Decatur Morgan
GI & Nutrition

1208 Somerville Road SE
Decatur, AL 35601
Phone: 256-973-2700
Fax: 256-686-3342

New Patient Welcome Packet

Dear Patient,

Thank you for choosing Decatur Morgan GI & Nutrition, we look forward to providing you with excellent care. Enclosed you will find our New Patient Forms. Please fill these forms out completely prior to your appointment and return them by fax or mail.

At your first visit, please bring:

- Completed New Patient Forms (if you have not already submitted them via fax or mail)
- Your photo ID
- Your insurance card(s)
- The bottles of all your medications, both prescription and over-the-counter meds (not just a list – please bring the actual bottles)
- If the patient is a minor, bring a vaccination record
- You will be responsible for your co-pay at arrival

We ask that all new patients arrive at least 15 minutes early so that we can confirm your medical history information.

If you are unable to keep your appointment or need to reschedule for any reason we ask for a minimum of 24 hour notice. If you are more than 15 minutes late for your appointment, we may need to reschedule you.

Our waiting room is open with limited seating and we ask that only the patient enter the clinic unless a visitor is needed to assist the patient. If you are more comfortable waiting in your car, please let us know at check in and we will call you once we have your room ready. Please wear a mask while in inside the clinic.

Sincerely,

Jeanette Keith, MD
Decatur Morgan GI & Nutrition

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Practice Policies

Office Hours: Monday - Thursday, 8:00 am - 5:00 pm

Paperwork: We require that new patient paperwork be submitted to the office prior to your appointment day so that we have time to enter and update all of your information. If we do not receive your paperwork at least 48 hours prior to your appointment, we will reschedule you to a later date.

Appointments & Procedures: We ask that you arrive on time for your appointment. If you are late for your appointment, we may have to reschedule. A $25 fee will be charged for missed clinic appointments or an appointment cancelled with less than 24-hour notice. A $100 no show fee will be charged for missed procedures. Please call 256-973-2700 to notify us of needing to reschedule or cancel. After office hours our answering service will assist you and forward your message to us the next business day.

Prescriptions: It is important to have accurate documentation of your medications, therefore please bring all prescription bottles to each appointment. We prefer to write new and refill prescriptions during appointments. If you require a prescription outside of an appointment, please call during office hours. We require 24-hours for prescriptions to be ready for pick-up or called to your pharmacy. Prescriptions may only be picked up by the patient or person listed on the Disclosure Release. **We do not call-in controlled substances or antibiotics.**

Health Forms: We are happy to complete health forms during your appointment at no charge, if time permits. Please complete all sections designated as "patient, employee, or beneficiary". Long forms may require more time and can be picked up when ready. Requests outside an office visit will be subject to a processing fee as listed:

- School Medication forms (if requested outside an office visit) are charged at $1 per form.
- All other requests for medical records will be charged at the currently existing rate as follows:
- $5.00 Administrative Fee, $0.50 cents per page, Postage fees if applicable.

Pain Control: Helping to control pain and making you comfortable is important to us and we can provide pain relief for a short time if required. However, we do not specialize in chronic pain management, and we will refer you to a provider who does if you require long-term pain management. The decision to provide controlled substances is at the sole discretion of the physician.

Dismissal: We sincerely hope that we never have to part ways with a patient, but occasionally extreme circumstances may make this necessary. If this occurs, you will be notified by certified mail and will have 30 days from that point to find another physician. During those 30 days we will be able to offer only urgent care.

Financial Policies

Proof of Insurance: Please bring your current government issued identification and insurance card to each appointment. Delays in verification of insurance may result in you being responsible for fees.

Insurance: Please be aware that knowing your insurance coverage is your responsibility including knowing which facilities and providers are covered. Please contact your insurance company for questions about your coverage.

Out of Pocket Fees: We collect co-payments at the time of service. You will be responsible for non-covered or routine charges, deductibles, and/or co-insurance amounts that apply.

Non-covered services: On occasion a service may not be covered by your insurance. We will notify you prior to the service if we are aware and payment or a portion will be due at the time of service.

Returned Checks: There is a $30 charge for returned checks.

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Patient Information

Legal Name as it appears on your Government-Issued ID

Last Name: _____ **First Name**: _____**Middle Initial:** _____
Maiden / Other Last Name: _____ **Date of Birth:** _____ / _____ / _____
Sex: ☐ M ☐ F ☐ Prefer Not to Say **Social Security Number:** _____/ _____/ _____

Address: _____
City: _____ **State:** _____ **Zip:** _____
Email: _____
Cell Number: _____ **Home Number:** _____

Marital Status: ☐ Divorced ☐ Life Partner ☐ Married ☐ Single ☐ Widow
Race: ☐ African American ☐ American Indian ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other: _____

Emergency Contact Name: _____ **Phone Number:** _____
Relationship to Patient: _____

Employment Status: ☐Full-Time ☐Part-Time ☐Retired ☐Not Employed ☐Active Military ☐Disabled ☐Housewife ☐Self-Employed
Employer: _____ **Employer Phone:** _____
Employer Address: _____
City: _____ **State:** _____ **Zip:** _____

Primary Insurance to File

Insurance Company:	Insured's Name:
Policy Number:	Insured's Date of Birth:
Group Number:	Relationship to Patient:
Insured's Social Security Number:	

Secondary Insurance to File

Insurance Company:	Insured's Name:
Policy Number:	Insured's Date of Birth:
Group Number:	Relationship to Patient:
Insured's Social Security Number:	

Person Responsible For Account: _____**Phone:** _____

I agree that payment will be made at the time of service. I agree to pay all co-pays, non-covered or routine charges, deductibles and co-insurance amounts that apply. In the event this account is turned over to a collection agency for collection, I will be responsible for all collection fees, court costs and attorney's fees. I authorize Decatur Morgan Primary Care to release information to insurance carriers and for insurance carriers to release information to Decatur Morgan Primary Care concerning my illness, treatment and payments (including workmen's compensation) and I hereby assign to the physicians all payments for medical services rendered to myself or my dependents if assignment applies.

Signature: _____ **Date:** _____

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Medical History Information

What current symptoms are you experiencing? _____

_____

Primary Care Provider:_ _____ Phone: _____

Have you seen another healthcare provider in the past 24 months?

Name: _____ Specialty: _____ Phone: _____

Name: _____ Specialty: _____ Phone: _____

Name: _____ Specialty: _____ Phone: _____

Name: _____ Specialty: _____ Phone: _____

Past Medical History: Check all that apply and/or use blank to list other medical history not listed

	Allergies		Chronic Renal Disease		Head Injury		Prostate Issues/Cancer
	Abnormal Pap Smear		Cirrhosis		Hemochromatosis		PUD (Stomach Ulcers)
	Anemia		Colon Cancer		Hemorrhoids		PVD (Peripheral Artery Disease)
	Asthma		Congestive Heart Failure		Hepatitis A		Rash
	Atrial Fibrillation / Palpitations		Constipation		Hepatitis B		Rheumatoid Arthritis
	Autoimmune Disease (Lupus)		COPD		Hepatitis C		Seizure Disorder
	Back Pain		Coronary Heart Disease		High Cholesterol		Sexually Transmitted Disease
	Biliary Cirrhosis		Crohn's Disease		High/Low Blood Pressure		Shortness of Breath
	Blood in Urine		Dental Issues/Dentures		HIV/AIDS		Sleep Apnea / Use of CPAP Yes / No
	Blood Transfusion		Depression		Hyperthyroidism		Swelling of Arms or Legs
	Bloody/Black Stools		DES Exposure		Hypothyroidism		Swollen Glands
	Blurry Vision/Eye Problems		Diabetes – Adult Onset		Irregular Periods		Thyroid Disorder
	Breast Disease/Cancer		Diabetes – Juvenile Onset		Joint Pain/Gout		Trouble Swallowing
	Brian Tumor		Diarrhea		Kidney Disease		Tuberculosis
	Cerebrovascular Disease		Diverticulitis		Liver Disease		Urinary Pain/Deficiency/Frequency
	Cervical Cancer		DVT (Blood Clots in Legs)		Memory Loss		UTI – Recurrent
	Chest Pain		Emphysema		Heart Attack		Varicose Veins/Phlebitis
	Chronic Cough		GERD (Acid Reflux)		Neurological Disorder		Vascular Heart Disease
	Chronic Headaches		Gestational Diabetes		Osteoarthritis		Vomiting
	Chronic Infections		GI Bleed		Pelvic Pain		Weight Loss/Gain (unexplained)

Other: _____

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Past Surgical History: Check all that apply and/or use blank to list surgical procedures not listed

	Appendectomy		CABG (Heart Bypass)		Gastric Bypass		Prostate Surgery
	AV Fistula Creation		Cardiac Surgery		Hemorrhoidectomy		Thyroid
	AV Graft		Carotid Endarterectomy		Hysterectomy Full / Partial		Tonsils / Adenoids
	Back Surgery		Colon Resection/Surgery		Nephrectomy		Valve Replacement Aortic / Mitral
	Bronchoscopy (Lung Scope)		Gallbladder Removed		Pneumonectomy		Vascular Surgery
	Amputation: Type/Location:						
	Implant: Type/Location:						
	Joint Replacement: Type/Location:						
	Transplant: Type/Location:						

Other: _____

Family History: Check all that apply and/or use blank to list other medical history not listed

	Father	Mother	Father's Parents	Mother's Parents	Other Relationship (Specify)
High Blood Pressure					
Heart / Artery Disease					
Heart Attack					
Diabetes					
Stroke					
Arthritis					
Thyroid Disorder					
Asthma					
Cancer (Type)					
Other (Specify)					

Social History:

Occupation: Full-time Employed _____ Part-time Employed _____ Retired _____ Disabled _____ Not Employed _____

Job Title: _____

Smoke Cigarettes: No _____ Yes _____ Former Smoker: _____ If yes, how many per day? _____

If former, how long ago did you quit? _____ Vape: No _____ Yes _____

Smokeless Tobacco: No _____ Yes _____ Exposed to secondhand smoke: No _____ Yes _____

Drink Alcohol: No _____ Yes _____ If yes, how much per day? _____

Illegal Drugs: No _____ Yes _____ If yes, what, and how much? _____

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Medications and Allergies

Your PREFERRED Pharmacy (Name & Location): _____

Medications: List all current medications including over the counter (Please also bring bottles to each appointment)

Medication	Dosage/Strength (MLs or MGs)	Frequency per Day	Type (Circle one)
			Pill Liquid Injectable Other
			Pill Liquid Injectable Other
			Pill Liquid Injectable Other
			Pill Liquid Injectable Other
			Pill Liquid Injectable Other
			Pill Liquid Injectable Other
			Pill Liquid Injectable Other
			Pill Liquid Injectable Other
			Pill Liquid Injectable Other
			Pill Liquid Injectable Other
			Pill Liquid Injectable Other
			Pill Liquid Injectable Other
			Pill Liquid Injectable Other

Date of Last Vaccine: Flu: _____ Covid: _____

Pneumonia: _____ Shingles: _____

Tetanus: _____

List all Allergies including environmental and medication:

Allergic to:	Type of Reaction:

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Consent Form

Patient Name: _____ Date of Birth: _____

I authorize the release of my health information necessary to my treatment, continuity of care, and the processing of insurance claims to the following entities:

Individual Insurance Companies	Billing Services	Providers Associated with Care
Hospital Lab and Ancillary Departments	Electronic Medical Record Software Company	Agencies Associated with Care

List any person(s) who we may speak to regarding your health information or that we may obtain your health information from, including family members, relatives, significant others:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Insurance release/assignment of benefit/payment authorization:
Your fee for service is due and payable by cash, check, credit card, or debit card at the time of treatment. We may not participate in all insurance plans and if your plan is one in which we do not participate, please ask for an office receipt so you can file for reimbursement if applicable. Regardless of any insurance, the guarantor listed on the Patient Information Form is responsible for his/her bill. The guarantor will also be responsible for all charges incurred by collection agencies or past due accounts.

By signing below, you are signifying that you understand and agree to the office and financial policies and the information regarding financial responsibility contained in this New Patient Packet. You are also agreeing to the release of your health information to the above listed entities for the purposes outlined and to the person(s) listed on this form. This listed of designated people can be updated at any time.

Patient/Guardian/POA Signature: _____

Date: _____ Relationship to Patient: _____

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Authorization for Release of Information

Patient Name: _____ Date of Birth: _____

Address: _____City: _____ State: _____ Zip: _____

Phone Number: _____

Guardian or POA Name: _____ Phone Number: _____

I hereby authorize Decatur Morgan GI & Nutrition to:* _____ Release To *and/or* _____ Obtain From *the following information pertaining to my care and/or treatment:

Release To or Obtain From: Practice/Provider: _____

Address: _____

Phone Number: _____ Fax Number: _____

Include the following information:

_____ Progress Notes	_____ History & Physical	_____ Labs
_____ Immunization Records	_____ Discharge Summary	_____ Pathology Reports
_____ Referrals	_____ Imaging Reports	_____ ER Reports
_____ Entire Medical Record	_____ Other_____	

Purpose of Disclosure: _____

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 service, and treatment for alcohol or drug abuse.

I authorize the use or disclosure of my protected health information (PHI) as described. I understand that the information I authorize a person or entity to receive may be re-disclosed and is no longer protected by federal privacy regulations.

Revocation: This authorization to release confidential information may be revoked by me, in writing, at any time, except to the extent that action has already been taken. Written revocation should be provided to the Dir3ector of Health Information Management at the above address.

I understand that authorizing the disclosure is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used on disclosure as provided in CFR 164.524. If I have questions about disclosure of my health records, I may contact the Health Information Director at 256.341.2125.

_____	_____	_____
Patient or person authorized to sign for Patient	Date	Time
_____	_____	_____
Witness	Date	Time

_____

Reason patient unable to sign

_____	_____	_____
Interpreter's Name (Please Print)	Interpretation Service (If Professional)	Interpreter's Number

_____ Refused Interpretation

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