Mitt Lary Family Practice
Dr. Malika Aryanpure
4815 Rose Blvd, Northport, AL 35475
Phone: (205) 722-0650
Fax: (205) 345-5178

OFFICE USE ONLY
☐Updated in ECW
☐Updated Guarantor Section
Employee Initial_____.

REGISTRATION – PLEASE PRINT

DATE____/____/____

Patient Name:_____
Last First Middle

Date of Birth____/____/____ Social Security # ____-____-____ Sex: ☐Male ☐Female

Mailing Address_____
City State Zip

Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed ☐Separated **Race:** ☐Black ☐White ☐Asian ☐Other

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino Email _____(Patient Portal)

Home Phone (____)_____ Cell Phone (____)_____

Employer _____ Employer Phone (____)_____

Emergency Contact:_____ Phone#_____

INSURANCE INFORMATION

Primary Insurance Company_____Contract #_____Group #_____

Policyholder's Name_____Policyholder's Social Security # ____-____-____

Policyholder's Date of Birth____/____/____ Relationship of Patient to Policyholder_____

Secondary Insurance Company_____Contract #_____Group #_____

Policyholder's Name_____Policyholder's Social Security # ____-____-____

Policyholder's Date of Birth____/____/____ Relationship of Patient to Policyholder_____

PHARMACY INFORMATION

Pharmacy Name:_____Address/Location_____Phone#_____
Consent to access medications at pharmacy Y N

FINANCIALLY RESPONSIBLE

Name_____ DOB:____/____/____ Social Security # ____-____-____

X_____ _____
Signature **PLEASE SIGN HERE** Your Relationship to Patient

TURN OVER

PLEASE READ CAREFULLY & SIGN →

Patient Consent to the Use and Disclosure of Health Information for Treatment, Insurance, Payment, and Healthcare Operations

I understand that as part of my or my child healthcare, *Mitt Lary Family Practice* originates and maintains paper and/or electronic records describing my health history, symptoms, examination, test results, diagnosis, treatment, medication history, procedures, and any plans for future care or treatment. I understand that this information serves as:

(1) A basis for planning my care and treatment, (2) A means of communication among the other health professionals who contribute to my care, (3) A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals, (4) A disclosure to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax, (5) A means by which a third-party payer can verify that services billed were actually provided, (6) A source of information for applying my diagnosis information to my bill, (7) A consent to release all information necessary to secure the payment of benefits, and (8) A approval to use this signature on all my insurance submissions.

Payment Agreement I understand that I am financially responsible for all charges whether or not paid by my insurance. I further understand and agree to pay all previously incurred and unpaid charges and for future charges. I also agree to pay all reasonable collection costs, including a reasonable attorneys' fee of one-third of the unpaid principle balance due on my account in the event my account is placed with an attorney for collection. I further agree to pay interest at the rate allowed by law on the unpaid balance on my account. I waive any right I may have according to the Constitution and Laws of the State of Alabama, or any other state, to claim exemptions as to personal property as to this obligation. *It is Mitt Lary Family Practice policy that we collect co-pays and past due balance before you see the doctor.

Non-Covered Services Policy There are certain routine services necessary for the maintenance of good health that are not covered by certain insurance contracts, such as X-rays, injections, labs, cultures, and outside tests. The patient will be expected to pay for these services in the event that they are not covered by insurance. Only services that the physician feels are necessary for the patient's treatment and care will be ordered. Several insurances companies now require referrals for office visits. Any referrals for visits are the patient's responsibility. In the event that an office visit is not covered by insurance because there was no referral prior to the visit, the patient will be expected to pay for the visit balance in full.

Notice of Privacy Policies I understand and have been provided with a *Notice of Privacy Policies* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

(1) The right to review the notice prior to signing this consent, (2) The right to object to the use of my health information for directory purposes, (3) The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that *Mitt Lary Family Practice* is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already took action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations. I further understand that *Mitt Lary Family Practice* reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should *Mitt Lary Family Practice* change their notice, they will provide me the revised notice.

Medicare Authorization I request that payment of authorized Medicare benefits be made either to me or my behalf to *Mitt Lary Family Practice*, for my services furnished to me by this physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents and any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of HCFA-1500 form, or elsewhere on other approved claims forms or electronically submitted claims, my signature authorizes releasing of information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charges determined of the Medicare carrier as the full charge, and the patient is responsible only for the deductible. Co-insurance and the deductible are based upon the charge determined of the Medicare carrier.

RESTRICTIONS TO THE USE OR DISCLOSURE OF MY HEALTH INFORMATION

***List the names that you authorize *Mitt Lary Family Practice* to release any information or medical records to:**

_____ _____ _____

I authorize Dr. Malika Aryanpure and any medical professionals at *Mitt Lary Family Practice* to perform treatments and procedures deemed necessary to my medical care and well-being.

X _____ ____/____/____

Signature Date

MITT LARY FAMILY PRACTICE, LLC
MALIKA ARYANPURE, MD
4815 ROSE BLVD
NORTHPORT, AL 35475
(P) 205-722-0650 (F) 205-345-5178

NEW PATIENT APPLICATION FORM

Name:_____ **Date of Birth:**_____ **Today's Date:**_____

Reason you are here:_____

Personal Medical History: Have you ever had any of the following conditions? (Check if yes)

☐ Anemia	☐ Crohn's Disease	☐ HIV/ AIDS
☐ Arthritis	☐ Depression	☐ Hypertension
☐ Asthma	☐ Diabetes	☐ Kidney Disease
☐ Cancer	☐ Emphysema	☐ Myocardial Infarction
☐ Chronic Obstructive Pulmonary	☐ Endocrine Problems	☐ Peptic Ulcer Disease
☐ Disease	☐ GERD	☐ Seizures
☐ Clotting Disorder	☐ Glaucoma	☐ Stroke
☐ Congestive Heart Failure	☐ Hepatitis	☐ Ulcerative Colitis

Personal Surgical History: Have you ever had any of the following surgeries? (Check if yes)

☐ Adrenal Gland Surgery	☐ Colon Surgery	☐ Kidney Surgery
☐ Appendectomy	☐ Coronary Artery Bypass Graft	☐ Neck Surgery
☐ Bariatric Surgery	☐ Esophagus Surgery	☐ Prostate Surgery
☐ Bladder Surgery	☐ Gastric Bypass Surgery	☐ Small Intestine Surgery
☐ Breast Surgery	☐ Hemorrhoid Surgery	☐ Spine Surgery
☐ Cesarean Section	☐ Hernia Repair	☐ Stomach Surgery
☐ Cholecystectomy	☐ Hysterectomy	☐ Thyroid Surgery

Do you have the following? If so, list the name of physician.

Primary Care _____

Gastroenterologist _____

Neurologist _____

Cardiologist _____

Psychologist _____

Pain Physician _____

Allergies: _____

_____

Family History: Has anyone in your family had any of the following conditions? (Check if yes, and indicate relationship to you)

☐ Cancer/Polyps_____	☐ Anemia_____	☐ High Blood Pressure_____
Colon, Rectum, Anal, Stomach, Breast,	☐ Diabetes_____	☐ Anesthesia Reaction _____
Prostate, Uterus, Ovaries, Thyroid, Lung,	☐ Blood Clots_____	☐ Bleeding Problems_____
Blood, Lymphoma	☐ Heart Disease _____	☐ Hepatitis_____
Other _____	☐ Stroke_____	☐ Other_____

Name:_____ **Date of Birth:**_____ **Today's Date:**_____

Social History:

Alcohol use - ☐ Never ☐ Occasionally ☐ Daily Type_____

Tobacco use - ☐ Never ☐ Previously, but quit ☐ Packs Per Day_____ for _____ years

Drugs use - ☐ Never ☐ Occasionally ☐ Daily Type_____

What is your occupation?_____

Marital Status: ☐ Single, ☐ Married, ☐ Divorced, ☐ Widowed, ☐ Separated

Name of spouse or significant other _____

Children: Number of Children_____ Number of grandchildren_____

Women: Number of pregnancies_____ , Number of deliveries_____ - Vaginal_____, C-sections_____,

Miscarriages_____, VIPs (abortions) _____

Cancer health habits: (Circle response)

Women				**Men**			
Breast:	Monthly self-exam	Y	N	Prostate:	Yearly rectal exam	Y	N
	Yearly physician exam	Y	N		Yearly PSA blood test	Y	N
	Last mammogram	Y	N				
GYN:	Yearly GYN exam	Y	N				
	Yearly PAP exam	Y	N				
All				Colon:	Yearly rectal exam	Y	N
Skin:	High sun exposure	Y	N		Yearly stool test for blood	Y	N
	Yearly skin exam	Y	N		Date of last colonoscopy _____		

LIST MEDICATIONS

*****THIS OFFICE DOES NOT TREAT CHRONIC PAIN!! THE DOCTOR WILL NOT PRESCRIBE NARCOTICS!!!!!

Have you had recent blood work done? If so, when and where?

_____

If Diabetic, last A1C result: _____

Last Eye Exam: _____

Any recent imaging: (X-ray, MRI, CT, Ultrasound)

_____