ALBERTVILLE
PRIMARY CARE

Paul Morris, MD

Office: 256.840.6380
Fax: 256.849.0693

New Patient Application

Patient Name: _____ **Date of Birth** ____ / ____ / _____

□ **Male** □ **Female** **Race:** □ Non-Hispanic □ Hispanic **Language:** _____

Address: _____ **City:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Patient Employer: _____ **Patient Occupation:** _____

Email Address: _____

Pharmacy: _____ **City:** _____

Referred by: _____ **Previous Primary Care Physician:** _____

Primary Insurance Carrier: _____

Insurance Identification Number: _____

Secondary Insurance Carrier (if applicable): _____

Secondary Insurance Identification Number (if applicable): _____

Current Medical Conditions:

Current Medications: *(include prescription, non-prescription, over-the-counter, supplements, etc.)*

Please note: We do not specialize in or offer ongoing chronic pain management services. If you currently take chronic pain medication, please list the Physician that is currently writing the prescription for the medication and what specialty the Physician practices.

Physician: _____ **Specialty:** _____

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Please complete this form and return to our office by fax, mail or in-person.

Fax: 256-849-0693 **Address:** *Albertville Primary Care, 312 Sand Mountain Dr. E., Albertville, AL, 35950*

Office Policies

As a patient, you are ultimately responsible for your own care. This can be exhibited by knowing what medications you are taking and why, arriving on time for appointments, completing labs and tests that are ordered by your physician, and obtaining refills/completing paperwork in a timely manner. We will do our best to ensure we do our part by keeping you informed and complete your orders and prescriptions in a timely manner at your visit.

_____ Fees—Patients are expected to pay all co-pays at the time of your visit.

_____ Nurse calls and questions—Any non-scheduling questions will be routed to the nurse line. Please leave a message with the requested information and we will return your call within one business day.

_____ Appointment times—Please arrive on time or early for your scheduled appointment. If you are late, you may be asked to reschedule.

_____ Cancellations—Except under extenuating circumstances, we request you give at least 24 hours of notice when cancelling an appointment. Failure to do so will cause any missed appointments to be considered as a "no show".

_____ No show policy/Rescheduling—Patients that "no show" for 3 appointments are subject to dismissal from our practice for non-compliance. If you no show for your initial/new patient appointment, you will be charged a $150 fee. This will be collected before you are allowed to reschedule your appointment.

_____ Conduct—Verbal or physical abuse of our physician or staff will NOT be tolerated for any reason or under any circumstance.

_____ Form completion—There is a 5 business day turnaround time for FMLA or other forms needing completion. There is a $25 charge per form.

_____ Medication refills—refills need to be requested at least 3 days in advance. Ideally, these will be handled during your routine visits, but if you realize your medication needs to be refilled you may call and leave a message with the nurse requesting a refill.

I understand and agree to these policies:

Signature: _____ **Today's Date:** ____ / ____ / _____

Must be signed by patient or legal guardian if patient is a minor.