Philip J. Fischer II, M.D., P.C.

Patient Information

Last Name		First Name		Middle Name
Sex	Last 4 Digits SS #	Marital Status		Date of Birth
Race	Language	Pharmacy Name & Number		Referring MD
Address		City	State	Zip Code
Home #		Cell#		Work #
Email				
Occupation		Employer		
Emergency Contact		Phone #		Relationship

Payment is due from the patient at the time that services are rendered.

The patient is responsible for payment and not the insurance company. We will file claims for any insurance coverage for which we are a participating provider; however, co-payments, deductibles and non-covered charges must be paid at the time that the services are rendered. If there are any questions regarding payment/insurance filing policies, please see one of the office staff at this time to make any necessary arrangements.

AGREEMENT TO PAY: The undersigned agrees to payment of all charges for services provided both before and after the date of the agreement and promises to pay said fee including the cost of collection, attorney fees and court costs, if such be necessary, waiving now and forever the right to claim exemption under the constitution and laws of the State of Alabama or any other state. The undersigned understands that accounts may be referred to an outside collection agency if the balance remains unpaid for sixty days unless alternate arrangements have been made and followed.

LIFETIME MEDICARE B SIGNATURE MEDIGAP AUTHORIZATION: I hereby authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, or to the billing agent of the Center, or Medigap insurer, any information needed for this claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical benefits to be made to the holder of this assignment on my behalf. I understand that I am responsible for any health deductibles and co-insurance. I understand that I do not need to provide my supplemental insurer with information concerning this Medicare claim, because my signing will cause payments to cross over automatically.
_____ (INITIALS)

EXPRESS PRIOR CONSENT TO CONTACT CONSUMER BY CELL PHONE: You agree, in order for us to service your account or to collect monies you may owe Philip J. Fischer II, M.D., P.C. and/or agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing devices, as applicable. I/We have read this disclosure and agree that Philip J. Fischer II, M.D., P.C., its employees and/or agents may contact me/us as described as above.

Signature of Responsible Party: _____

Date: _____

Philip J. Fischer II, M.D., P.C.

Patient History and Physical

Date: _____

Name: _____

Date of Birth: _____ Age: _____ Height _____ Weight _____

Referring Doctor: _____ Primary Doctor_____

Reason for visit: _____

DRUG ALLERGIES: _____

Latex Allergy: yes no

Past Medical History (Please circle all that apply)

High Blood Pressure Heart disease Stroke Asthma Sleep Apnea
Kidney/Bladder disease Hepatitis HIV/AIDS Diabetes
Seizure Cancer of _____
Thyroid Disease Other: _____

Past Surgical History (include year of procedures, if known)

_____ _____
_____ _____
_____ _____

Current Medications (Include over-the-counter)

_____ _____
_____ _____
_____ _____

Bleeding History YES NO

Family History

	Mother	Father	Siblings	Grandparents	Children
High Blood Pressure					
Liver Disease					
Heart Disease					
Ulcers					
Diabetes					
Thyroid Disease					
Kidney Disease					
Cancer					
Other					

Social History (Please circle)

Smoke _____ packs per day for _____ years

Alcohol _____ use for _____ years

Marital Status: Married Single Divorced Widowed

Occupation: _____

Review of Symptoms: (*Please circle all that apply)*

Constitutional: Weight Loss Weight Gain Fevers

Skin: Skin Infection Bruising Rash

Non-healing wounds Skin Disease

Eyes: Decreased Vision Glasses

ENT: Deafness Sore Throat Ringing in ears

Nose Bleed Hoarseness Nasal Drainage

Cardiac: Palpitations Chest pain Shortness of breath

Fatigue Swelling in feet/legs

Respiratory: Cough Production of sputum Wheezing Snoring

GI: Painful swallowing Nausea Vomiting Diarrhea

Vomiting Blood Constipation Indigestion Change in BMs

Tarry Stools Yellow jaundice Bloody stools

Muscle/Bone: Weakness Trauma Limited motion Bone/Joint Deformity

Neuro: Paralysis Weakness Seizure Fainting

Tension Headache Migraine Incoordination Head Trauma

Numbness/Tingling in extremities

Hematology: Swollen Lymph Nodes Bleeding Disorders

Psych: Anxiety Depression Hallucinations

Review of Systems (continued - ALL PATIENTS):

Endocrine: Change of appetite Excessive thirst/Urination

Goiter

Immune: Immune disorders Immunosuppression

Covid-19 Vaccine: Yes No 1st vaccine Date: _____ 2nd Vaccine Date:_____

Flu Vaccine: Yes No Date_____

Pneumonia Vaccine: Yes No Date_____

FEMALES ONLY: ***(circle all that apply)***

Breast: Lumps Pain Nipple Discharge

GYN: Hormone Therapy Menopause Hysterectomy Removal of ovaries

Signature: _____ Date: _____

CONSENT AND ACKNOWLEDGEMENT

Philip J. Fischer II, M.D., P.C.

800 St. Vincent's Drive, Suite 630

Birmingham, Alabama35205

(PLEASE PRINT)

Patient Name_____ Date of Birth:_____

Patient Address_____ Last 4 number of SS#:_____

I give Philip J. Fischer II M.D., P.C. permission to release medical information to the following persons:

None _____

Parents_____ Spouse_____

Father (only) _____ Mother (only)_____

Other _____ Guardian_____

I wish to be contacted in the following manner by Philip J. Fischer II, M.D., P.C.
(Check or circle all that apply):

Home Telephone_____ Email _____

Cell _____ Work _____ Written Communication _____

_____OK to leave message with detailed information _____ OK to email to following email address

_____ Leave message with call back number only _____ OK to mail to home address

The Privacy Act generally requires healthcare providers to take responsible steps to limit the use and disclosure of and requests for protected health information to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of protected health information disclosures. Information provided below, if completed properly, will constitute an adequate record

NOTE: Uses and disclosures for protected health information may be permitted without prior consent in an emergency.

ACKNOWLEDGMENTS
I acknowledge that I have received Philip J. Fischer II, M.D.,P.C. Notice of Privacy Practices.

_____

Signature of Patient or Personal Representative Date ☐

_____

Relationship of Personal Representative to the Patient Signature of Witness

Print Personal Representative's Name _____

Philip J. Fischer II, M.D., P.C.
General Surgery

Welcome to our clinic. We are here to serve you. If you have any questions or concerns, please discuss them with our office manager.

Your co-pay is due at the time services are rendered. Co-pays are due EVERY visit unless we have recently performed your surgery.

If it is required, your insurance referral must be in the office at the time of your visit. If we do not have your insurance referral, we will have to reschedule your appointment.

Routine prescriptions will not be called in after hours or on weekends. Please call ahead to have your refills called in to your Pharmacy. We cannot call in narcotic pain medications. A written prescription is required for narcotic pain medication.

$25.00 charge for all FMLA/Short term Disability forms.

ATTENTION

There will be a $150.00 fee charged for any surgery cancelled or rescheduled by the patient within 48 hours of the scheduled surgery. The same fee applies if you do not show up for your scheduled surgery.

* Please update any information changes *

By signing this form I acknowledge Philip J. Fischer II, M.D., P.C. policies and procedures.

Patient Signature Date

If you would like a copy of this form for your records please request at the time of your visit.