Allegra Family Clinic
1116 Mitt Lary Road • Northport, AL 35473
Phone: 205-556-5634 • Fax: 205-556-5644

ALLEGRA FAMILY CLINIC
Your Family is our Focus

Allegra Wellness
4804 SR-69N • Northport, AL 35476
Phone: 833-633-5874 ext. 2

PLEASE PRINT CLEARLY & FILL OUT ALL FIELDS COMPLETELY.

Failure to complete correctly may result in denial to our clinic.

Name
If Married, Maiden Name
Social Security #
Date of Birth (MM/DD/YYYY)
Marital Status (check one)
married ☐ single ☐ domestic partner ☐
Gender at birth (check one) male ☐ female ☐
Race
Ethnicity Language

Physical Address
Street
City State Zip
Mailing Address (if different)
Street
City State Zip
Home Phone
Mobile Phone
Work Phone
Email
Pharmacy
Method of appointment reminders (check one)
Email ☐ Text ☐ Phone ☐

How did you here about us:
Radio ☐ Billboard ☐ Website ☐ Social Media ☐
Referral/Friend

Responsible Party self ☐ other ☐
If other, Name
Relationship to patient
Mailing Address

Phone #
Insured DOB
Email
Emergency Contact responsible party ☐ other ☐
If other, Name
Relationship to patient
Mailing Address

Phone #

Primary Insurance Co.
Plan Name
Plan Type
Group Name
Group #
Policy # (ID#)
Start/Effective Date
Office Copay $

Secondary Insurance Co.
Secondary Group #
Secondary Policy #

HIPPA INFORMATION
Please allow my medical information to be shared with the following: (NAME, DOB, RELATIONSHIP)

Current or Previous Primary Care Physician:

Have you had the following vaccines? (check all that apply)

Flu ☐ Shingles ☐ Pneumonia ☐ Hep B ☐ Other ☐
Covid ☐ 2nd ☐ Booster ☐ Tetanus ☐

List ALL the Medications you are currently taking - **Failure to complete correctly may result in being denied any refills for medications not listed:**

Name	**Dose**	**Frequency**

I agree that all of my medications are listed above and understand that failure to complete correctly, that refills may be denied.

I agree to be notified of all health information and test results via text message:
I opt out of text messaging and prefer to be notified by phone:

PAST MEDICAL HISTORY

Condition Year

Do you have, or have you ever had, any of the following:

- Diabetes
- High Blood Pressure
- High Cholesterol
- Hypothyroidism
- Goiter
- Cancer (type)
- Leukemia
- Psoriasis
- Angina
- Urinary Incontinence
- Heart Murmur
- Pneumonia
- Pulmonary Embolism
- Asthma
- Emphysema
- Stroke
- Epilepsy (seizure)
- Cataracts
- Kidney Disease
- Kidney Stones
- Crohn's Disease
- Colitis
- GERD/Heartburn
- Anemia
- Jaundice
- Hepatitis
- Stomach or peptic ulcer
- Tuberculosis
- HIV/AIDS
- Migraine Headaches
- Depression
- Anxiety
- Other

Surgeries: Type Year

Hospitalization History:

Reason Length of Stay Year

Do you use tobacco? YES ☐ NO ☐

Do you drink alcohol? YES ☐ NO ☐

Do you use illicit drugs? YES ☐ NO ☐

Do you eat healthy meals? YES ☐ NO ☐

Do you exercise regularly? YES ☐ NO ☐

Do you take a daily aspirin? YES ☐ NO ☐

If Male:

Date of last PSA

Date of last Colonoscopy

Personal or family history of prostate cancer? YES ☐ NO ☐

Any issues with erectile dysfunction? YES ☐ NO ☐

If Female:

Date of onset of last menses

Date of last PAP Smear

Date of last Mammogram

Date of last Bone Density Scan

Date of last Colonoscopy

Have any of your family had any of the following?

- arthritis
- asthma
- bleeding disorder
- heart disease
- diabetes
- high cholesterol
- hypertension
- lung disease
- mental illness
- osteoporosis
- stroke
- cancer (if yes, what type(s)
- other

List all allergies (if none, check the blank below):

No known allergies

Medications

Foods

Other

I acknowledge that I have been provided Allegra Clinic's Notice of Privacy Practices

Signature:

Date:

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Name _____ Date:

MEDICATION REFILL POLICY - I understand that if I have not kept my scheduled appointment and call to request a refill of my medication, a $30 fee will be paid before my medication is sent to the pharmacy. (initials)

NO SHOW AND CANCELLATION POLICY
I understand that if i fail to show up for my appointment without a 24 hour notice, I may be subject to a "no show" fee of $30 that is not billable to insurance. (initials)

FINANCIAL POLICY
I understand that charges incurred for services rendered by Allegra Family Clinic are my responsibility, regardless of insurance coverage. I understand and agree that insurance policies are and agreement between the insurance carrier and me; and not between my insurance carrier and Allegra Family Clinic. Furthermore, I understand Allegra Family Clinic will prepare any necessary reports and forms to assist in making collections from my insurance company and that any amount authorized to be paid directly to Allegra Family Clinic will be credited to my account upon receipt.

Assignment will be accepted for all insurance with which Allegra Family Clinic participates. It is my responsibility to provide this office with accurate insurance information and to notify Allegra Family Clinic of any changes in health insurance coverage. If I have any questions on network status/participation with my insurance, it is my responsibility to contact the customer service number on my insurance card.

I understand if any insurance company sends a check or reimbursement to me, THE CHECK DOES NOT BELONG TO ME. I am to bring the check and Explanation of Benefits to Allegra Family Clinic. (initials)

PATIENT RESPONSIBILITY
If my insurance has an office co-payment, co-insurance, or deductible that has not been satisfied, I must pay this at the time of my appointment. I understand that charges for professional services rendered are due and payable immediately. Any amount unpaid by my insurance company is my responsibility and is due immediately upon notification on the denial by my insurance company. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. All cost for my care is my responsibility. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect. (initials)

BILLING: KNOW YOUR INSURANCE POLICY
I understand that I am responsible for any rejected claims, non-covered expenses, deductibles, and co-insurance/co-payments. Cash, money order, Visa and MasterCard are acceptable means in which to pay the balance. (initials)

I understand that at times, no matter how diligent Allegra Family Clinic's billing may be, my insurance company might decline a claim for services. In that event, it is most effective for me to contact the insurance company since I am their paying customer. Allegra Family Clinic's billing department will be glad to assist me, but I may be asked to intervene as this is the most effective means of settling dis-putes with my insurance company. If there remains an unpaid balance and I make no payment or make no contact as the responsible party despite all Allegra Family Clinic's effort to contact me, then I understand that my account could be turned over to collections or pursued legally.

Informing our patients about our financial policy assists us providing the best service to our patients. Thank you for taking the time to read this statement. Should you have any further questions, or comments, please kindly contact our Business Office Supervisor.

I hereby understand the financial policy of this practice. I guarantee payment of all charges incurred for the account of the patient names below. I further agree to pay any attorney's fees, court costs, and related collection fees incurred. I also agree that my employer may be contacted to verify employment status.

Patient's Name/Signature Date

Guarantor/Responsible Party Signature Date