth_____

Indicate special communication needs of which we should be aware

☐ Vision ☐ Speech ☐ Learning Disability ☐ Mental Retardation
☐ Hearing ☐ Language

Recent Immunizations Indicate whether or not you have received the following immunizations. If yes, indicate approximate year received.

Yes	No		Yes	No	
☐	☐	Hepatitis A_____	☐	☐	Flu_____
☐	☐	Hepatitis B_____	☐	☐	Chicken Pox_____
☐	☐	Pneumonia_____	☐	☐	TB Skin Testing_____
☐	☐	Tetanus_____	☐	☐	Other_____

Alternative Medicine Indicate whether or not you use any of the following.

Yes	No		Yes	No	
☐	☐	Chiropractic_____	☐	☐	Acupuncture_____
☐	☐	Massage Therapy_____	☐	☐	Other_____

Nutrition

Yes	No	
☐	☐	Do you follow any special diet (diabetic, low protein, low sodium, low fat)? If yes, specify: _____
☐	☐	Do you have any other nutrition needs (food preferences, food intolerance, texture modification)? If yes, explain: _____

Life Habits

Yes	No	
☐	☐	Do you live alone? If no, with whom do you live?_____
☐	☐	Have you ever used nicotine? (Circle Cigarettes, pipe, cigar) How much per day?_____ For how many years?_____
☐	☐	Do you currently use nicotine? If yes, what do you use? (Circle Cigarettes, pipe, cigar, smokeless tobacco, nicotine gum/patch?) How much per day?_____ For how many years?_____
☐	☐	Are you regularly exposed to secondhand smoke?
☐	☐	Do you currently use alcohol? If yes, how much per day?_____ How often?_____ Past use?_____ Do you currently use any illicit drugs? If yes, what?_____ How often?_____ Past use?_____
☐	☐	Are you currently exposed to occupational hazards? If yes, what kind?_____
☐	☐	Do you have problems sleeping? If yes, explain_____
☐	☐	Will you need help in planning for your care?_____
☐	☐	Do you walk independently? If not, explain_____
☐	☐	Do you need help with feeding ☐ dressing ☐ bathing ☐ toileting ☐ If yes, explain_____

Domestic Violence

Yes	No	
☐	☐	Are you being abused, injured or frightened by anyone at home or in another area of your life?

Beliefs, Rights, and Values

Yes	No	
☐	☐	Do you have ethnic, religious, spiritual or cultural practices that need to be part of your care? _____
☐	☐	Do you have financial concerns related to your medical care? Circle those that apply: job insurance other
☐	☐	Do you have children? How many? Adult_____ Minor_____
☐	☐	Do you have a guardian? If yes, whom?_____
☐	☐	Do you have an Advance Directive (e.g. living will or durable medical power of attorney)? If yes, bring a copy with you to the office upon your admission. If not, information is available upon request.
☐	☐	Are you an organ/tissue donor?

Patient's Name: _____ **Date of Birth:** _____

Family History (Complete Health Information about your family)

Disease	Family Member (Circle one)				
Alzheimer's / Dementia	Father	Mother	Sibling	Grandparent	Other: _____
Asthma, Hay Fever	Father	Mother	Sibling	Grandparent	Other: _____
Cancer, Type: _____	Father	Mother	Sibling	Grandparent	Other: _____
Cataracts	Father	Mother	Sibling	Grandparent	Other: _____
CHF	Father	Mother	Sibling	Grandparent	Other: _____
CVA / Stroke	Father	Mother	Sibling	Grandparent	Other: _____
COPD	Father	Mother	Sibling	Grandparent	Other: _____
Diabetes	Father	Mother	Sibling	Grandparent	Other: _____
GI Problems	Father	Mother	Sibling	Grandparent	Other: _____
Glaucoma	Father	Mother	Sibling	Grandparent	Other: _____
Heart Attack	Father	Mother	Sibling	Grandparent	Other: _____
Heart Bypass	Father	Mother	Sibling	Grandparent	Other: _____
Heart Disease	Father	Mother	Sibling	Grandparent	Other: _____
Heart Stent	Father	Mother	Sibling	Grandparent	Other: _____
Hyperlipidemia	Father	Mother	Sibling	Grandparent	Other: _____
Hypertension	Father	Mother	Sibling	Grandparent	Other: _____
Kidney Problems	Father	Mother	Sibling	Grandparent	Other: _____
Seizures	Father	Mother	Sibling	Grandparent	Other: _____
Thyroid Disease	Father	Mother	Sibling	Grandparent	Other: _____
Other: _____	Father	Mother	Sibling	Grandparent	Other: _____
Other: _____	Father	Mother	Sibling	Grandparent	Other: _____

List any other family history on back of this form.

MEDICATIONS CURRENTLY IN USE

All Medications must be listed below or we have a right not to take you as a Patient

Medication Name	Dose	Frequency

List any additional medications on back of this form.

Our office does **NOT prescribe long term **Narcotics** or any **Controlled Medications for Anxiety**.**
These are managed with your pain clinic and/or mental health center

ALLERGIES

Check Appropriate Allergy, Then Write Specific Allergy / Reaction

- ❑ **NO KNOW DRUG ALLERGIES**
- ❑ **FOOD:** _____
- ❑ **MEDICATIONS:** _____
- ❑ **OTHER:** _____

WADDELL CENTER FAMILY MEDICINE PAST MEDICAL HISTORY FORM

Name _____

Date of Birth _____

Check the box if the condition pertains to you and write comments if necessary.

Respiratory

	Comment
❑ Asthma	
❑ COPD	
❑ Emphysema	
❑ Sinus problems	
❑ Sleep Apnea	
❑ TB	
❑ Other	

Gastrointestinal

	Comment
❑ Constipation	
❑ Diarrhea	
❑ Diverticulosis	
❑ GERD	
❑ Heartburn	
❑ Hepatitis	
❑ Hiatal hernia	
❑ Jaundice	
❑ Other	

Genitourinary

	Comment
❑ Kidney Disease	
❑ Kidney Stone	
❑ Prostate Disease	
❑ UTI	
❑ Other	

Other Conditions

	Comment
❑ Anxiety	
❑ AIDS/HIV	
❑ Cancer	
❑ Cataracts	
❑ Depression	
❑ Diabetes	
❑ Eye Problems	
❑ Glaucoma	
❑ Hearing Problems	
❑ Peripheral Artery Dz	
❑ Rheumatic Fever	
❑ STD	
❑ Thyroid Disease	
❑ Other	

Neurological

	Comment
❑ Dementia	
❑ Fibromyalgia	
❑ Osteoarthritis	
❑ Osteopenia	
❑ Osteoporosis	
❑ Other	

Musculoskeletal

	Comment
❑ Arthritis	
❑ Chronic Headaches	
❑ Faint/Dizziness	
❑ Migraines	
❑ Numbness/Weakness	
❑ Seizures	
❑ Stroke	
❑ Other	

Previous Surgeries

Date	Reason

Cardiovascular

	Comment
❑ Anemia	
❑ Angina	
❑ Heart Dz	
❑ CHF	
❑ Heart Attack	
❑ High Blood Pressure	
❑ High Cholesterol	
❑ Pacemaker	
❑ Valve Problem	
❑ Other	

Are there any other medical conditions not listed above? Please list them on back of form.

WADDELLCENTER FamilyMedicine

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Phone (256) 216-9777 Fax (256) 216-9776

DUE TO THE PRIVACY CONFIDENTIAL ACT, please list the people that you approve to have access to your information as stated below:

BILLING INFORMATION: _____ Relationship_____

_____ Relationship_____

MEDICAL INFORMATION: _____ Relationship_____

_____ Relationship_____

AUTHORIZATION TO LEAVE MESSAGES:

I hereby authorize Waddell Center Family Medicine staff to leave messages regarding my medical condition, such as lab reports, other test results, medications, and appointment reminders on my home answering machine. This authorization will be in effect until I have given written notice to Waddell Center Family Medicine.

Check one of the following:

Agree _____ Disagree _____

We are required by law to maintain the privacy of, and provide individuals with a notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at Athens-Limestone Hospital.

Signature below is acknowledgement that you have received this Notice of our Privacy Practices and agree to all information listed above. Signature below also indicates that you have received a copy of the Patient Rights & Responsibilities for Athens-Limestone Health Services Clinics.

Print the Patient's Name: _____

Patient's Date of Birth: _____

_____ _____

Signature of patient or patient's representative Date

WADDELL CENTER FAMILY MEDICINE

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____

Signature_____

Date_____

3. Office Copy

Waddell Center Family Medicine
902 W. Washington Street, Athens, AL 35611
Phone: 256-216-9777 Fax: 256-216-9776

Patient Authorization for Use and/or Disclosure and/or Patient Request to Inspect/Copy Protected Health Information.

Patient Name: _____ Date of Birth: _____

I hereby authorize Waddell Center Family Medicine to use, disclose, and/or obtain my health information as follows: (please check all that apply)

Dr. Samantha Ross Dr. William Woodall
Dr. Phillip Ingram
Neha Patel, CRNP Jaclyn Collie, CRNP

Please fax records to 256-216-9776 or mail to 902 W. Washington Street, Athens, AL 35611

_____ Disclose health information to:

_____Obtain health information from: _____
(Name of Physician or Facility)

_____
(City/State)

_____
(Phone Number)

_____
(Fax Number)

All records, most recent, or specific description of the health information to be disclosed/obtained (please include dates of service; examples such as drug and alcohol test results, mental health information, etc.) _____

By providing this Authorization, I understand as follows:

1. I understand this Authorization is voluntary. I may refuse to sign this Authorization and my treatment and/or payment obligations will not be affected. However, PHI (protected health information) will not be released without signature.
2. I understand that I may revoke this Authorization at any time by notifying Waddell Center Family Center in writing, but if I do, it will not have any effect on disclosures prior to the receipt of the revocation.
3. I understand that this Authorization will expire in one (1) year from the date signed.

_____ Today's Date: _____
(Signature of patient or patient's representative)

_____ Today's Date: _____
(Signature of Witness)

_____
(Printed name of patient's representative, if applicable)

_____
(Representative's relationship to patient, if applicable)