VALLEY MEDICAL CLINIC
VALLEY PEDIATRICS

1436 GUNTER AVENUE
GUNTERSVILLE, AL 35976
PHONE: 256-202-1111 FAX: 256-202-1112

DR. FRINE T. ROCA, MD AMBER LEWIS, CRNP

PATIENT INFORMATION:

NAME:_____ SEX: _____ RACE: _____
LAST FIRST MIDDLE

DATE OF BIRTH:____/____/____ SOCIAL SECURITY #: _____ TELEPHONE: _____
MONTH DAY YEAR

ADDRESS: _____
STREET/PO BOX CITY STATE ZIP CODE

MOTHER/GUARDIAN INFORMATION:

NAME: _____ RACE: _____
LAST FIRST MIDDLE

DATE OF BIRTH:____/____/____ SOCIAL SECURITY #: _____ TELEPHONE: _____
MONTH DAY YEAR

ADDRESS: _____
STREET/PO BOX CITY STATE ZIP CODE

FATHER/GUARDIAN INFORMATION:

NAME: _____ RACE: _____
LAST FIRST MIDDLE

DATE OF BIRTH:____/____/____ SOCIAL SECURITY #: _____ TELEPHONE: _____
MONTH DAY YEAR

ADDRESS: _____
STREET/PO BOX CITY STATE ZIP CODE

REFERRED BY: _____

PLEASE STATE WHAT BRINGS YOU TO OUR OFFICE: _____
_____

GUARANTEE OF ACCOUNT: I/We accept financial responsibility and guarantee payment to Valley Medical Clinic, M.E. Ata, MD for all professional services and expenses related thereto, to the above named persons, this to include any and all future services, as well as those presently contemplated. I authorize the release of any medical information necessary to process this claim and request payment of benefits to Valley Medical Clinic. I/We also agree that any controversy including any malpractice claim in any way relating to the present, past, and future care, diagnosis, and treatment of the patient by Valley Medical Clinic, M.E. Ata, MD including partners, agents, or employees of the physician shall be submitted to binding arbitration.

Signature of Patient or Authorized Person Date

_____ _____

VALLEY MEDICAL CLINIC
Patient Medical and Social History

Does your child have any drug allergies? _____

_____

Does your child have any active health problems such as allergies, ADHD, asthma, etc.? _____

_____

Has your child ever had any surgeries? Please list all. _____

_____

Family History: CIRCLE ALL THAT APPLY.

Maternal: Cancer, High Blood Pressure, Heart Problems, Stroke, Diabetes

Paternal: Cancer, High Blood Pressure, Heart Problems, Stroke, Diabetes

Are your child's immunizations up to date? _____

List all current medications your child takes. _____

_____

What pharmacy do you use? _____

Who does your child live with? Please list everyone in the home. _____

_____

Is there any smoking in the home? _____

Child's current grade in school: _____

_____

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

THESE POLICIES DESCRIBE HOW MEDICAL INFORMATION ABOUT ME MAY BE USED, DISCLOSED, AND HOW I CAN OBTAIN ACCESS TO THIS INFORMATION.

I HAVE BEEN MADE AWARE OF THE PRIVACY POLICIES FOR THE PISGAH MEDICAL CLINIC, PREMIER MEDICAL CLINIC, AND VALLEY MEDICAL CLINIC. THESE POLICIES ARE POSTED IN THE OFFICES LISTED AND I UNDERSTAND THAT I HAVE THE RIGHT TO A PAPER COPY OF THIS NOTICE AT ANY TIME.

I ALSO AUTHORIZE THE PISGAH MEDICAL CLINIC, PREMIER MEDICAL CLINIC, AND VALLEY MEDICAL CLINIC'S STAFF TO DISCLOSE HEALTH INFORMATION ABOUT ME TO:

SPOUSE/SIGNIFICANT OTHER	YES	NO
FAMILY MEMBERS	YES	NO
FRIENDS	YES	NO

YOU MAY ASSUME THAT I DO NOT HAVE ANY OBJECTION TO RELEASE HEALTH INFORMATION TO MY SPOUSE, FAMILY, OR FRIENDS IF I FAIL TO CHECK NO ON THE ABOVE QUESTIONS. I HAVE THE RIGHT TO INSPECT AND OBTAIN A COPY OF MY HEALTH INFORMATION.

I ALSO UNDERSTAND THAT THE HEALTH INFORMATION USED OR DISCLOSED BY MY AUTHORIZATION BY THE PISGAH MEDICAL CLINIC, PREMIER MEDICAL CLINIC, AND VALLEY MEDICAL CLINIC MAY BE SUBJECT TO RE-DISCLOSURE BY THE RECIPIENT AND MAY NO LONGER BE PROTECTED UNDER FEDERAL LAW.

_____ _____
PATIENT NAME DATE

_____ _____
PATIENT REPRESENTATIVE (IF MINOR) DATE

WHO MAY BRING PATIENT TO APPOINTMENTS OR HAVE ACCESS TO MEDICAL INFORMATION?
PATIENT NAME:
I authorize the following person(s) to obtain treatment (including immunizations) for the patient listed.
(Please list yourself)

Name:	Relation to patient:
Name:	Relation to patient:
Name:	Relation to patient:
Name:	Relation to patient:
Name:	Relation to patient:
Name:	Relation to patient:

Signature of parent/responsible party _____ Date _____

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GENERAL CONSENT TO OUTPATIENT TREATMENT

I, the patient, request and authorize Valley Medical Clinic to administer outpatient care as my physician or his designees/assistants (collectively called "the physicians' ') may deem necessary or advisable. This care may include, but is not limited to, routine diagnostic, radiology, and laboratory procedures, administration of routine drugs, biologicals, and other therapeutics, and routine medical and nursing care. I authorize my physician(s) to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my care is directed by my physician(s) and that other personnel render care and services to me according to the physician's instructions.

I do/do not consent to Hepatitis and/or HIV testing in the event that a healthcare professional becomes exposed to my blood or other bodily fluids.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or promises have been made to me with respect to the results of such diagnostic procedures and treatments.

Personal Valuables
I understand that I am responsible for any and all personal valuables that I bring with me to the clinic. I hereby release the clinic from any liability for the loss or damage of any and all personal possessions which I choose to keep with me during my care and treatment.

I HAVE HAD THE OPPORTUNITY TO READ THIS FORM (OR HAVE IT READ TO ME), ASK QUESTIONS, AND HAVE THESE QUESTIONS ANSWERED.

Name of Patient (Print): _____

Signature of Patient: _____

Consent of Parent, Legal Guardian, Patient Advocate, or Nearest Relative if patient is unable to sign or is a minor.

Name of person signing consent (Print): _____

Signature of person signing consent: _____

Relation to patient: _____ Date: _____