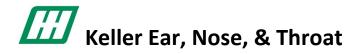


AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

NAME		SS NUMBER			
DATE OF BIRTH	MARITAL STATUS		PRIMARY CARE PROVIDER		
ADDRESS					
CITY	s	TATE	ZIP CODE	COUNTY	
HOME #	c	ELL#		Preferred: 🗆 Home 🗆 Cell	
EMAIL*PATIENT PORTAL INFORMA	TION WILL BE RELEASED TO THIS EI	 MAIL*	_		
IF YES, THE ANSWER TO TH	ED TO THE PATIENT PORTAL? O HE SECURITY QUESTION SENT TO YOU E AND DISCLOSURE OF THE ABOVE NAME.	OUR EMAIL I	S YOUR ZIP CODE	ITION AS DESCRIBED - FACESHEET.	
	NOTES, OUT PATIENT RECORDS, LAB RE THORIZE THE RELEASE OF MY PROTECT ME.				
DISEASES, ACQUIRED IMMUNO		AN IMMUNO	DDEFICIENCY VIRUS (HI	RELATING TO SEXUALLY TRANSMITTED V). IT MAY ALSO INCLUDE INFORMATION	
NAME	DOB	RELATIC	NSHIP	PHONE NUMBER	
				REVOKE THIS AUTHORIZATION, I MUST CT UNTIL TERMINATED OR CHANGED BY	
SIGNATURE:			DATE:		
AUTHORIZATION TO CALL I authorize HH System Clinics	s to leave the following messages o	n my answe	ring machine/voicem	nail:	
[] Reminder appoir [] Lab and/or Test	ntment calls [] Do not leave a results [] Only leave a me	_	g me to return your c	all	



Basis of Authority to sign for Patient: _____

HH System Clinics Registration Update Sheet
Patient: Date of Birth:
HH SYSTEM CLINICS ADVANCE DIRECTIVE POLICY
In our practices we have decided that we will initiate resuscitative measures anytime they are needed.
FINANCIAL FEES AND ASSISTANCE
FINANCIAL ASSISTANCE: I understand that financial assistance may be available for individual patients who are uninsured or who otherwise meet financial aid criteria. The hospital's overall ability to remain financially stable and provide essential health care services to all members of our community is dependent upon financial resources available to cover services provided to patients. My assistance in providing such information is necessary to determine possible financial aid available to me. If I am uninsured and need financial assistance, I may contact a Financial Counselor and make a request to see if I qualify at 256-265-9438.
AUTHORIZATION OF TREATMENT
I hereby consent and authorize my physician and/or Allied Health professional to render usual and customary medical/emergency treatment that they deem advisable and necessary. I also authorize HH System Clinics to electronically request my medication history if my pharmacy participates in electronic prescribing in order to assist the provider in prescribing necessary medication therapy.
ASSIGNMENT OF BENEFITS, AGREEMENT AND GUARANTY
I authorize HH System Clinics to release any information regarding services rendered to me to third party payers in consideration of payment for my care or to other healthcare providers involved in my care. I understand payment of all insurance benefits, basic and major medical for this period of service must be made directly to HH System Clinics. If the check must be made out to me, I understand the check must be sent to this address: PN Billing P.O. Box 2705 Huntsville, AL 35804. I understand the HH System Clinics must collect for all charges not covered by insurance payments. Payment for all collection costs, securing, or attempting to collect and secure including reasonable attorney fees or Collection Agency fees, whether suit be necessary or otherwise is the financial responsibility of the patient and guardian. Patients who are considered a legal adult are financially responsible for all services rendered.
HH HEALTH SYSTEM NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT
I acknowledge that a copy of the Notice of Privacy Practices for HH Health System has been made available to me. In connection with the Notice, I also acknowledge that I have been provided with an opportunity to ask questions regarding the Notice and its contents. I understand that the most current version of the Notice will be posted with the Health System and on www.huntsvillehospital.org .
EXPRESS PERMISSION TO CONTACT PATIENT BY CELL PHONE
I agree in order for HH System Clinic to service my account or to collect monies I owe, HH System Clinics and/or our agents may contact me by any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. HH System Clinics may also contact me by sending text messages or emails, using any email address I provided. Methods of contact may include pre-recorded/artificial voice messages and/or use of automatic dialing devices, as applicable. I have read this disclosure and agree that HH System Clinics, its employees, and/or agents may contact me as described.
PHOTOGRAPHY CONSENT
I authorize photography for purposes of clinical treatment and staff education. I understand that any images or photographs will be used solely for these purposes and that I have the right to revoke this authorization or to refuse to be photographed at any time. I understand that only hospital authorized or issued equipment will be used to take photographs, and that privacy and confidentiality will be maintained in the use of these images. Consent to Photography for Medical Treatment/Staff Education Decline Consent to Photography for Medical Treatment & Staff Education
Patient: Date of Birth:



Medical History

Circle any of the following that you have experienced:

Emphysema	Tuberculosis	Acid Reflux Ston	nach Ulcers Heart At	ttack Mitral Valve Prolapse			
Anemia	Bleeding Disorde	r Blood Transfusions	s Diabetes Mellitus	Migraine Headaches			
Hypertension	Stroke	Epilepsy/Seizures	Thyroid Disease H	IIV+ Hepatitis			
Pneumonia	Asthma						
	l History (PMH had cancer? □ YE		e list type:				
Any other med	lical problems:						
When was you	PSA:	copy: ear:	Flu Vaccin	gram: ation: a Vaccination:			
Current Med	lications:						
What Phari	nacy do you use	e?		Location:	_		
Are You Allergic to Any Medications/Latex? □ YES □ NO							
List the Name and Your Reaction:							

Social History (SH):						
Occupation:						
Have you ever smoked? YES How old were you when you star At most, how many packs a day of	Are you a current smoker? \square YES \square NO When did you last smoke?					
Alcohol Intake (amount per weel	x):		Any Recreational Drug Use? □ YES □ NO			
	Past Surgica	al History (PSI	H)			
List any previous surgeries, date	of surgery, and name of s	surgeon: \square Neve	er Had Surgery			
Procedure Name:	Date	of Procedure:	Surgeon Name:			
Family History (FH):		Cinala all that				
Mother: Alive/Deceased	Age:	Cancer:	r Hypertension Lung Disease Stroke Heart Disease			
Father: Alive/Deceased	Age:	Cancer:	r Hypertension Lung Disease Stroke Heart Disease			
Siblings: Alive/Deceased	# of Sisters: # of Brothers:	Cancer:	r Hypertension Lung Disease Stroke Heart Disease			