Welcome to East Alabama Primary Care (EAPC)

We are honored to be your providers, and we are committed to providing you with the best care we can. Our hope is that we form a partnership to keep you healthy as possible, no matter your current state of health. We will share our medical expertise with you and hope you will take responsibility for working toward the healthy lifestyle that is important to your well-being. Few of us have a completely healthy lifestyle, but each day we can take a step closer to a healthier life.

Here are some important steps you can take toward better health:

- Do not smoke cigarettes or use other tobacco products.
- Drink alcohol in moderation, if at all, and never drive when you have been drinking.
- Eat a diet low in fat and high in vegetables and fruits.
- Exercise at least three times a week.
- Wear your seat belt whenever you are in a car.
- Learn about ways to deal with stress and tension.
- Discover what spirituality means to you and practice it.
- Maintain ties with your family, neighbors, co-workers, and your church community.

It will give us immense pleasure to collaborate with you on these goals – either through our expertise, through reading we may give you, or by referral to other health professionals.

We want everyone to be involved in our health maintenance program. Everyone who joins our practice should start by having a complete physical exam, followed by periodic check-ups to evaluate for specific diseases. We suggest keeping a list of any questions/concerns you may have.

We look forward to collaborating with you as your family doctor. Please contact us whenever you would like to talk about anything you think may be affecting your health. It is our hope that we can have a relationship in which the lines of communication are open and communication goes both ways. We will listen to you at least as much as we talk. Let us work together to help you live the satisfying life that you deserve.

Sincerely,

Dr. Sarat Meka, MD and Dr. Ruby Powar, MD

East Alabama Primary Care

1518 Professional Parkway, Auburn, Alabama 36830

Phone: +1 (334) 321-0060 | Fax: +1 (334) 321-0063

Dr. Sarat Meka, MD | Dr. Ruby Powar, MD

Today's Date: _____

PATIENT INFORMATION (Legal Name):

Last Name: _____ First Name: _____ Middle Initial:_____

Social Security #:_____ Date of Birth:_____ Gender:_____

Address: _____

City:_____ State:_____ Zip:_____

Phone #: _____ Alternative Phone #: _____

Email Address:_____ Marital Status:_____

Employer Name/Occupation: _____

Work #:_____ May we contact you at work, if necessary? Y ___ N___

Emergency Contact Name:_____ Relationship to Patient:_____

Emergency Contact Phone #:_____ Alternative #:_____

*Please tell us how you heard about us:*_____

GUARANTOR INFORMATION (Only complete is patient is a dependent):

Relation of Guarantor to Patient:_____

Last Name: _____ First Name: _____ Middle Initial:_____

Social Security #:_____ Date of Birth:_____ Gender:_____

Address: _____

City:_____ State:_____ Zip:_____

Phone #: _____ Alternative Phone #: _____

Employer Name/Occupation: _____

Work #:_____ May we contact you at work, if necessary? Y ___ N___

INSURANCE INFORMATION (Please bring Insurance cards and allow Receptionist to copy):

Primary Insurance Plan Name:_____

Policy/ID #:_____ Group #:_____ Effective Date:_____

Primary Policy Holder Name: _____

Policy Holder Social Security #:_____ Policy Holder Date of Birth: _____

Relationship to Patient: Self___ Spouse___ Parent___ Other:_____

Secondary Insurance Plan Name (if applicable): _____

Policy/ID #:_____ Group #:_____ Effective Date:_____

Primary Policy Holder Name: _____

Policy Holder Social Security #:_____ Policy Holder Date of Birth: _____

Relationship to Patient: Self___ Spouse___ Parent___ Other:_____

PHARMACY INFORMATION (Please choose one even if you are not on any current medications):

Name of Pharmacy: _____ Pharmacy Phone #: _____

Pharmacy Address: _____

Secondary Pharmacy (if applicable): _____ Pharmacy Phone #: _____

Pharmacy Address: _____

ALLERGIES (Please indicate NKDA if you have No Known Drug Allergies):

Medication	Type of Reaction

MEDICATIONS (Please list any current prescriptions or over the counter medications):

Medication	Dosage	Frequency

****PLEASE NOTE THAT WE DO NOT FILL CONTROLLED MEDICATIONS – INCLUDING BUT NOT LIMITED TO: HYDROCODONE/OXYCODONE, XANAX, ADDERALL/VYVANCE, TRAMADOL. WE WILL REFER YOU TO A SPECIALIST.**

PAST MEDICAL HISTORY (Please check any current or previous conditions):

- ☐ Acid Reflux
- ☐ ADHD
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bipolar disorder
- ☐ Blood clots
- ☐ Blood transfusion
- ☐ Cancer – (what type) _____
- ☐ Colon Polyps
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes – (circle) Type1/Type2
- ☐ Diverticulitis
- ☐ Gout
- ☐ Headaches
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Hepatitis – (circle) A/B/C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lupus
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Stroke
- ☐ Other:_____ _____

Elaborate, if necessary _____

_____

_____

_____

PAST SURGICAL HISTORY (Please list all surgeries, performing doctor, and surgery date):

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

SOCIAL HISTORY (Please complete entirely):

Tobacco/Nicotine Use: Current ___Former___Never____ Type and How Often: _____

Duration of Use:_____ If you quit, how long ago: _____

Alcohol Use: Daily___Socially___Rarely___None____ Frequency (in a month): _____

Recreational Drug Use: Current___Former___ Never____ Type and For How Long: _____

Family History of Substance Abuse: _____

Exercise: Y____ N____ How often and what kind: _____

Diet: Regular____ Other: _____

Caffeine: Y____ N____ Average amount: _____ per day/week/month (circle) Type: _____

Other liquid intake during the day: _____

Who are you living with: _____

How often do you feel stressed: None____A little____To some extent____Rather much____Very much____

Any pets at home? Y____N____

Do you have smoke and carbon monoxide detectors in your home? Y____N____

Are you passively exposed to smoke? Y____N____

Do you use sunscreen routinely? Y____N____

Are you able to care for yourself? Y____N____

Are you blind or have difficulty seeing? Y____N____

Are you deaf or have serious difficulty hearing? Y____N____

Do you have difficulty concentrating, remembering, or making decisions? Y____N____

Do you have difficulty walking or climbing stairs? Y____N____

Do you have difficulty dressing or bathing? Y____N____

Do you have difficulty doing errands alone? Y____N____

Are you able to walk? Without restrictions____With an assistive device____No____

Are you sexually active? Y____N____

How many children do you have? _____

Do you have an advanced directive? Y____N____

What is the highest grade or level of school you have completed? _____

HEALTH MAINTENANCE (Please indicate performing doctor, date, and results if possible)

Previous Primary Care Provider: _____ Location: _____

Last Tetanus/TDAP vaccine: _____

Last Flu Vaccine: _____

Last COVID-19 Vaccine: _____

Last Shingles Vaccine: _____

Last Pneumonia Vaccine – (circle) Prevnar13/Pneumovax23: _____

Last Colonoscopy: _____ Performing Doctor/Clinic: _____

Last ColoGuard: _____

Last Vision Exam: _____ Performing Doctor/Clinic: _____

Last Dental Exam: _____ Performing Doctor/Clinic: _____

Last EKG: _____ Performing Doctor/Clinic: _____

Any Specialists You Follow (name, specialty, and date of last visit):

_____

_____

_____

_____

_____

Any recent Emergency Room/Urgent Care Visits or Hospitalizations (location, date, and reason for visit):

_____

_____

_____

WOMEN ONLY: OBGYN Doctor: _____OBGYN Phone #: _____

Last Pap Smear: _____ Mammogram: _____ DEXA:_____

FAMILY HISTORY (Please list any of the following or any other family medical history):

Anemia	Cancer (indicate type)	Heart Failure	Lupus
Anxiety	COPD	High Blood Pressure	Seizures
Asthma	Coronary Artery Disease	High Cholesterol	Stroke
Atrial Fibrillation	Depression	HIV/AIDS	Sudden Cardiac Death
Bipolar Disorder	Diabetes	Hyperthyroidism	
Blood Clots	Heart Attack	Hypothyroidism	

Brother: _____

Daughter: _____

Father: _____

Maternal Grandfather: _____

Maternal Grandmother: _____

Mother: _____

Paternal Grandfather: _____

Paternal Grandmother: _____

Sister: _____

Son: _____

****AT THIS TIME, PLEASE MAKE SURE YOU HAVE FILLED OUT THIS ENTIRE FORM TO THE BEST OF YOUR CAPABILITY.** USE "N/A" OR "NEVER" IF NOT APPLICABLE TO YOU. WE ARE UNABLE TO SCHEDULE YOU UNTIL WE HAVE THIS FORM IN ITS ENTIRETY. THANK YOU FOR YOUR COOPERATION. WE LOOK FORWARD TO WORKING WITH YOU**

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MEDICAL INFORMATION RELEASE FORM

I, _____, give the physicians and staff at East AL Primary Care permission to release information to the following Family Members, regarding my medical condition (s), test results, appointment, drug and (or) alcohol abuse and financial status.

1) Name: _____

   Relationship to Patient: _____ Phone #: _____

2) Name: _____

   Relationship to Patient: _____ Phone #: _____

I, the undersigned, allow the facsimile as E-Mail process of prescription request, medical records, orders, and appointment listing to referred facilities to expedite your healthcare.

Patient Signature: _____ Date: _____

Witness (Printed Name): _____ Date: _____

Witness Signature: _____

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PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protection health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessment and physicians' certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of uses and disclosures of my health information. I have been given the right to review such Notices of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact East AL Primary Care, at any time at the address above to obtain a current copy.

I understand that I may request in writing that you restrict how confidential information is used or disclosed to conduct treatment, payment, or healthcare operations. I also understand that you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have acted relying on this consent.

Patient Name (PRINT): _____

Patient Signature: _____ Date: _____

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NON-COVERED WAVIER

Under your health plan, you are financially responsible for co-payments, coinsurance, and deductibles for covered services, as well as those services that exceed benefit limits. You are also financially responsible for all non – covered services as defined by your health plan contract. For example, this may include services such as Flu Vaccinations, EKG's etc. The services or products may or may not be covered according to your health plan.

Your acknowledgement below indicates that you have been advised of this information and that you agree to pay for any services not covered under your plan.

Patient Name (PRINT): _____

Patient Signature: _____ Date: _____

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MEDICAL RECORDS RELEASE REQUEST

Patient's Name: _____ DOB: _____ SS#: XXX-XX-_____

I hereby authorize East AL Primary Care to use, disclose and/or obtain my medical records from:

Clinic/Hospital/Physician: _____

Address: _____

Fax: _____ Phone: _____

- This information may be transferred by: Mail or Fax (circle)
- This information may be picked up in person by:

  Name: _____ Relationship to Patient: _____

Patient Signature:_____ Date: _____

Guardian Name (if applicable): _____ Relationship to Patient: _____

Guardian Signature: _____ Date: _____

EAPC Representative: _____

EAPC Representative Signature: _____

----------For Office Use Only ----------

Office Notes_____ Imaging Reports_____ Lab Results_____ Colonoscopy/EDG Reports_____

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND ABOUT HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

EFFECTIVE DATE: _____

The policy of EAST ALABAMA PRIMARY CARE, LLC is to protect the confidentiality, integrity and security of the protected health and personal information of our patients and to prevent unauthorized access to, or the use or disclosure of such information. We are required by law to maintain the privacy of your health information and provide you with this notice of our duties and obligations. This policy applies to patients who are current or former patients of EASTALABAMA PRIMARY CARE, LLC.

Individually identifiable health and personal information are any information obtained by EAST ALABAMA PRIMARY CARE, LLC in connection with providing healthcare treatment, obtaining payment and related health care operations. This relates to past, present or future information that EAST ALABAMA PRIMARY CARE, LLC receives from you as our patient.

EAST ALABAMA PRIMARY CARE, LLC collects personal information in order to learn about your medical history, medical conditions, render treatment and collect payment for our services. We gather this information from your patient forms, health questionnaires and other forms you will be asked to complete from time-to-time, In addition, we will assemble information based on our discussions and conversations with you, your personal representative, and your family members. Your healthcare plan or insurance carrier may provide information to our office.

We will use this information to provide. caring and quality medical care to you, Examples include diagnosis, treatment and communications such as follow up and appointment reminders, as well as treatment alternatives or other health-related benefits that may be of interest to you or your medical condition. As part of our standard treatment and healthcare operations, we may share information with a facility such as a hospital, laboratory, diagnostic service, or healthcare provider to efficiently coordinate your treatment plan. We will obtain your written authorization before using your information for marketing purposes. For contracted insurers, your information will be used for claims management and to obtain payment from your insurance canier. We will exchange paper and electronic data with your insurance carrier for activities such as eligibility, benefit and coverage determinations, precertification, utilization review and related activities. For worker's compensation, information about a work-related condition can be exchanged with the employer.

Your information is maintained in our office in our computer system. We also maintain information about you in your medical chart. EAST ALABAMA PRIMARY CARE, LLC limits the access to your protected health

information to those employees and business associates who need to know that information. With some limitations, you have the right to inspect amend copy and receive an accounting of disclosures of your medical and billing records.

We do not disclose personal information to third parties unless one of the following exceptions applies:

- We will receive an explicit authorization from you to release individually identifiable information. This authorization must be in writing and give exact details regarding to whom the disclosure applies, the nature of the data to be released, the applicable dates and signed by the patient (or guardian). You may revoke this authorization by providing a written statement to Dr. Ruby Powar, EAST ALABAMA PRIMARY CARE, LLC, 1518 Professional Parkway, Auburn, AL 36830.

- Federal, state or other applicable law requires us to share protected information or records. Your information may be disclosed to a health-agency for purposes such as licensure, certification, audits, investigations and inspections. As required for law enforcement purposes or in response to a valid subpoena or court order, your information may be disclosed. Other disclosures could be required by law for military duty, national security activities or for coroners/funeral directors to carry out their duties.

We are obligated to abide by the terms of this notice. We will obtain a signed, written authorization from you for permission to use and disclose your information for reasons not described in this Notice of Privacy Practices. The authorization will have an expiration date and a description of the purpose or the event you are authorizing. You will be provided with a copy of the signed authorization. You have the right to revoke the authorization in writing, at any time, and mail to Dr. Ruby Powar at EAST ALABAMA PRIMARY CARE, LLC, 1518 Professional Parkway, Auburn, AL 36830.

We will notify you in the event you are affected by an unsecured breach of information. We reserve the right to change the terms of this Notice of Privacy Practice and to make new notice provisions effective for all health information that we maintain. The revised notice will be made available on our website/portal and any new notices will be distributed to you upon your return to the practice.

With some exceptions, you have the right to inspect, review or obtain a copy of your health information. This request must be in writing and there may be a reasonable charge to provide you with a copy of your information, You also have the right to request your records be amended, to request special accommodations and restrictions of your health information, including to your health plan, and to receive an accounting of the disclosures of your information. You have the right to request to receive communications of your information in a special manner or location. EAST ALABAMA PRIMARY CARE, LLC is not obligated to agree to a requested restriction unless the disclosure to your heal plan is for payment or health care operations and is not otherwise required by law AND it pertains solely to a health care item or service has paid the health care provider/entity in full. We must receive a written request from you to administer these rights. Please ask to speak to the Privacy Officer or office Manager for further information or to begin the process to exercise any of these rights.

If you have a complaint about the management of your health information or believe your privacy rights have been violated, please contact our Privacy/Security Officer, Dr. Ruby Powar at 334-321-0060 or you may file a complaint in writing to our Privacy Officer EAST ALABAMA PRIMARY CARE, LLC., 1518 Professional Parkway, Auburn, AL 36830.

You have the right to file a complaint with our office and the Office for Civil Rights (OCR) and there will be no retaliation for filing a complaint with either entity.

Other optional uses of PHI:

- Your medical information may be reviewed by our medical staff for possible inclusion and referral in research studies. Yon will be contacted prior the use of your information in a research study. You will be required to sign and complete a written authorization. The authorization will have an expiration date and a description of the purpose or the event you are authorizing. You have the right to revoke the authorization in writing and then mail to Dr. Powar at EAST ALABAMA PRIMARY CARE, LLC 1518 Professional Parkway, Auburn, AL 36830 or this may done at our office. You will be provided with a copy of the signed authorization.
- We may contact you for fundraising opportunities and you have the opportunity to opt out of such communications.
- In order to coordinate your care or service your account, EAST ALABAMA PRIMARY CARE, LLC and our agents may contact you by telephone at any telephone number you provide, including wireless telephone numbers, which could result in charges. EAST ALABAMA PRIMARY CARE, LLC may also contact you by sending text messages or emails, using any e-mail address you provide. Methods of contacting may include prerecorded or artificial voice messages and or use of automatic dialing devices, as applicable.

I acknowledge that I received the Notice of Privacy Practices upon registration as a patient for East AL Primary Care, LLC and I acknowledge that I was offered a copy of the Notice of Privacy Practices upon registration as a patient for East AL Primary Care, LLC but declined receipt.

Patient Name (PRINT): _____

Patient Signature: _____ Date: _____

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OFFICE AND FINANCIAL POLICIES

Welcome to East AL Primary Care, LLC. We have outlined a few policies associated with our practice here for you.

- **CELLPHONE USE**: Please do not use your cellphone when you are brought back to see your provider. Please put your cellphone on silent or turn it off while with your provider.
- **FINANCIAL POLICY**: All payment due is required at the time of service. Co-Payments, Deductibles and Balance Due will be COLLECTED during Check-In. No checks are accepted currently but we accept debit cards and all major credit cards.
- **RESCHEDULE/CANCELLING/NO SHOW**: We understand that circumstances arise that you may need to cancel or reschedule your appointment. If you must reschedule or cancel, please contact the office 24 hours in advance. On weekends, leave a Voice Mail. We do contact you via text, email and by phone to remind you of your appointment.
    - ***IF YOU DO NOT SHOW UP FOR YOUR APPOINTMENT (NO SHOW), YOU WILL BE CHARGED A $25 NO SHOW FEE THAT WILL BE COLLECTED PRIOR TO YOUR NEXT APPOINTMENT.***
- **REQURIED FORM COMPLETION**: Forms are time consuming but are necessary at times to be completed by your care team. We will complete your form (s) upon request, but we charge a normal fee for the completion of varied forms. Please inquire as to the charges associated with your form.
- **PRIOR AUTHORIZATIONS FOR MEDICATIONS**: There is a $10 fee for a prior authorization on a medication. Completion of a prior authorization does not guarantee your insurance company will approve your medication. The $10 fee will be enforced regardless of approval for your medication.
- **MEDICATION REFILLS**: Patients are required to be seen at least EVERY 6 Months to receive medication refills. Please contact your PHARMACY for refills on the following medications: Acid Reflux, Arthritis, Blood Pressure/Blood Sugar/Diabetic, Cholesterol and Stomach Medications.

Patient Name (PRINT): _____

Patient Signature: _____ Date: _____