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

PLEASE PRINT CLEARLY

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)
_____
_____
_____
_____
_____

Have you had the following vaccines? (check all that apply)
Flu ☐ Shingles ☐ Pneumonia ☐ Hep B ☐ Other ☐
Covid ☐ 2nd ☐ Booster ☐ Tetanus ☐
List the Medications you are currently taking:
Name Dose Frequency
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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

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
_____ Heart Problems
_____ 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 _____

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 $20 that is not billable to insurance.

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.

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.

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.

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 disputes 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 efforts to contact me, then my account could be turned over to collections or pursued legally.

Informing our patients about our financial policy assists us in providing the best service to our patients. Thank you for taking the time to read this policy statement. Should you have 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 _____