ALAN J. BERLIN, M.D.
214 MITYLENE PARK DRIVE
MONTGOMERY, ALABAMA 36117

LAST NAME _____ FIRST NAME _____ MI _____

ADDRESS _____ CITY _____ STATE ____ ZIP CODE _____

MAILING ADDRESS: _____ CITY _____ STATE ____ ZIP CODE _____

SS# _____-____-_____ HOME # _____ WORK# _____

SEX: MALE/ FEMALE CELLULAR# _____ E-MAIL _____

DATE OF BIRTH: MONTH _____ DAY _____ YEAR _____ AGE _____ DRIVER'S LICENSE # _____

MARITAL STATUS **(CIRCLE ONE):** SINGLE/MARRIED/WIDOW/DIVORCED

PHARMACY NAME:_____ PHONE # _____ ADDRESS _____

SPOUSE'S NAME _____ EMPLOYER _____ WORK#_____

RELATIVE/FRIEND: _____ PHONE#_____ WORK#_____

FOR EMERGENCY CALL: _____ PHONE#_____ WORK#_____

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INSURANCE INFORMATION

PRIMARY INSURANCE: _____ POLICY # _____ GROUP# _____

NAME OF SUBSCRIBER: _____DATE OF BIRTH_____ SUBSCRIBER'S SS# _____

RELATIONSHIP TO PATIENT: **(CIRCLE ONE)** SELF / SPOUSE / CHILD / OTHER

SECONDARY INSURANCE: _____ POLICY# _____ GROUP# _____

NAME OF SUBSCRIBER: _____ DATE OF BIRTH _____ SUBSCRIBER'S SS# _____

RELATIONSHIP TO PATIENT: **(CIRCLE ONE)** SELF / SPOUSE / CHILD / OTHER

OTHER INSURANCE: _____ POLICY# _____ GROUP# _____

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EMPLOYER'S NAME _____ OCCUPATION _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE_____

REFERRED BY: _____

****

AUTHORIZATION: I request that payment under Medicare or any other Insurance program be made to ALAN J. BERLIN, M.D. for any charges of services. I also request that the office of Alan J. Berlin, M.D. file for these charges on my behalf and I have provided the appropriate insurance to them. **I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION TO DR. ALAN BERLIN'S OFFICE. I authorize Dr. Berlin's office to release any information necessary for medical or insurance purposes**. I understand that **I AM PERSONALLY RESPONSIBLE** for all charges incurred, whether or not these charges are covered by my insurance. I understand that **PAYMENT IS DUE AT THE TIME OF SERVICE** and that Dr. Berlin's office is under no obligation to file for said insurance. If for any reason the account becomes delinquent, I agree to pay all refilling (late) charges, interest, collections and/or court costs and reasonable legal fees. **CHARGES ON ANY ACCOUNT OVER THIRTY (30) DAYS FROM DATE OF SERVICE RENDERED SHALL ACCRUE AT 1 ½ % PER MONTH (18).**

DATE _____ PATIENT/RESPONSIBLE PARTY _____

ALAN J. BERLIN, M.D.
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NAME _____ DATE _____

PAST MEDICAL HISTORY HAVE YOU EVER HAD? **(CIRCLE YES OR NO)**

DIABETES .....Yes No
HEART PROBLEMS .....Yes No
HIGH BLOOD PRESSURE.....Yes No
SEIZURES OR STROKES..... Yes No
LIVER DISEASE..... Yes No
AIDS/HIV OR HEPATITIS.....Yes No
ULCER PROBLEMS.....Yes No
BLOOD IN URINE/STOOL.....Yes No
COUGH.....Yes No
SHORTNESS OF BREATH.....Yes No
CHEST PAIN.....Yes No

LUNG DISEASE.....Yes No
THYROID PROBLEMS.....Yes No
KIDNEY PROBLEMS .....Yes No
BLEEDING DISORDERS.....Yes No
CANCER.....Yes No
NERVOUS CONDITION.....Yes No
HIATAL HERNIA.....Yes No
SLEEP APNEA.....Yes No
URINARY INCONTINENCE.....Yes No
ARTHRITIS.....Yes No
OTHER _____

****

HAS ANYONE IN YOUR FAMILY EVER HAD? **(CIRCLE YES OR NO)**

HEART PROBLEMS..... Yes No
DIABETES.....Yes No
CANCER.....Yes No

TB.....Yes No
HEPATITIS.....Yes No
AIDS/HIV.....Yes No

****

SURGERIES YOU HAVE HAD IN THE PAST: DATE OF LAST COLONOSCOPY _____

_____

_____

****

LIST ANY HOSPITALIZATIONS THAT WERE NON-SURGERY RELATED:

_____

****

ARE YOU ALLERGIC TO ANY DRUGS OR OTHER KNOWN ALLERGIES? YES /NO
IF YES, WHAT ARE THEY AND WHAT SYMPTOMS DO YOU HAVE?

_____

_____

****

ARE YOU ALLERGIC TO PENICILLIN? (CIRCLE ONE) YES / NO
CAN YOU TAKE KEFLEX? (CIRCLE ONE) YES / NO / NEVER TAKEN IT

****

MEDICATIONS YOU NOW TAKE: (INCLUDE DOSAGES) ASPIRIN _____

_____

_____

_____

****

DO YOU SMOKE? YES NO HOW MUCH? _____ HOW LONG? _____
DO YOU DRINK ALCOHOL? YES NO HOW MUCH? _____ HOW LONG? _____

I ACKNOWLEDGE THAT THE ABOVE INFORMATION IS CORRECT.

_____
PATIENT/GUARDIAN

ALAN J. BERLIN, M.D.
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Name _____ Date _____

Have you had any of the following during the **past three months**? **(PLEASE CIRCLE YES OR NO)**

CONSTITUTIONAL
Good general health lately.....Yes No
Fatigue.....Yes No
Fever .....Yes No
Chills ..... Yes No
Night Sweat .....Yes No
Weight Change .....Yes No
Appetite Change .....Yes No

ENT
Headache .....Yes No
Sinus pain .....Yes No
Hoarseness .....Yes No
Nose bleed .....Yes No

NECK SYMPTOMS
Neck Pain.....Yes No
Neck Stiffness.....Yes No
Lump or swelling in neck.....Yes No

BREAST SYMPTOMS
Breast Lump .....Yes No
Nipple Discharge .....Yes No
Breast Pain.....Yes No
Skin Changes of the breast..... Yes No

RESPIRATORY
Shortness of Breath.....Yes No
Persistent Cough.....Yes No
Coughing up Blood.....Yes No
Wheezing.....Yes No

CARDIOVASCULAR SYMPTOMS
Chest Pain.....Yes No
Palpitations.....Yes No
Fast Heart Rate.....Yes No

GASTROINTESTINAL
Difficulty swallowing .....Yes No
Heartburn .....Yes No
Nausea..... ..Yes No
Vomiting.....Yes No
Abdominal Pain ....Yes No
Black or Bloody Stools.....Yes No
Diarrhea .....Yes No

GENITOURINARY
Blood in urine.....Yes No
Difficulty urinating.....Yes No

MUSCULOSKELETAL
Muscle pain.....Yes No
Joint pain.....Yes No

NEUROLOGICAL
Muscle Weakness.....Yes No
Dizziness.....Yes No

SKIN
Itch.....Yes No
Lesion.....Yes No
Rash.....Yes No

ENDOCRINE
Excessive thirst.....Yes No
Excessive sweating .....Yes No

PSYCHIATRIC
Anxiety.....Yes No
Depression.....Yes No
Sleep problems.....Yes No

NOVEL CORONAVIRUS (COVID-19) SCREENING QUESTIONAIRE

1. Are you having fevers, body aches, headaches, cough, shortness of breath, sore throat or other respiratory symptoms? YES NO

2. Have you traveled outside the United States within the last 14 days to China, Hong Kong, Iran, Italy, Spain, Japan, South Korea or another area where there is known widespread 2019 coronavirus infection? YES NO

3. Does someone in your home or work area, or another close contact have the 2019 Coronavirus infection? YES NO

4. Have you had the COVID-19 Vaccination? YES NO

Patient's name _____ Date _____

Date of birth _____

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MONTGOMERY, ALABAMA 36117
Notice of Privacy Practices Summary

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions about this Notice please contact:
Alan J. Berlin, M. D., Privacy Officer, (334) 244-7874.

This is a summary of our Notice of Privacy Practices which describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. We are required by law to maintain the privacy of your protected health information and to provide you with a notice of our legal duties and privacy with respect to your protected health information. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time, and reserve the right to do so. The new notice will be effective for all protected health information that we maintain at that time.
We will use your protected health information as part of rendering patient care, including treatment, payment and healthcare operations. Other uses and disclosures of you protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.
We may use or disclose your protected health information in certain situations without your authorization or opportunity to agree or object.
You have the right to request a restriction of your protected health information.
You have the right to request to receive confidential communications of your protected health information. You have the right to inspect and copy your protected health information.
You have the right to amend your protected health information.
You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
You have the right to obtain a paper copy of this notice from us.
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.
This summary was published along with the notice of privacy practices.

In addition to myself, I consent to the following adult individuals (spouse, child, friend, etc.) to have access to my medical records:

(PLEASE GIVE FULL NAME AND PHONE NUMBER)

_____

_____

_____

I, _____, acknowledge I have been given the opportunity to read the notice of privacy practices. I understand that I may request a copy of this notice if I so desire.

_____ _____
Signature of Patient/Personal Representative Print Name of Person Signing Form

_____ _____
Date Relationship to Patient

ALAN J. BERLIN, MD.
214 MITYLENE PARK DR
MONTGOMERY, ALABAMA 36117

I, Alan J. Berlin, M.D., have implemented the following policies, in order to better serve our patients. We reserve the right to make changes to these policies without notice, as changes arise. We will make every attempt to provide these changes to our patients as expeditiously as possible. **Your signature below indicates you have read and understand our policies.**

NO SHOW POLICY

We require a 24 hour notice for appointment/surgical cancellation. We shall charge **$25.00** for an **OFFICE VISIT**-no show; **$50.00** for an **ULTRA/SOUND appointment**-no show; **$250.00 for a SURGICAL PROCEDURE**-NO SHOW; and **$10.00 for a X-RAY appointment that has been pre-certed and scheduled**. No show fees **MUST** be paid before you next appointment. No show charges are not covered by your insurance.

PATIENT ASSISTANCE POLICY

In order to meet and comply with our insurance liability, we are unable to lift or assist in lifting patients. Any assistance required must be provided by the patient.

INSURANCE CLAIMS

As a courtesy to our patients, we will file your claim with the insurance information you provide us. In the event this information is incorrect and we re-file your claim there will be a **$30.00** charge (that your insurance company will not pay).

MINOR CHILDERN

Minor children (under the age of 19) must be accompanied by a parent or guardian upon each visit.

DISABILITY FORMS

There is a **$40.00** charge for completion of all disability forms/letters, due at the time of request. There is a $20.00 charge for each additional form. Forms are filled out in the order they are received. Please allow 7-10 business days. We are aware tha everyone needs their forms as soon as possible.

COPY OF MEDICAL RECORDS

The charge for Medical Records is a **$5.00 search fee** and an additional charge of **$1.00 per sheet**.

ORDERS FOR SURGICAL PROCEDURES/TESTS

In the event you fail to carry the **yellow sheet/orders** for your surgery/test with you to the hospital you will be charged **$25.00**.

DATE_____ PATIENT /GUARDIAN _____