

**PREMIER MEDICAL CLINIC, LLC  
PREMIER PEDIATRICS  
506 HARLEY ST.  
SCOTTSBORO, AL 35768  
PHONE: 256-259-1234 FAX: 256-259-6838**

**M.E. ATA, MD  
BETHANY NEMATI, MD**

**CATHY OLINGER, CRNP  
JANNA CULPEPPER, 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 Premier 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 Premier 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 Premier Medial 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 \_\_\_\_\_



PREMIER MEDICAL CLINIC, LLC  
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? \_\_\_\_\_

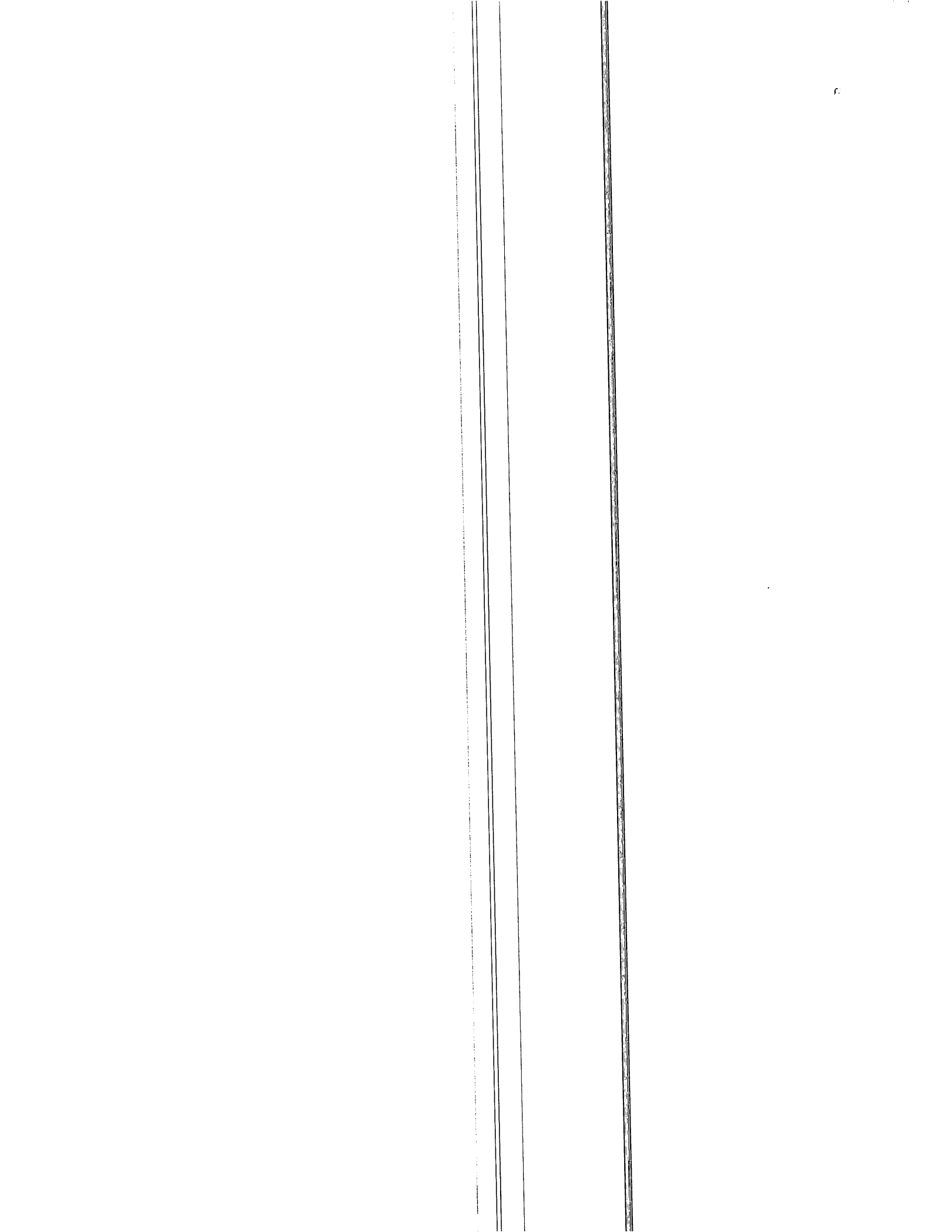
List all current medications your child takes. \_\_\_\_\_

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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**GENERAL CONSENT TO OUTPATIENT TREATMENT**

I, the patient, request and authorize Premier 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): \_\_\_\_\_

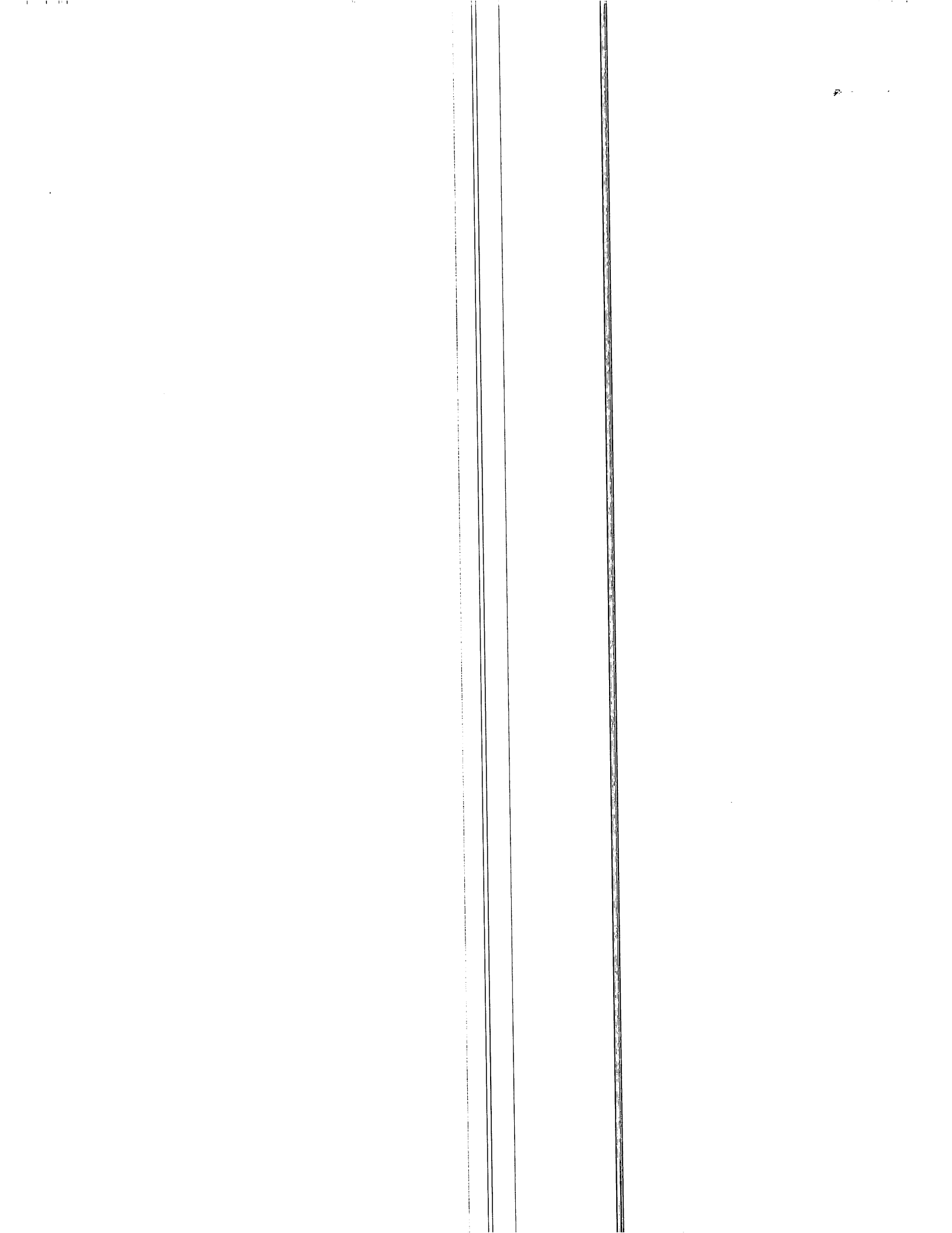
Signature of Patient: \_\_\_\_\_

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: \_\_\_\_\_



**WHO MAY BRING PATIENT TO APPOINTMENTS OR HAVE ACCESS TO MEDICAL INFORMATION?**

**PATIENT NAME:**

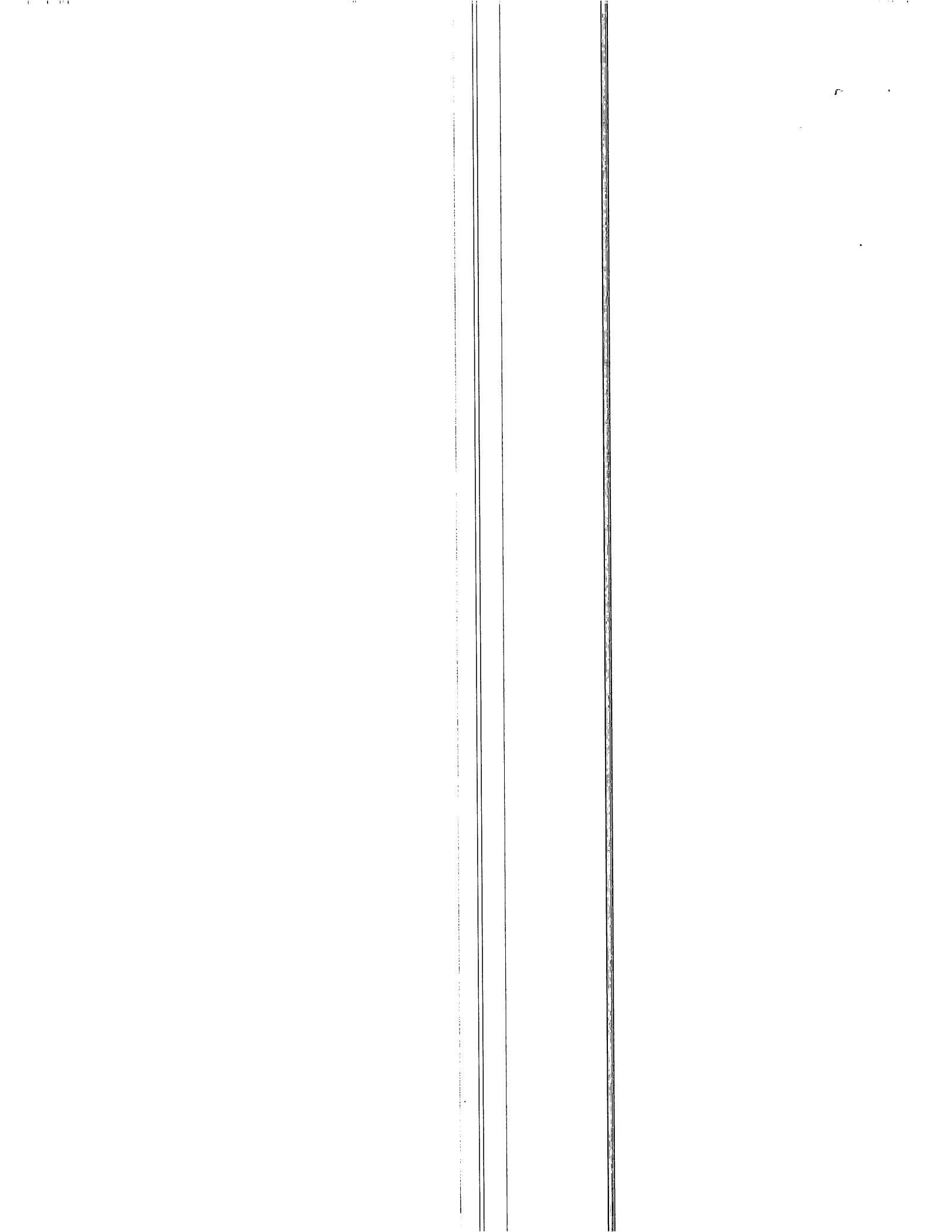
I authorize the following person(s) to obtain treatment (including immunizations) for the patient listed.

(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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**ACKNOWLEDGEMENT FO PRIVACY PRACTICES**

THESE POLICIES DESCRIBE HOW MEDCAL 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 HEAD 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 HEAD 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 HEAD 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

