



Fabian Berru, MD
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Newborn Intake Paperwork

Patient's Name: _____

Date of Birth: _____ Sex: Male _____ Female _____

Address: _____

City: _____ State: _____ Zip: _____

Responsible Party Information:

Name: _____

Date of Birth: _____ Sex: Male _____ Female _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Pharmacy: _____

Email: _____

Patient Lives With: (ie. Both parents, Mother, Father, Relatives, Adoptive parents, Foster parents, other) _____

Birth History:

Birth Measurements: _____ lb _____ oz _____ in Length of Pregnancy: _____ weeks

Emergent? Yes ___ No ___ Type of Delivery: (ie. Vaginal, c-section, forceps) _____

Birth Hospital: _____

Any Complications During Pregnancy: _____

Feeding/Nutrition:

- ☐ Breastfeeding
- ☐ Formula
- ☐ Both/Combination

Is the patient on any current medications? If so, please list:

Are you planning for your child to receive routine vaccines according to the recommended schedule? Yes_____ No_____ Unsure_____

Family Medical History: (Please limit to parents, grandparents, siblings, aunts/uncles ONLY)

Check all that apply:

- ☐ Alcohol/Drug abuse
- ☐ Asthma
- ☐ Birth Defects
- ☐ Blood Disorders
- ☐ Bone Disorders
- ☐ Cancer
- ☐ Lung Disease
- ☐ Intellectual Disability
- ☐ Metabolic Disorders
- ☐ Neurologic Disease
- ☐ Psychiatric Disorders
- ☐ Seizures or Epilepsy
- ☐ Diabetes
- ☐ Skin Disease
- ☐ Heart Disease
- ☐ Smoker/Tobacco Use
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Kidney or Bladder Disease
- ☐ Thyroid
- ☐ Unexplained or Early Deaths in the Family
- ☐ Other _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Integra Family Medicine's Notice of Privacy Practices or have had the opportunity to receive the Notice of Privacy Practices.

Patient Name (Printed)

Signature: _____

Date: _____

RELEASE OF INFORMATION AUTHORIZATION:

Due to federal privacy guidelines (HIPAA), Integra Family Medicine is not allowed to divulge information to anyone other than the patient (or guardian of the patient) unless explicit written authorization is given to discuss personal medical information with someone other than you.

I, _____, give Integra Family Medicine permission to release / discuss personal medical information to include the pickup of prescriptions and / or financial information to:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

GUARANTEE OF ACCOUNT: MUST BE 19 YEARS OF AGE TO SIGN

I, the undersigned, directly assign to Integra Family Medicine all surgical and / or medical benefits, if any, otherwise payable to me for services rendered.

In consideration of services rendered or to be rendered, the undersigned agrees to pay all costs of collection and / or reasonable attorney fees, should the account be turned over to enforce collections of said charges. The undersigned hereby waives all claims or rights of exemption allowed by the constitution of the state of Alabama or any other state of the United States.

I hereby authorize Integra Family Medicine to release any information necessary to secure payment of benefits to my account.

Signature: _____ Date: _____

May we leave voicemails on the numbers you've provided? ____ Yes ____ No

Comments: _____

Medical Records Release

Please Print

Patient Name: _____ Date of Birth ____ / ____ / ____
Address: _____ City: _____ Zip: _____
Phone Number: _____

Release Information from Integra Family Medicine to:

Name / Facility: _____ Attention: _____
Address: _____ City: _____ Zip: _____
Phone Number: _____ Fax Number: _____
Purpose of Request: ☐ Personal ☐ Treatment ☐ Legal ☐ Insurance ☐ Transfer
☐ Other: _____

Release Information to Integra Family Medicine from: Please Fax to 833.468.5230

Name / Facility: _____ Fax Number: _____
Date Range: _____
☐ Progress Notes ☐ Radiology Reports ☐ Labs ☐ Operative Reports ☐ Injections/Immunizations
☐ Physical Therapy ☐ Discharge summary ☐ Billing Statement
☐ Other: _____

Release Information to Integra Family Medicine from: Please Fax to 833.468.5230

I understand that: I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information. * _____ (Please Initial)

- ✓ I may refuse to sign this authorization and that it is strictly voluntary.
- ✓ My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
- ✓ I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
- ✓ Unless otherwise revoked, this authorization will expire on the following date, event or condition:
_____.
If I do not specify expiration this authorization will not expire.
- ✓ I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.
- ✓ I understand that I may see and obtain a copy of the information described in this form, for a reasonable copy fee, if I ask for it.
- ✓ I can request a copy of this form after I sign and date it.

Signature*: _____ Today's Date: ____ / ____ / ____

Office Policies

As a patient, you are ultimately responsible for your own care. This can be exhibited by knowing what medications you are taking and why, arriving on time for appointments, completing labs and tests that are ordered by your physician, and obtaining refills/completing paperwork in a timely manner. We will do our best to ensure we do our part by keeping you informed and complete your orders and prescriptions in a timely manner at your visit.

- _____ Fees—Patients are expected to pay all co-pays at the time of your visit.
- _____ Nurse calls and questions—Any non-scheduling questions will be routed to the nurse line. Please leave a message with the requested information and we will return your call within one business day.
- _____ Appointment times—Please arrive on time or early for your scheduled appointment. If you are late, you may be asked to reschedule.
- _____ Cancellations—Except under extenuating circumstances, we request you give at least 24 hours of notice when cancelling an appointment. Failure to do so will cause any missed appointments to be considered as a “no show”.
- _____ No show policy/Rescheduling—Patients that “no show” for 3 appointments are subject to dismissal from our practice for non-compliance. If you no show for appointment, you may be subject to a \$50 fee. This will be collected before you are allowed to reschedule your appointment.
- _____ Conduct—Verbal or physical abuse of our physician or staff will NOT be tolerated for any reason or under any circumstance.
- _____ Form completion—There is a 5 business day turnaround time for FMLA or other forms needing completion. There is a \$25 charge per form.
- _____ Medication refills—refills need to be requested at least 3 days in advance. Ideally, these will be handled during your routine visits, but if you realize your medication needs to be refilled you may call and leave a message with the nurse requesting a refill.

I understand and agree to these policies:

Signature: _____ **Today's Date:** ____ / ____ / ____

Must be signed by patient or legal guardian if patient is a minor.