



1 Hospital Drive, SW Suite 201  
Huntsville, AL 35801  
(256) 489-2442

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_  
Cell Number: \_\_\_\_\_ Cell Phone Provider: \_\_\_\_\_  
Home Number: \_\_\_\_\_ Work Number: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
City/State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
E-Mail: \_\_\_\_\_ Relationship Status: S M W D  
Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_  
Pharmacy with Location: \_\_\_\_\_

**INSURANCE INFORMATION**

Primary Insurance: \_\_\_\_\_ Contract# /Group#: \_\_\_\_\_  
Policy Holder/DOB: \_\_\_\_\_ Relation: \_\_\_\_\_  
Secondary Insurance: \_\_\_\_\_ Policy Holder: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Relation: \_\_\_\_\_

**ATTENTION: OUR OFFICE USES PATHGROUP FOR ALL LABS.**

I CONSENT TO TREATMENT NECESSARY FOR THE CARE OF THE ABOVE NAMED PATEINT. I ACKNOWLEDGE FULL FINANCIAL RESPONSIBILITY FOR SERVICES RENDERED BY RACHEL PETERSEN, M.D. I AGREE TO PAY ALL REASONABLE ATTORNEY FEES AND COLLECTION COSTS IN THE EVENT OF DEFAULT OF PAYMENT. I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT FOR GTREATMENT AND FINANCIAL RESPONSIBILITY.

DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_

**CONSENT FOR THE RELEASE OF MEDICAL INFORMATION TO SPECIFIED INDIVIDUALS**

Rachel Petersen, M.D. is committed to the protection of our patient’s personal health information. However, we recognize that individuals other than themselves attend to many of our patient’s healthcare needs. In accordance with new HIPPA regulations, we ask that you take a moment to give us the names of individuals with whom we are able to discuss your medical appointments, condition, treatment options, insurance payment information, or other information necessary to our responsibility in your treatment. Please list the names (and phone numbers, if readily available) of any individuals with whom we may have communication, which may include all, or part of your personal health information. If you fail to list any names, we will not discuss your medical information with anyone other than yourself.

**Contact/Relationship to Patient:**

**Telephone Number:**

1) _____	_____
2) _____	_____
3) _____	_____

**Please check all approved methods that our office may contact you:**

- ( ) Home phone/voicemail
- ( ) Cell phone/voicemail
- ( ) Reminders through text message – Cell Phone Provider \_\_\_\_\_

**DATE** \_\_\_\_\_ **SIGNATURE** \_\_\_\_\_

**MEDICARE EXTENDED PATIENT SIGNATURE AUTHORIZATION (Medicare Patients Only)**

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO THE PHYSICIAN RACHEL PETERSEN, M.D. FOR ANY HOLDER OF MEDICAL INFORMATION ABOUT TO RELEASE TO HEALTHCARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NECESSARY TO DETERMINE THESE BENEFITS FOR RELATED SERVICES.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

**NOTICE OF PRIVACY PRACTICES RECEIPT**

I HAVE RECEIVED AND REVIEWED THE NOTICE OF PRIVACY PRACTICES PROVIDED BY RACHEL PETERSEN M.D.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

**FINANCIAL RESPONSIBILITY AND MEDICAL RECORDS**

I UNDERSTAND THAT PAYMENT OF CHARGES INCURRED IS DUE AT THE TIME OF SERVICE UNLESS OTHER FINANCIAL ARRANGEMENTS HAVE BEEN MADE PRIOR TO TREATMENT. I AUTHORIZE AND REQUEST THAT INSURANCE PAYMENTS BE MADE DIRECTLY TO RACHEL PETERSEN, M.D. I UNDERSTAND RACHEL PETERSEN, M.D., WILL ATTEMPT TO COLLECT ASSIGNED INSURANCE BENEFITS FOR A PERIOD OF 45-DAYS AFTER DATE OF SERVICE AT WHICH TIME PAYMENT OF THE FULL AMOUNT WILL BE MY RESPONSIBILITY. I REALIZE THAT RACHEL PETERSEN, M.D. MAY SEEK ASSISTANCE OUTSIDE THIS OFFICE TO EXPEDITE COLLECTION OF THE BALANCE DUE.

I AUTHORIZE THE RELEASE OF ALL MEDICAL RECORDS TO THE REFERRING AND FAMILY PHYSICIANS AND TO MY INSURANCE COMPANY, IF APPLICABLE. I ALLOW FAX TRANSMITTAL OF MY MEDICAL RECORDS IF NECESSARY.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

### OFFICE POLICIES

1. Please notify our office as soon as possible if you are unable to make your scheduled appointment. There will be a \$25.00 “No Show” fee charged if we are not notified before your appointment time.
2. You may be asked to reschedule your appointment if you are more than 15-minutes late.
3. There will be a \$50.00 “No Show” fee charged for surgeries that are not cancelled or rescheduled within 36-hours of the schedule date.
4. There will be a \$25.00 processing fee for standard FMLA, disability, and any other paperwork that needs to be completed by our office. Additional \$10.00 fee may apply for extra FMLA paperwork. Please **allow 7-10 business days for completion.**
5. A \$35.00 charge will be assessed on all returned checks.
6. If you call to leave a message with your doctor or nurse please allow up to **24-hours** for a return call. Your call will be returned in a timely manner by a nurse after discussion with the physician.
7. Prescriptions requested on Friday after 10am, will not be filled until the next business day.
8. Any non-emergency messages left with the answering service may be subject to a \$25 fee.
9. All unpaid balances over 30-days after insurance has made its final determination will be subject to a \$35.00 late fee if no arrangement is made with the billing office. All balances over 60-days will be subject to an additional \$28.00 collection fee and further legal action.
10. We will not release any medical records or perform any other services, i.e. refills on prescription, or filling out forms until your **OLD BALANCE IS PAID IN FULL.**
11. **Our office uses PathGroup for all papsmeears and labs.**

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Signature

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Date

**PATIENT CONSENT FOR USE AND DISCLOSURE  
OF PROTECTED HEALTH INFORMATION**

I hereby give my consent for Rachel Petersen, M.D. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (RACHEL PETERSEN, M.D. Notice of Privacy Practice provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practice prior to signing the consent. RACHEL PETERSEN, M.D. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Retina Clemons, Privacy Office at Rachel Petersen, M.D. – 1 Hospital Dr SW, Suite 201, Huntsville, Alabama 35801.

With this consent, RACHEL PETERSEN, M.D. may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminder, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, RACHEL PETERSEN, M.D. may email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that RACHEL PETERSEN, M.D. restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to RACHEL PETERSEN, M.D. use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, RACHEL PETERSEN, M.D. may decline to provide treatment to me.

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Signature of Patient or Legal Guardian

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Date

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Patient's Name

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Print Name of Patient or Legal Guardian

PATIENT'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ DATE: \_\_\_\_\_

If a doctor referred you today, please provide us with the doctor's name.

Name of Referring Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

If you were not referred by a doctor, how did you hear about Dr. Petersen?

- Friend     Facebook     Huntsville Times Ad     Health Ins./Website     Just for Women Magazine  
 Family     Internet Search     Yellow Pages Ad     Hospital Referral     Other: \_\_\_\_\_

What is your reason for coming in today?  
\_\_\_\_\_  
\_\_\_\_\_

Name of Family Doctor:  
\_\_\_\_\_  
\_\_\_\_\_

Pharmacy (please list name, street and city)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**OB/GYN History**

Please check all that apply:

- Menopausal  
     If yes, state year: \_\_\_\_\_  
 Hysterectomy  
     If yes, state year: \_\_\_\_\_  
     Ovaries removed? ( Y / N )

Date of last menstrual period: \_\_\_\_\_

How often each month: \_\_\_\_\_

Average length: \_\_\_\_\_

Average Flow (Heavy / Light / Moderate)

Do you pass clots? ( Y / N )

Cramps? (Mild / Moderate / Severe)

Any Recent changes in periods? Please list  
\_\_\_\_\_  
\_\_\_\_\_

Present method of birth control (including  
tubal ligation or vasectomy):  
\_\_\_\_\_  
\_\_\_\_\_

Date of last Pap smear? \_\_\_\_\_

Result: \_\_\_\_\_

Ever have abnormal Pap smear? ( Y / N )

# of pregnancies: \_\_\_\_\_

# of living children: \_\_\_\_\_

# of miscarriages: \_\_\_\_\_

# of ectopic pregnancies: \_\_\_\_\_

# of abortions: \_\_\_\_\_

# of vaginal deliveries: \_\_\_\_\_

# of C-Sections: \_\_\_\_\_

Date of last mammogram: \_\_\_\_\_

Result: \_\_\_\_\_

Date of last colonoscopy: \_\_\_\_\_

Results: \_\_\_\_\_

Date of last bone density: \_\_\_\_\_

Result: \_\_\_\_\_

**SURGERIES**

Please include date:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CURRENT MEDICATIONS**

Please list all current medications you are  
taking:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICATION ALLERGIES**

Please list any medication allergies and the  
response the medication causes:  
\_\_\_\_\_  
\_\_\_\_\_

**SOCIAL HISTORY**

Please check all that apply:

I have smoked in the past  
     For how long? \_\_\_\_\_  
     Date stopped? \_\_\_\_\_

I smoke currently  
     Packs per day? \_\_\_\_\_  
     For how long? \_\_\_\_\_

I drink alcohol  
     Drinks per week? \_\_\_\_\_  
     Type of alcohol? \_\_\_\_\_

I have a history of illicit drug use  
     Please list substance \_\_\_\_\_  
     \_\_\_\_\_  
     \_\_\_\_\_

**FAMILY MEDICAL HISTORY**

Please specify which relative:

Diabetes: \_\_\_\_\_

Heart Disease: \_\_\_\_\_

Blood Clots: \_\_\_\_\_

High Blood Pressure: \_\_\_\_\_

High Cholesterol: \_\_\_\_\_

Osteoporosis: \_\_\_\_\_

Alcohol/Drug Issues: \_\_\_\_\_

Breast Cancer: \_\_\_\_\_

Colon Cancer: \_\_\_\_\_

Ovarian Cancer: \_\_\_\_\_

Cervical Cancer: \_\_\_\_\_

Uterine Cancer: \_\_\_\_\_

Other Cancer: \_\_\_\_\_

Mental Illness: \_\_\_\_\_

Other: \_\_\_\_\_

**PAST MEDICAL HISTORY**

Please check all that apply:

- Asthma
- Kidney Infections
- Kidney Stones
- Tuberculosis
- Infertility
- HIV / AIDS
- Heart Attack
- Heart Disease
- Diabetes
- High Blood Pressure
- Blood Clots
- Stroke
- Eating Disorders
- Breast Cancer
- Colon Cancer
- Ovarian Cancer
- Cervical Cancer
- Uterine Cancer
- Other Cancer

Please specify: \_\_\_\_\_

- Reflux
- Hiatal Hernia
- Gastric Ulcers
- Mental Illness

Please specify: \_\_\_\_\_

- Anemia
- Blood Transfusion
- Seizures / Convulsions
- Bowel Problems

Please specify: \_\_\_\_\_

- Arthritis

Please specify: \_\_\_\_\_

- Back Problems

Please specify: \_\_\_\_\_

- Hepatitis
- Liver Disease
- Thyroid Disease
- Bleeding Disorders
- Other: \_\_\_\_\_

**CURRENT MEDICAL PROBLEMS**

Please check all that PRESENTLY apply:

**Constitutional:**

- Unexplained Weight Loss
- Fever
- Extreme Fatigue
- Change in Height

**Eyes:**

- Recent Vision Changes
- Glasses
- Contacts

**Ears, Nose and Throat:**

- Earaches
- Ringing in Ears
- Hearing Problems
- Sinus Problems
- Sore Throat
- Mouth Sores
- Dental Problems

**Cardiovascular:**

- Chest Pain/Pressure
- Difficulty Breathing on Exertion
- Swelling of legs
- Rapid/Irregular Heartbeat

**Respiratory:**

- Shortness of Breath
- Chronic Cough

**Gastrointestinal:**

- Frequent Diarrhea
- Bloody Stool
- Frequent Nausea
- Frequent Vomiting
- Heartburn
- Chronic Constipation
- Involuntary Loss of Gas/Stool

**Genitourinary:**

- Blood in Urine
- Pain with Urination
- Strong Urgency to Urine
- Frequent Urination

**NAME:** \_\_\_\_\_

**Genitourinary (Continued):**

- Incomplete Bladder Emptying
- Involuntary Urine Loss
- Urine Loss Due to Coughing/Lifting
- Premenstrual Syndrome (PMS)

**Musculoskeletal:**

- Joint Pain

**Skin:**

- Rash
- Moles (Growth/Changes)

**Breast:**

- Tenderness
- Nipple Discharge
- Lump/Mass in Breast

**Neurologic:**

- Dizziness
- Numbness
- Frequent Headaches

**Psychiatric:**

- Depression
- Anxiety

**Endocrine:**

- Hair Loss
- Hot Flashes
- Night Sweats

**Hematologic/Lymphatic:**

- Difficulty Stopping Bleeding
- Enlarged Lymph Nodes (Glands)

**Please list any other current symptoms not listed:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## NOTICE TO NEW PATIENTS

Please be advised, that at this time, Dr. Petersen is not accepting any new Medicaid patients. This includes patients who have another primary insurance. Should you decide to get Medicaid, we will not be able to continue your care. Upon notification, we will transfer all records to the physician of your choice.

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Patient Name Printed & DOB

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Patient Signature

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Date