Patient Information

Name:_____ SS#:_____

Date of Birth:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone: (____)_____ Work Phone(____)_____

Employer:_____

Employer's Address:_____

Referred by:_____ Referring Doctors #:_____

Primary Care Physician:_____

Emergency Contact:_____ Phone:_____

Responsible Party:_____ Relationship:_____

Responsible Party Address:_____

Responsible Party Phone:_____

Insurance Information

Primary Insurance Company:_____

Policy Holder:_____

Policy Holder Date of Birth :_____

Secondary Insurance Company:_____

Secondary Insurance Policy Holder:_____

Secondary Insurance Policy Holder DOB:_____

Medications

Please list all medications you are currently taking

Please list all allergies

Pharmacy
Name:_____

Pharmacy
Phone:_____

Pain Scale

Definition of Pain- "An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage."

Please circle the scale that appropriately describes your pain.

0	No Pain
1	Mild Pain does not interfere with activity
-3	Pain interferes with what patient wants to do, but not what patient needs to do
4-5	Pain interferes with what patient needs to do like work and household duties
-7	Pain interferes such that the patients requires assistance with self Care
8-9	Pain is incapacitating patient and requires hospitalization
10	Pain is uncontrolled

Prescription Drug Policy

We will not fill or refill medications that are lost, stolen, or damaged in any way. All medications are controlled substances and it is your responsibility to take care of your medication. **We only refill medication during office hours.** The answering service will not forward messages about refills until the office is open.

Altering Prescriptions is a felony. If you alter or forge any prescription you will be prosecuted. We will not treat any patient engaged or implicated in any criminal activities.

Some forms of chronic pain can be treated with narcotics when appropriately indicated. It is your responsibility to **exercise self-control** when taking these medications. If you feel that your medication is not helping or feel that you need something stronger or different, **you must call and make an appointment to talk with the doctor concerning your medication. Please do not ask for early refills.**

We will make efforts to assure you have the appropriate supply of pain medication to treat your condition. **We must be the only physician prescribing pain medications for you. We will not treat or prescribe medications for patients who seek to receive pain medications from other physicians.**

Do not take any other medications other than those prescribed for you by your doctor. Do not give your medications to others. Please let **all** your treating physicians know what you are taking and why.

If you fail to keep your follow-up appointments and run-out of your medications, **the doctor may not be able to authorize any medication to be called in until your return appointment and you will be without medication until the first available make-up appointment can be scheduled.** If you fail to keep a make-up appointment, we wil not call in additional medications, you must see the doctor in order to get your prescription refilled.

Periodic blood tests and/or urine tests may be required to determine if liver or kidney functions are normal, if toxic levels of medication are present, or if there are potentially dangerous drug combinations in your system. These tests are not intended for legal purposes or workman's compensation. The results of these tests are held strictly confidential, as are your medical records. **However, we will cooperate fully and disclose this information to city, county, state, and federal law enforcement agencies in the event of an investigation.**

I, _____ have read, understand, and agree with the above prescription drug policy this____ day of _____, 20___.

Dr. James Beretta, P.C.
2501 Meadowview Lane, Suite 101
Pelham, AL 35124

Health Insurance Portability and Accountability (HIPPA) Authorization Form

I, _____ hereby authorize use or disclosure of protected health information concerning my treatment as described below.

1. I authorize the following specific person or class of persons are named facility to make the requested protected health information use disclosure: Dr. James Beretta, D.O.

2. Patient's name and date of birth is: _____

   Patient's address is: _____

The specific information that should be disclosed is any individually identifiable health information that is subset of health information, including demographic information collected form an individual, and

1. **Is created or received by a health care provider, health plan, employer, or other health care entity: and**
2. **Relates to the past, present, or future treatment of named patient; the provision of healthcare or named patient; of future payment for the provision of health care to an individual.**
3. **I understand that the information used or disclosed may be subject to re-disclose by the person(s) or facility receiving it, and would then no longer be protected by federal privacy regulation.**

I may revoke this authorization by notifying Dr. James Beretta, P.C. in writing of my desire to revoke this disclosure. However, I understand that any action already taken is reliance on authorization cannot be reversed and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

<u>This form must be fully completed prior to signing.</u>

_____ _____ _____
Signature of patient Date signed Social Security #

_____ _____
_____Signature of Guardian or Description of Representative of Patient's Estate to Act Date signed Authority

Worker's Compensation Information

Employers
Name:_____

Employer's
Address:_____

Insurance Company
Name:_____

Billing
Address:_____

Insurance
Phone:_____

Adjuster's
Name:_____

Date of
Injury:_____

Financial Agreement

The undersigned certify that I (or my dependent) have insurance coverage and assign directly Dr. Beretta all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to procure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Print
Name:_____

Signed: _____ Date:_____

Legal Guardian Signature (if under 18):
_____