UAB MEDICINE
RUSSELL MEDICAL CANCER CENTER

PLEASE COMPLETE ALL INFORMATION

Name: _____ DOB: _____

Street Address: _____ City: _____ State: _____ ZIP _____

Mailing Address if Different: _____ Nursing Home: No Yes

Home Phone: _____ Cell Phone: _____ Other: _____

Social Security Number: _____ Email: _____

Primary Language: _____ Language of preference for discussing health care: _____

Next of Kin: _____ Relationship: _____ Phone: _____

Person to notify in case of an emergency if different from above: _____

Relationship: _____ Phone _____

I consent to a photograph of my face for identification purposes.
I consent to and understand my medical information may be discussed in a medical Multidisciplinary setting for education and or treatment plan development purposes.

For Alabama full Medicaid Recipients: I hereby **authorize** UAB Medicine Russell Medical Cancer Center to submit, on my behalf, requests to the Non Emergency Transportation Program for any eligible benefits.

Agreement to Pay: I, the undersigned, do **agree** to pay for services rendered by UAB Medicine Russell Medical Cancer Center. I agree to pay reasonable attorney's fees if it becomes necessary to use attorney services for collection of this account.

I hereby **authorize** UAB Medicine Russell Medical Cancer Center to furnish information, including X-Ray copies to insurance carriers and referring physicians concerning my treatments.

I hereby **assign** to UAB Medicine Russell Medical Cancer Canter all payments for medical services rendered to my dependents or myself. I understand I am responsible for any amount not covered by insurance.

_____ Date: _____
Patient or Patient Representative / Relationship

Reason patient unable to sign: _____

Authorization for Release of Information
Russell Medical Center
Alexander City, Alabama

Account #: _____

Medical Record #: _____

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand this authorization is voluntary. I understand if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Date of Request:	
Patient Name:	Date of Birth:
Requestor:	Relationship:

DISPOSITION

Pick Up ( )	Fax ( ) No.	Email ( ) Address:
Mail ( ) Address:		
Other ( ) Describe		

PURPOSE OF THE REQUEST

( ) At the request of the individual	( ) Other healthcare provider (specify)
( ) Other	Specify

MEDIA PROVIDED

( ) Paper copies	( ) CD	( ) Flash Drive	( ) Email ( ) Encrypted Email	Other(Specify)

DATES TO BE RELEASED

From	To	( ) Not limited

INFORMATION REQUESTED

( ) Anesthesia Report	( ) Bill(s)	( ) Blood Type	( ) Complete Record	( ) Consultation Report
( ) Discharge Sum	( ) Echocardiogram	( ) EKG	( ) ED Report	( ) History/Physical
( ) Immunization	( ) Laboratory	( ) Medication Rept	( ) Operative Report	( ) Physician Orders
( ) Procedure Note	( ) Profile	( ) Progress Notes	( ) Radiology Report	( ) Registration Form
( ) DRUG SCREEN	( ) Marketing	( )	( )	( )

INFORMATION MAY BE RELEASED TO: (LIST INDIVIDUALLY)

Understandings:

1. I understand I may revoke this authorization in writing at any time except to the extent where information has previously been disclosed.
2. I understand this consent may include disclosure of records related to treatment of Alcohol Abuse, Drug Abuse, Psychiatric Disorders, Sexually Transmitted Disease, HIV/AIDS.
3. I understand the information used pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal Law.
4. I understand this authorization will expire upon completion of the requested information.
5. I understand my health care and the payment for my healthcare will not be affected if I do not sign this form.
6. I understand I may receive a copy of this form upon request.

I, the undersigned, authorize Russell Medical Center to release information from my records.

_____ _____

Signature of patient (or representative if patient less than age 14) **Date**

FOR RUSSELL MEDICAL CENTER USE ONLY:

Date Received:	Date Completed:	Charge $	Paid
Processed by:			
PHI REVIEWED WITH	NAME	OTHER	
DATE/TIME	STAFF ASSISTING		

Medicaid Notified ( )Yes ( )No ( ) Not applicable

UAB MEDICINE
RUSSELL MEDICAL CANCER CENTER

Review of Systems

Patient Name: _____ **Date of Birth:** _____

Please check the symptoms that apply

CONSTITUTIONAL
- ☐ Fever
- ☐ Chills
- ☐ Change in weight
- ☐ Fatigue
- ☐ Malaise
- ☐ Night Sweats
- ☐ Change in sleep patterns
- ☐ Other:

EYES
- ☐ Change in vision
- ☐ Blurry Vision
- ☐ Eye Discomfort
- ☐ Other:

EARS/NOSE/MOUTH/THROAT
- ☐ Throat pain
- ☐ Neck pain
- ☐ Tinnitus
- ☐ Difficulty Swallowing
- ☐ Nose Bleeds
- ☐ Hoarseness
- ☐ Mouth pain
- ☐ Other:

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Palpitations
- ☐ Edema
- ☐ Shortness of breath with exertion
- ☐ Shortness of breath lying down
- ☐ Other:

ENDOCRINE
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Other:

RESPIRATORY
- ☐ Shortness of breath
- ☐ Cough
- ☐ Wheezing
- ☐ Coughing up blood
- ☐ Other:

GASTROINTESTINAL
- ☐ Abdominal pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Difficulty swallowing
- ☐ Blood in stool
- ☐ Other:

GENITOURINARY
- ☐ Painful urination
- ☐ Urinary frequency
- ☐ Urinary urgency
- ☐ Blood in urine
- ☐ Difficulty urinating
- ☐ Other:

SKIN
- ☐ Rash
- ☐ Itching
- ☐ Redness
- ☐ Jaundice
- ☐ Other:

BREAST
- ☐ Breast pain
- ☐ Breast swelling
- ☐ Nipple discharge
- ☐ Mass
- ☐ Change in shape
- ☐ Other:

MUSCULOSKELETAL
- ☐ Back pain
- ☐ Neck pain
- ☐ Extremity pain
- ☐ Extremity swelling
- ☐ Joint pain
- ☐ Limited range of motion
- ☐ Joint swelling
- ☐ Muscle cramps
- ☐ Muscle weakness
- ☐ Other:

HEMATOLOGIC/LYMPHATIC
- ☐ Easy bruising
- ☐ Easy bleeding
- ☐ Enlarged lymph nodes
- ☐ Other:

NEURO
- ☐ Headache
- ☐ Numbness
- ☐ Weakness
- ☐ Lack of coordination
- ☐ Dizziness
- ☐ Confusion
- ☐ Behavioral changes
- ☐ Other:

PSYCH
- ☐ Anxiety
- ☐ Depression
- ☐ Other:

Date:

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Name:_____ Date of Birth: _____

Reason for Consult : _____

Referring Physician: _____ Primary Physician: _____

Surgeon: _____ Other Physicians: _____

Name of Medication	Dose	Frequency	Date Started	Ordering Physician

Please bring all medications to your first visit

ALLERGIES

Food	Drug	Other	Reaction

SUPPORT SYSTEMS

- ☐ Lives with Spouse
- ☐ Lives with Family Member
- ☐ Lives Alone
- ☐ No Support System
- ☐ Lives in Nursing Home
- ☐ Lives in assisted living
- ☐ Incarcerated
- ☐ Homeless

SOCIAL HISTORY

Tobacco Use

# Years	# Packs per Day	Years Quit

Alcohol Use

# Days per Week	# Drinks per Day	Years Quit

Hazardous Materials

☐ Contact	☐ No Contact	☐ Unknown
☐	☐	☐

(This includes: asbestos, benzene, lead, radiation, other petroleum products, etc.)

Products

- ☐ Cigarettes
- ☐ Cigar
- ☐ Chewing Tobacco
- ☐ Pipe Snuff
- ☐ Recreational drug use
- ☐ Illicit drug use

Activities: _____

Nutrition:

☐ Regular Diet	☐ Nutritious Diet	☐ Liquid Diet
☐ Diabetic Diet	☐ Vegetarian Diet	

FAMILY HISTORY

	Alive / Deceased	Age at Death	Cause of Death
Mother			
Maternal Grandmother			
Maternal Grandfather			
Father			
Paternal Grandmother			
Paternal Grandfather			
Brother			
Sister			
Children			
Children			

MEDICAL HISTORY

Please indicate the date of diagnosis and type of treatment

Anxiety	Depression	Hepatitis A	Diabetes Type I
Asthma	Kidney Stone	Hepatitis B	Diabetes Type II
Atrial Fibrillation	Melanoma	Hepatitis C	Hyperlipidemia
Cancer	Obesity	Hyperthyroidism	Hypertension
COPD	Osteopenia	Thalassemia	Stroke
Osteoarthritis	Seizure	Osteoporosis	Thrombocytosis
Benign Prostatic Hypertrophy	Congestive Heart Failure	Coronary Artery Disease	Peripheral Neuropathy

Please note when diagnosis made and what treatment received for problem

_____

_____

_____

SURGICAL HISTORY

Please indicate the date of procedure

Bone Marrow Biopsy	Appendectomy	Breast Implant	C-Section
Gallbladder	Breast Biopsy	Hernia Repair	Implanted Defib.
Hysterectomy	Colonoscopy	Laminectomy	Cholecystectomy
Coronary Artery Bypass	Intubation	Back Surgery	Cataract Removal
Lumbar Puncture (Diag)	Mammoplasty	Mastectomy	Pacemaker
Lumbar Puncture (Ther)	Thoracentesis	Tonsillectomy	Tubal Ligation
TURP	Prostate Surgery	Vasectomy	Paracentesis

ACTIVITES

☐ Sedentary	☐ Daily Activities	☐ Occasional Exercise
☐ Light Exercise	☐ Regular Exercise	☐ Extensive Exercise

TREATMENT

	Age	Date	Location
Radiation Therapy			
Chemotherapy			

MENSES

Menses Start Age	
Last Menstrual Period	
Menstrual Cycle Length	

PREGNANCIES

Grava	
Para	
Age at first birth	
# interrupted pregnancies	

MENOPAUSE STATUS	MENOPAUSE DETAILS	HORMONE USE
☐ Pre ☐ Peri ☐ Post ☐ Unknown	Age at Menopause :	Contraceptive Hormone # Years ____
	Reason:	Post Menopausal Use # Years _____
	☐ Natural ☐ Chemotherapy	Other Hormone Use # Years ____
	☐ Ovary Removal ☐ Other	

Date of Last Mammogram		**Date of Last Pap Smear**	

UAB MEDICINE
RUSSELL MEDICAL CANCER CENTER

Cancellation / Missed Appointment Policy

Our goal is to provide quality medical care that is delivered in a timely manner. To achieve this goal, we have implemented a Cancellation/Missed Appointment Policy. This policy enables us to utilize available appointments for our patients needing immediate care.

Cancellation of an Appointment:

In order to be mindful of the medical needs of other patients, please call the office promptly if you are unable to attend an appointment. If it is necessary to cancel your appointment, we ask that you please call the clinic 24 hours in advance. To cancel your appointment, please call 256-329-7888, Monday-Friday between the hours of 8:00am and 4:30pm.

No-Show Policy:

A No-Show is a patient who misses an appointment without calling the clinic to notify us of cancellation. "No-Shows" can negatively impact other patients who need access to care in a timely manner, as well as the physician. A failure to show up at your scheduled appointment time will be recorded in your chart.

***after two "No-Shows" or cancellations of an appointment, permission must be granted by the Physician before the appointment can be rescheduled. After 3 "No-Shows", you could be dismissed from the practice.**

- Note: if a new patient reschedules or "No-Shows" more than two times, we will require a new referral from your referring physician to reschedule this appointment.
- Any appointments rescheduled by the clinic will not be counted against the patient.
- Extraordinary circumstances will be taken into consideration.

Late Arrival Policy:

To ensure that we see everyone in a timely manner, it is very important to arrive on time for your appointment. This allows us to keep to schedule and deliver patient care efficiently.

If you are more than 10 minutes late for your appointment, your appointment will have to be rescheduled. We will do our best to get you in as soon as possible, but it may not be on the same day as your original appointment.

I understand the policy outlined above:

Patient or responsible party: _____ Date: _____

Printed Name: _____

Authorization for Release of Information
Russell Medical Center
Alexander City, Alabama

Account #: _____

Medical Record #: _____

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Date of Request:				
Patient Name:			Date of Birth:	
Requestor:		Relationship:		
DISPOSITION				
Pick Up ( )	Fax ( ) No.	Email ( ) Address:		
Mail ( ) Address:				
Other ( ) Describe				
PURPOSE OF THE REQUEST				
( ) At the request of the individual	( ) Other healthcare provider (specify)			
( ) Other	Specify			
MEDIA PROVIDED				
( ) Paper copies	( ) CD	( ) Flash Drive	( ) Email ( ) Encrypted Email	Other(Specify)
DATES TO BE RELEASED				
From	To	( ) Not limited		
INFORMATION REQUESTED				
( ) Anesthesia Report	( ) Bill(s)	( ) Blood Type	( ) Complete Record	( ) Consultation Report
( ) Discharge Sum	( ) Echocardiogram	( ) EKG	( ) ED Report	( ) History/Physical
( ) Immunization	( ) Laboratory	( ) Medication Rept	( ) Operative Report	( ) Physician Orders
( ) Procedure Note	( ) Profile	( ) Progress Notes	( ) Radiology Report	( ) Registration Form
( ) DRUG SCREEN	( ) Marketing	( )	( )	( )

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6. I understand I may receive a copy of this form upon request.

I, the undersigned, authorize Russell Medical Center to release information from my records.

_____ _____

Signature of patient (or representative if patient less than age 14) **Date**

FOR RUSSELL MEDICAL CENTER USE ONLY:

Date Received:	Date Completed:	Charge $	Paid
Processed by:			
PHI REVIEWED WITH	NAME	OTHER	
DATE/TIME	STAFF ASSISTING		

Medicaid Notified ( )Yes ( )No ( ) Not applicable

ADVANCE DIRECTIVE FOR HEALTH CARE

(Living Will and Health Care Proxy)

This form may be used in the State of Alabama to make your wishes known about what medical treatment or other care you **would** or **would not** want if you become too sick to speak for yourself. You are not required to have an advance directive. If you do have an advance directive, be sure that your doctor, family, and friends know you have one and know where it is located.

Section 1. Living Will

I, _____, being of sound mind and at least 19 years old, would like to make the following wishes known. I direct that my family, my doctors and health care workers, and all others follow the directions I am writing down. I know that at any time I can change my mind about these directions by tearing up this form and writing a new one. I can also do away with these directions by tearing them up and by telling someone at least 19 years of age of my wishes and asking him or her to write them down.
I understand that these directions will only be used if I am not able to speak for myself.

If I become terminally ill or injured:

Terminally ill or injured is when my doctor and another doctor decide that I have a condition that cannot be cured and that I will likely die in the near future from this condition.

Life sustaining treatment – Life sustaining treatment includes drugs, machines, or medical procedures that would keep me alive but would not cure me. I know that even if I choose not to have life sustaining treatment, I will still get medicines and treatments that ease my pain and keep me comfortable.

Place your initials by either "yes" or "no": I want to have life sustaining treatment if I am terminally ill or injured. ____ Yes ____ No

Artificially provided food and hydration (Food and water through a tube or an IV) – I understand that if I am terminally ill or injured I may need to be given food and water through a tube or an IV to keep me alive if I can no longer chew or swallow on my own or with someone helping me.

Place your initials by either "yes" or "no":

I want to have food and water provided through a tube or an IV if I am terminally ill or injured.
____ Yes ____ No

If I Become Permanently Unconscious:

Permanent unconsciousness is when my doctor and another doctor agree that within a reasonable degree of medical certainty I can no longer think, feel anything, knowingly move, or be aware of being alive. They believe this condition will last indefinitely without hope for improvement and have watched me long enough to make that decision. I understand that at least one of these doctors must be qualified to make such a diagnosis.

Life sustaining treatment – Life sustaining treatment includes drugs, machines, or other medical procedures that would keep me alive but would not cure me. I know that even if I choose not to have life sustaining treatment, I will still get medicines and treatments that ease my pain and keep me comfortable.

Place your initials by either "yes" or "no":
I want to have life-sustaining treatment if I am permanently unconscious. ____ Yes ____ No

Artificially provided food and hydration (Food and water through a tube or an IV) – I understand that if I become permanently unconscious, I may need to be given food and water through a tube or an IV to keep me alive if I can no longer chew or swallow on my own or with someone helping me.

Place your initials by either "yes" or "no":

I want to have food and water provided through a tube or an IV if I am permanently unconscious.
____ Yes ____ No

Other Directions: Please list any other things you want **done** or **not done.**

In addition to the directions I have listed on this form, I also want the following:

_____

_____

_____

_____

If you do not have other directions, place your initials here:

____ No, I do not have any other directions.

Section 2. If I need someone to speak for me.

This form can be used in the State of Alabama to name a person you would like to make medical or other decisions for you if you become too sick to speak for yourself. This person is called a health care proxy. You do not have to name a health care proxy. The directions in this form will be followed even if you do not name a health care proxy.

Place your initials by only one answer:

_____ I **do not** want to name a health care proxy. (If you check this answer, go to Section 3)

_____ I **do** want the person listed below to be my health care proxy. I have talked with this person about my wishes. I want him/her to make health care decisions for me in non-terminal situations in which I am unable to make or communicate decisions for myself, as well as those in which I am terminally ill or prematurely unconscious. Even though my Proxy may only make decisions for me when I am not able to do so, I specifically intend for him/her to have immediate access to my protected health information and I designate him/her as my "personal representative" as defined by 45 CFR §164-502 (HIPAA), and authorize him/her to have the same access to my protected health information as I would myself, including but not limited to viewing records, requesting and obtaining copies thereof, and executing releases as may be required. I further authorize and direct covered entities to provide my Proxy/Health Care Agent/Personal Representative with the same access to my protected health information as I would have myself. I intend this authority to remain in full force and effect until my death unless earlier revoked by me. This Power of Attorney shall not be affected by my disability, incompetency, or incapacity and grants to my proxy the authority to make health care decisions for me as defined in Section 26-1-2 of the Code of Alabama 1975.

First choice for proxy: _____

Relationship to me: _____

Address: _____

City: _____ State _____ Zip _____

Day-time phone number: _____

Night-time phone number: _____

If this person is not able, not willing, or not available to be my health care proxy, this is my next choice:

Second choice for proxy: _____

Relationship to me: _____

Address: _____

City: _____ State _____ Zip _____

Day-time phone number: _____

Night-time phone number: _____

Instructions for Proxy

Place your initials by either "yes" or "no":

I want my health care proxy to make decisions about whether to give me food and water through a tube or an
IV. ____ Yes ____ No

Place your initials by only one of the following:

____ I want my health care proxy to follow only the directions as listed on this form.

_____ I want my health care proxy to follow my directions as listed on this form and to make any decisions about things I have not covered in the form.

_____ I want my health care proxy to make the final decision, even though it could mean doing something different from what I have listed on this form.

Section 3. The things listed on this form are what I want.

I understand the following:

- If my doctor or hospital does not want to follow the directions I have listed, they must see that I get to a doctor or hospital who will follow my directions.

- If I am pregnant, or if I become pregnant, the choices I have made on this form will not be followed until after the birth of the baby.

- If the time comes for me to stop receiving life sustaining treatment or food and water through a tube or an IV, I direct that my doctor talk about the good and bad points of doing this, along with my wishes, with my health care proxy, if I have one, and with the following people:

_____

_____

Section 4. My signature

Your name: _____

The month, day, and year of your birth: _____

Your signature: _____

Date signed: _____

Section 5. Witnesses (need two witnesses to sign)

I am witnessing this form because I believe this person to be of sound mind. I did not sign the person's signature, and I am not the health care proxy. I am not related to the person by blood, adoption, or marriage and not entitled to any part of his or her estate. I am at least 19 years of age and am not directly responsible for paying for his or her medical care.

Name of first witness: _____

Signature: _____

Date: _____

Name of second witness: _____

Signature: _____

Date: _____

Section 6. Signature of Proxy

I, _____, am willing to serve as the health care proxy.

Signature: _____ Date: _____

Signature of Second Choice for Proxy:

I, _____, am willing to serve as the health care proxy if the first

choice cannot serve. Signature: _____

Date: _____