



KEVIN L. JACKSON, M.D.
INTERNAL MEDICINE

2430 Village Professional Drive, Opelika, AL 36801

Patient Registration

Patient Name: _____
Birth Date: _____ S.S. #: _____ Gender: Male Female
Mailing Address: _____
Phone Number: H: _____ WK: _____ C: _____
Would you be interested in text reminders? Yes _____ No _____
If so, who is your cell phone provider? _____
Marital Status: _____ Email Address: _____
Occupation: _____ Employer: _____
Preferred Language: _____ Race: _____
Ethnicity: Hispanic or Latino Not Hispanic or Latino
Emergency Contact: _____ Relationship: _____
Phone: _____

Insurance Information

Primary Insurance: _____
Policy or Contract Number: _____ Group Number: _____
Name on Card: _____ D.O.B.: _____
Secondary Insurance: _____
Policy or Contract Number: _____ Group Number: _____
Name on Card: _____ D.O.B.: _____

Please notify our office if your insurance policy requires a referral. If you fail to notify our office of procedures, appointments, ER visits, etc. your insurance may not cover those charges and you will be responsible.

I certify that the information I have reported above to be true to the best of my knowledge. I am aware of the services and procedures performed today for my continued healthcare. I understand and agree that they are medically necessary, therefore, I am responsible for the charges not considered "medically necessary" or non-covered service by my insurance company. Should this occur, Dr. Jackson's office will inform me before performing any service or procedure which may include, but is not limited to EKG, lab work and/or injections. I authorize Dr. Jackson's office to release information as necessary for my continued healthcare. I authorize Dr. Jackson's office to file my insurance claims to clear unpaid balances on my account and assign benefits payable to physician.

It is the policy of our office that payment is due at the time of service unless other financial arrangements are made in advance. We require all patients to pay their deductible, copay and/or coinsurance payment at each visit.

Agreement to pay: the undersigned accepts the fee charged as a lawful debt and promises to pay said fee including the cost of collection, attorney fees and court cost if such is necessary, waiving now and forever the right to claim exemption under the constitution and laws of the state of Alabama, or any other state.

This signature will be valid for the duration of my medical care with Kevin L. Jackson, M.D.

Signature: _____ Date: _____



KEVIN L. JACKSON, M.D.
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**2430 Village Professional Drive
Opelika, AL 36801**

**(334) 821-6300
Fax (334) 821-1849**

By signing below, I hereby acknowledge receipt of this privacy policy notice

Printed Name of Patient

Date

Signature of Patient or Patient Representative

Printed name of Patient's Representative (If applicable)

Representative's Relationship to Patient (If applicable)



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Condensed HIPPA Explanation and Policies

The HIPPA rules are designed to protect the Private Health Information (PHI) of our patients. There are several explanations and policies that, by law, you must know and agree to.

A Privacy Officer is required by law, Donna Hill, is the Privacy Officer for this office. If there are any questions about privacy, from employees or patients, put them in contact with the Privacy Officer at (334) 821-6300.

We are prohibited from using (within the Company) or disclosing (outside of the Company) PHI without patient authorization unless such use or disclosure falls within an exception.

- The most notable exceptions are to carry out treatment, pursue payment or improve management of the Company.
- We are permitted to use and disclose a patient's health information without obtaining the patient consent or authorization for the purposes set forth below.

Permitted Uses and Disclosures

- For the Company's treatment, payment or health care operations.
- Required by law.
- Public health activities.
- Information regarding decedents.
- Cadaveric organ, eye or tissue donation purposes.
- Research
- To avert serious threat to health or safety.
- Specialized government functions.

Permitted Disclosures

- Subject to certain limitations, disclosures for the treatment, payment or health care operations of a third party.
- Victims of abuse, neglect or domestic violence.
- Judicial and administrative proceedings.
- Law enforcement purposes.
- Worker's compensation.

It is our policy to obtain a release of information from the patient at intake.

Examples of inappropriate uses of patient private health information include:

- Health care professional accessing or using the health information of patients they are not treating or assisting others in treating.
- Accessing/using medical records or the Company's computer system to determine whether an individual (i.e. coworker, relative, celebrity, etc.) is receiving treatment and there is no legitimate reason to have such knowledge.
- Using the medical record of a member of the Company's personnel to verify they were really sick, had a worker's compensation injury, etc.

Others involved in patient's care. We may disclose to a family member, other relative or a close personal friend of patient, or any other person identified by the patient, health information directly relevant to such person's involvement with the patient's care or payment related to the patient's health care. We are permitted to orally inform the patient of and obtain the patient's oral agreement or objection to or the use or disclosure.

- Before releasing information to a person covered by this category, we must either obtain the patient's agreement; or provide the patient with the opportunity to object to the disclosure and the patient does not object to the disclosure; or reasonably infer from the circumstances, based on the exercise of professional judgement that the patient does not object to the disclosure.
- Examples of situations in which we can "reasonably infer from the circumstances" that the patient doesn't object to the disclosure include:
 - When a spouse is present when treatment is being discussed with the patient; or when a colleague or friend has brought the patient to us for treatment and the patient allows them to come into the examination room.

When we use or disclose PHI or an authorized person requests PHI, we must make reasonable efforts to limit the information to the minimum amount necessary to accomplish the intended purpose of the use, disclosure or request.

- This minimum necessary standard, however, does not apply to, among other things, disclosures to or requests by other health care providers for treatment.

Clinical, billing and management employees have rights to access the patient files in order to perform their work. However, employees must refrain from using or disclosing patient health data unless they are helping that patient.

- No employee is allowed to disclose (orally, by fax or mail) PHI unless it is to the patient, the patient's health care providers, the patient's insurance company or designated payer, the patient's legal caregiver or the direct family members of the patient (that are known to be involved in patient's care).
- No information can be disclosed to a patient's employer without written authorization from the patient.
- If an unauthorized disclosure occurs – YOU MUST CONTACT THE PRIVACY OFFICER IMMEDIATELY.

All employees are responsible for keeping PHI secure – this includes all information in the medical record. Do not yell or broadcast PHI in or near the reception area.

Patients are allowed to have copies of their file for a nominal photo copy fee. The file must first be reviewed by the treating practitioner and the Facility Manager.

Patients have the right to place reasonable restrictions on disclosures of their information. All restrictions have to be approved and accepted by the Privacy Officer.

If another health care provider's office seems concerned about our HIPPA compliance or we are concerned about another provider's HIPPA compliance, the Privacy Officer can implement a signed Business Associate Contract with that other party to ensure HIPPA compliance is understood and agreed to.

If we remotely access electronic PHI (E PHI) we will do so in a manner that is secure and consistent with the permission granted by the patient.

We require Business Associate Contracts from all companies with whom we must share PHI.



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Patient Authorization

I hereby consent to the use and disclosure of all Medical Date and prescription history access about me or my minor children for uses allowed by law, including for the following purposes:

Treatment	Payment	Health Care Operations
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1. I understand that you have prepared a Notice of Privacy Practices that provides a more complete description of the uses and disclosures that you are permitted or required by law to make and that I have a right to review such notice prior to my signing this consent.
2. I understand that you may change the terms of your current Notice of Privacy Practices and if you change such notice I may contact you to obtain the most recent version.
3. I understand that I have the right to request restrictions on how you use and disclose my protected health information to carry out treatment, payment and health care operations, but that you do not have to agree to my request. Nevertheless, if you agree to my requested restriction it is binding on you.
4. I understand and consent for my health related message to be left on my answering machine.
5. I understand that I may be contacted at my place of employment if necessary.
6. I understand that I have the right to revoke this consent in writing, except to the extent that you have already taken action in reliance upon this consent.
7. I understand that this authorization will remain in effect until a written amendment or revocation has been provided to our office.
8. I understand that the names listed below will be **required to know my date of birth in order to discuss my medical condition.**

You may discuss my medical information with the following:

Name: _____	Phone: _____	Relationship: _____
Name: _____	Phone: _____	Relationship: _____
Name: _____	Phone: _____	Relationship: _____
Name: _____	Phone: _____	Relationship: _____

You may list additional persons on the reverse side of the page.

Patient Signature: _____ Date of Birth: _____
 Printed Name: _____ Date: _____
 Witness: _____
 Notice of Privacy Practices given to patient on: Date: _____ Initials: _____



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Welcome to the practice of Dr. Kevin L. Jackson. Here are a few guidelines we would like you to be aware of:

1. You must notify the office of changes in address, telephone number or insurance.
2. Please bring your insurance card to every visit. **You will be responsible for payment of charges from services rendered if we are unable to verify benefits.**
3. Insurance companies require collection of your co-pay or contracted percentage of services at every visit. If you have a deductible that has not been met you will be required to pay for the visit in full. If your insurance company does not pay for a service, the charges will be the responsibility of the patient. We recommend that you always question your insurance company regarding your benefits and do not assume that everything done in our office is covered by your insurance carrier. Many insurance policies now require referrals, if your policy requires referrals to other physicians it is your responsibility to notify our front office prior to your scheduled visit with other physicians in order for your visit to be covered.
4. We accept cash, check, Visa, Master Card and Discover.
5. Financial arrangements will be required for balances which remain unpaid after two statements have been received prior to scheduling an appointment.
6. There is a \$35 fee for returned checks.
7. Medical records can be sent to another physician as a courtesy free of charge upon receipt of signed medical records release. Patient copies of medical record can be obtained for a fee. Copies of the medical record will be provided within 7 days with a prepayment.
8. Requests for FMLA, Disability or Leave of Absence paper work will be completed for a flat fee of \$25, please also allow 7 days for completion of these forms.
9. Patients are seen by appointment only.
10. Rescheduling may be necessary if you are more than 10 minutes late for your appointment. We will try to work you in if time allows.
11. If you are unable to keep your appointment kindly give notice no later than 24 hours. If 24 hour prior notification is not given, you will be charged \$30 for the missed appointment.
12. Sample medications will only be provided at the time of your scheduled appointment.
13. In general, wellness/physical examinations cannot be scheduled on the day you call. We reserve only a certain number of these exams per day. We recommend that you schedule your wellness/physical well in advance to get your preferred time of day or day of the week.
14. Patients on medication for ADHD will be seen for medication check-ups every 6 months. Refills for ADAD medications will be provided only if these appointments are kept. You may call our office to request a refill for ADHD medications. .
15. Medication refills can be requested over the phone to treat stable, chronic medical conditions (maintenance medications) that require ongoing medication (i.e. blood pressure, diabetes), as long as the patient is established and has been seen for the condition within 6 months. Refills will not be provided after hours or on weekends. Please allow 24 hours for these refills to be completed.
16. Prescriptions for acute illness may be called in from time to time as long as the patient's account and regular appointments are current and up to date. There is a fee of \$10 for local pharmacies and \$15 for out of town pharmacies.
17. You may access the Clinical Summary for each visit via our patient portal.
18. Our nurses are always available during business hours to serve your needs. You can ask to leave a message for any questions you may have. All messages will be returned on that business day; however, depending on the daily schedule, these calls may not be returned until the end of the day. If you feel you need to be seen you should speak with someone in the front office to schedule an appointment, as the schedule fills quickly.
19. An on-call physician is available to you via our answering service for calls after regular business hours. After hours contact with the physician is intended for urgent medical problems only. Questions about appointments, billing, referrals, refills or other issues of a non-urgent nature should be placed during normal business hours.
20. In case of emergency, call 911 or go to the nearest hospital emergency room.

By signing below you acknowledge that you have read and understand the office policies.

Signed: _____

Date: _____



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Patient Personal History

Patient Name: _____ **Date:** _____

Confidential Record: Information contained here will not be released except when you have authorized us to do so.

Present Medical Complaints/Symptoms: _____

Drug Allergies and Reactions: _____

Please provide a list of your current medications and attach to this document?

Preferred Pharmacy Name and Location: _____

Physicians currently treating you: _____

Family History:	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Epilepsy/Convulsions	_____	_____	_____	_____	_____	_____
Bleeding Disorder	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Thyroid Disease	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Osteoporosis	_____	_____	_____	_____	_____	_____

Hospitalization or Surgery

Reason	Date	Reason	Date

Past Medical History

Headache	Claudication	Liver disease	Incontinence
Hypertension	MI	Ulcer	Venereal disease
Stroke/TIA	Congenital heart disease	GI disorder	Anemia
Epilepsy	Orthopnea	Lactose intolerance	Gout
Fatigue	Hyperlipidemia	Renal disease	Scarlet fever
Shortness of breath	Congestive heart failure	GU disorder	Rheumatic fever
Heart palpitations	Arrhythmia	Sexual dysfunction	Diabetes
Heart murmur	Allergies/Hay fever	Menstrual dysfunction	Endocrine disease
Chest pain/Angina	Asthma	Bowel Irregularity	Arthritis
Dizziness/Fainting	COPD	Prostate disease	Osteoporosis
Anxiety			

Routine Health Screening

Colonoscopy: _____
 Mammogram: _____
 Eye Exam: _____

PSA: _____
 Pap Smear: _____
 Flu/Pneumonia Vaccine: _____

Habits

Tobacco Use Packs daily: _____ How many years? _____ Date stopped: _____
 Smokeless: _____ How many years? _____ Date stopped: _____
 Caffeine How much consumed daily? _____
 Alcohol How much consumed daily? _____
 Exercise Routine and frequency? _____
 Sleep Routine? _____

Do you have any metal in your body? Yes No
 If so, where? _____

Do you need any assistance with and of the following?

Taking medications	Meal preparation	Bathing/Toileting	Shopping
Finances	Housework	Bladder Control Issues	Transportation Issues

Have you recently experienced any of the following?

Little interest or pleasure in doing things?	Yes	No
Feeling down, depressed or hopeless?	Yes	No
Loss of energy?	Yes	No
Difficulty sleeping?	Yes	No
Difficulty getting motivated or enjoying yourself?	Yes	No
Difficulty controlling thought?	Yes	No
Feeling blue?	Yes	No
Hoarseness?	Yes	No
Thoughts of suicide or hurting yourself or others?	Yes	No
Loss of memory?	Yes	No
Dislike of being around others?	Yes	No
Recent falls?	Yes	No

Neurologic:

Do you frequently have severe headaches?	Yes	No
Do they throb or pulsate?	Yes	No
Do they cause visual disturbance?	Yes	No
Do they occur on one side of the head?	Yes	No
Have you ever fainted?	Yes	No
Have you ever had a seizure?	Yes	No
Have you ever had double vision?	Yes	No
Spells of weakness of an arm or leg?	Yes	No
Dizziness?	Yes	No
ringing in ears?	Yes	No

G.U.

Have you experienced recent:

Burning when urinating?	Yes	No
Blood in urine?	Yes	No
Trouble starting to urinate?	Yes	No
Getting up frequently at night to urinate?	Yes	No
Loss of control of bladder?	Yes	No
Dark colored urine?	Yes	No
Trouble holding urine?	Yes	No
Passed a kidney stone?	Yes	No

Hematologic

Do you frequently have bleeding gums?	Yes	No
Have you recently had increased bruising?	Yes	No
Do you tend to "bleed freely"?	Yes	No

G.I.

Have you recently had pain in the stomach which:

Occurs one to two hours after eating?	Yes	No
Awakens you at night?	Yes	No
Is brought on by eating fried or gassy foods?	Yes	No
Is relieved by antacid medications?	Yes	No
Is relieved by bowel movements?	Yes	No
Occurs while eating or immediately after?	Yes	No
Loss of appetite?	Yes	No
Blood in stools or black stools?	Yes	No
Cramping pain in abdomen?	Yes	No

Alternating diarrhea and constipation?	Yes	No
Pain during and after bowel movement?	Yes	No
Required use of laxative or enemas?	Yes	No

Musculoskeletal

Have you ever experienced back trouble or injury?	Yes	No
Loss of feeling or numbness?	Yes	No
Staggered gait?	Yes	No
Phlebitis or inflamed leg veins?	Yes	No
Paralysis or weakness of limbs?	Yes	No
Swollen or painful joints?	Yes	No
Varicose veins?	Yes	No
Pain in big toe?	Yes	No

Cardiovascular

Have you ever experienced shortness of breath?	Yes	No
If yes, when and what seemed to bring it on? _____		
Have you ever experienced chest pain?	Yes	No
If yes, when and what seemed to bring it on? _____		
Have you ever experienced palpitations?	Yes	No
If yes, when and what seemed to bring it on? _____		
Have you ever experienced swelling in the ankles?	Yes	No
If yes, when and what seemed to bring it on? _____		
Do you have a pacemaker?	Yes	No

To be answered by men only:

Loss of sexual activity?	Yes	No
Prostate issues?	Yes	No
Discharge from penis?	Yes	No

To be answered by women only:

Are you still having regular monthly menstrual periods?	Yes	No
Have you ever had bleeding between periods?	Yes	No
Do you have very heavy bleeding with your periods?	Yes	No
Do you feel bloated and irritable before your period?	Yes	No
Are you now on or have you ever taken birth control pills?	Yes	No
Have you ever had a miscarriage?	Yes	No
Have you ever had discharge from the nipple of your breast?	Yes	No
Do you regularly have the cancer test of the cervix?	Yes	No
How many children born alive? _____	How many miscarriages? _____	
How many stillbirths? _____	How many cesarean operations? _____	
How many premature births? _____	Any complication of pregnancy? _____	
Date of last menstrual period? _____		

Detailed list of Medications:

Additional comments:
