ATHENS LIMESTONE SURGICAL CLINIC

Phil Tranqui, MD
Danisa Clarrett, MD

Phone: 256-262-6190 Fax: 256-262-6199

Thank you for choosing Athens Limestone Surgical Clinic for your medical needs. Please complete the enclosed paperwork and return it to our office as soon as possible. Afterwards, we will request your medical records from your previous physician(s). Once your records have been reviewed, by the physician of your choice, our office will contact you regarding your request for an appointment.

Phil Tranqui, MD
Danisa Clarrett, MD

If you already have an appointment scheduled at Athens Limestone Surgical Clinic, please arrive 30 minutes before your scheduled appointment and bring your driver's 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. It is very important that you always bring your medication bottles with you to every visit.

We look forward to seeing you!

101 Fitness Way, Suite 2100, Athens, AL 35611

ATHENS LIMESTONE SURGICAL CLINIC

101 Fitness Way, STE 2100
Athens, AL 35611

Phone: 256-262-6190 Fax: 256-262-6199

PATIENT INFORMATION:

Last Name ___________________ First Name ___________________ Middle ___________________

Male/Female ________ SS# _________________ Marital Status _____________ DOB ___________

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 _________________

DOB ___________ Marital Status ___________SS#__________________ Relationship___________

Primary Insurance _________________ Contract # _________________ Group # _______________

Secondary Insurance ______________ Contract # _________________ Group # _______________

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How did you hear about us?

___Source Magazine ___Facebook ___Friend/Family

___Internet search ___Hospital Inpatient ___Billboard ___Postcard ___Radio

___Other, please explain ____

I hereby authorize and direct payment to Athens Limestone Surgical Clinic 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 Athens Limestone Surgical Clinic 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 _________________________

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WELCOME TO OUR PRACTICE!

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 bring them with you on your appointment day.

APPOINTMENTS: Your initial visit with the doctor will consist of routine checking of your vital signs, weight, etc., including a complete discussion of your medical history, medications you are taking, and health issues you may be currently experiencing. If you are sick, and seen on an urgent, work-in basis, only your acute problems 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, 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. If you miss 3 scheduled appointments, you may be subjected to a no-show fee.

MEDICATIONS: In order to maintain a harmonious flow within the office, we ask that you always request 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 p.m., excluding 12:00 to 1:00 for lunch. Our office telephone number is **256-262-6190**. Please feel free to contact us with any questions or problems.

Athens-Limestone Health Services

PATIENT RIGHTS

Welcome to Athens Limestone Surgical Clinic. 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 Athens Limestone Surgical Clinic 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 Athens Limestone Surgical Clinic, 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

HIPAA Notice of Privacy Practices

ATHENS LIMESTONE SURGICAL CLINIC

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.

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.**

ATHENS LIMESTONE SURGICAL CLINIC

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: ____

Office Copy

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

It is the policy of Athens Limestone Surgical Clinic 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 Athens Limestone Surgical Clinic, for failure to show. A patient who consistently fails to present themselves more than five (5) times can be dismissed from Athens Limestone Surgical Clinic.

__________Please initial here

Medication Refill Policy

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**

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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 Athens Limestone Surgical Clinic 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 Athens Limestone Surgical Clinic.

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

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MEDICAL HISTORY

Name: ______________________________________ **DOB:** ____________________

Current Healthcare Providers:

1. ______________________________ 2. ______________________________

3.________________________________ 4. ______________________________

5. ______________________________ 6. ______________________________

PLEASE MARK IF YOU HAVE OR HAD THE FOLLOWING:

___ Acute Hepatitis
___ Alzheimer's Disease/Dementia
___ Anemia
___ Anxiety
___ Arthritis
___ Asthma
___ Atrial Fibrillation
___ Bleeding Disorders
___ Blood Clots (DVT)
___ Cancer, Type ______________
___ Cirrhosis
___ COPD/Emphysema
___ CVA (Stroke), Year _________
___ Depression
___ Diabetes
___ Fibromyalgia
___ Heart Attack (MI), Year ______
___ Heart/Coronary Artery Disease
___ Heart Valve Disease
___ High Cholesterol
___ HIV
___ Hypertension
___ IBD (Crohn's Disease/Ulcerative Colitis)
___ Liver Disease
___ Multiple Sclerosis
___ Nervous Disorder
___ Neuropathy
___ Renal Insufficiency/Failure
___ Seizure Disorder
___ Sleep Apnea
___ Thyroid Problems
___ TIA (Mini-Stroke)
___ Other, please explain:
____
____
____

Name: ____________________________________ **DOB:** ___________________

SURGICAL HISTORY:

___ Appendectomy (Appendix Removal)
___ Back/Neck Surgery
___ Bladder/Kidney Stone Surgery
___ Breast Biopsy
___ CABG (Open Heart Surgery)
___ Carpal Tunnel Surgery
___ Cataract Surgery
___ Cholecystectomy (Gallbladder Removal)
___ Colon Resection
___ Colonoscopy
___ C-Section
___ D&C
___ Dialysis Access Surgery
___ EGD
___ Exploratory Surgery
___ Foot Surgery
___ Fundoplication (Anti-Reflux Surgery)
___Gastric Band
___ Gastric Bypass
___ Gastric Sleeve
___ Heart Stents
___ Heart Valve Replacement
___ Hemorrhoid Surgery
___ Hernia Repair
___ Hysterectomy
___ Joint Replacement
___ Kidney Transplant
___ Knee Surgery
___ Lung Surgery
___ Mastectomy (Breast Removal)
___ Nephrectomy (Kidney Removal)
___ Pacemaker/Defibrillator
___ Prostatectomy (Prostate Removal)
___ Shoulder Surgery
___ Sinus Surgery
___ Skin Cancer Surgery
___ Splenectomy (Spleen Removal)
___ Tonsillectomy/Adenoidectomy
___ Tubes in Ears (Tympanostomy Tubes)
___ Vasectomy
___ Other Prior Surgeries, please explain:
____
____
____
____
____

FAMILY HISTORY:

Has anyone is your family had any of the following? If so, please list your relation.

___ Adopted/Unknown Family History
___ CVA (Stroke) If yes, who ______________________________
___ Bleeding Disorders If yes, who ______________________________
___Heart Attack (MI) If yes, who ______________________________
___ Cancer, Type If yes, who ______________________________
___ High Blood Pressure If yes, who ______________________________
___ Colon Polyps If yes, who ______________________________
___ IBD (Crohn's Disease/Ulcerative Colitis) If yes, who ____________________
___ Congestive Heart Failure If yes, who ______________________________
___ Kidney Disease If yes, who ______________________________

What is your current residence?
___ Home ___ Apartment/Condo ___ Other

Do you currently use a Home Health Agency? (Please circle) YES NO
If yes, which agency? ______________________________

Name: ______________________________________ **DOB:** ____________________

SOCIAL HISTORY:

	YES	NO
1. Did you smoke in the past? If yes, when did you quit? _____________________	___	___
2. Do you vape?	___	___
3. Do you use smokeless tobacco?	___	___
4. Do you have a living will?	___	___

Do you experience any of the following? If so, please explain.

___ Drug Allergies, ____
___ Food Allergies, ____
___ Latex
___ Other, ____
____
____
____
____

Do you currently use any of the following?

___ Cane
___ Contact Lenses
___ CPAP Device
___ Crutches
___ Dentures
___ Glasses
___ Hearing Aid
___ Home Oxygen
___ Hospital Bed
___ Nebulizer
___ Walker
___ Wheelchair

Please list current medications and dosage amounts:

____
____
____
____
____
____
____
____
____
____
____
____

Name: ___________________________________ DOB: __________________

REVIEW OF SYSTEMS

Are you currently experiencing any of the following? Please check all that apply:

___ Fatigue
___ Fever/Chills
___ Night Sweats
___ Weakness
___ Weight Gain
___ Weight Loss

___ Abdominal Pain
___ Bloating
___ Blood in Stool
___ Constipation
___ Dark, Tarry Stool
___ Diarrhea
___ Difficulty Swallowing
___ Fecal Incontinence
___ Heartburn/Reflux
___ Nausea/Vomiting

___ Atypical Lesions or Moles
___ Rashes
___ Sores or Ulcers

___ Decreased Hearing
___ Earache
___ Headache
___ Hoarseness
___ Loss of Vision
___ Ringing in Ears

___ Cough (Acute)
___ Cough (Chronic)
___ Hemoptysis (Blood in Sputum)
___ Shortness of Breath
___ Wheezing

___ Joint Pain
___ Leg Pain
___ Leg Swelling
___ Leg Weakness

___ Fainting
___ Paralysis
___ Neuropathy
___ Seizures

___ Breastfeeding
___ Breast Mass
___ Nipple Discharge
___ Breast Pain

___ Blood in Urine
___ GU Discharge
___ Frequent Urination
___ Pain or Burning with Urination
___ Urinary Incontinence

___ Anxiety
___ Panic Attacks
___ Depression

___ Chest Pain
___ Heart Murmur
___ Palpitations
___ Swelling of the Legs or Feet

If female, what was the age of your first menstrual cycle? ________

What was the date of your last menstrual cycle? _________________

If you have ever been pregnant, what was your age during your first pregnancy? _______

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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 Athens Limestone Surgical Clinic to use, disclose, and/or obtain my health information as follows: (please check all that apply)

Dr. Phil Tranqui
Dr. Danisa Clarrett

Please fax records to 256-262-6187 or mail to 101 Fitness Way, Suite 2100, 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 Athens Limestone Surgical Clinic 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)