FAMILY MEDICINE FOR YOUR FAMILY

Mark C. Cooper, MD

505 Burlington Street

Scottsboro, AL 35768

By signing below I give my consent for your staff to retrieve and share my medical records and/or medication history from any pharmacies, hospitals, or health care providers.

Print name_____

Sign_____ Date_____

Patient portal is a way to access your personal medical records online. If you would like to participate in this please list your email below. If you have any questions about this service, and what it provides, please speak to someone at the front desk.

Email: _____

Initial: _____I **do not** wish to participate in the patient portal

HIPAA INFORMATION

Name: _____ **DOB:** _____

Emergency Contact: _____

Emergency Contact Phone Number: _____

Emergency Contact Relationship to you: _____

Medical Information Release
I authorize any person(s) on the staff of Family Medicine for Your Family, PC to release medical information about me or my child/dependent to the following person(s) (please indicate relationship)

_____
_____
_____
_____
_____

Patient Manual, Notice of Privacy, and Individual Rights I acknowledge that I have read the Patient Manual and understand the office policies on hours of operation, appointment scheduling, medication prescriptions, labs/studies results, and billing. I also acknowledge by signing below that a copy of Notice of Privacy and Notice of Individual Rights has been made available to me.

Insurance and "Signature on File" Authorization I authorize my insurance company to pay the benefits to my physician, and I also authorize my signature to remain on file for insurance claims

Signature_____ Date_____

Addendum:

Date Updated	**Signature**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

(Patient, Representative, Parent, or Legal Guardian

Expiration date 1 year from the date last signed.

Financial Policy (revised 11/16/16)

Co-payments and deductibles: Payments such as co-pay, deductibles, previous balances, and charges for forms to be filled out are due at the time of check-in.

Insurance and self-paying patients: We file insurance as a courtesy to you. It is your responsibility to ensure that we have current insurance information. Regardless of what your insurance tells you there is NEVER a guarantee of payment. If your insurance requests paperwork it is your responsibility to respond in a timely manner, and not doing so could result in denial of a claim, and you will be responsible for payment.

Patients without insurance who pay their office visit bill in full on the date of service will be given a 33% discount.

Charges for paperwork:

Disability forms require an appointment.

Patient assistance forms are subject to a fee of $5 per prescription.

Assisted Living Annual Paperwork requires an appointment.

FMLA Paperwork is $25.00, but does not require a fee if the patient has been seen in the past 3 months for the condition.

College Physicals require an appointment.

School Sport Physicals require an appointment unless physical has been done within the last 12 months.

Payment: We accept cash, check, and debit/credit cards for payment. There will be a fee of $25.00 for all returned checks. Our office does offer payment plans in certain circumstances. We expect you to pay your bill in a timely manner. If no attempt to contact us is made after 3 statements, we will have no other option than to turn your account over to a collection agency, and dismiss you from our practice.

No-shows: If you have three no-show/no-call appointments in an 18 month period, you will be dismissed from our practice.

By signing below you acknowledge that you have read and received a copy of our Financial Policy, and agree to the terms therein.

Sign: _____ Date: _____

PERSONAL INFORMATION & MEDICAL HISTORY

Name: _____ **DOB:** _____

SS#: _____ **Phone:** _____ **Cell:** _____

Address: _____ **City/ST/Zip:** _____

Gender: female or male **Marital Status:** single, married, divorced, widowed

Race: _____ **Ethnicity:** Hispanic/Latino or Not Hispanic/Latino

Employer: _____ **Phone:** _____

Guarantor Information (person responsible for payment)

Name: _____ **DOB:** _____ **SS#:** _____

Address: _____ **City/ST/Zip:** _____

Drug Allergies

Medications

Vaccine	Year of Last	Vaccine	Year of Last	Test/Exam	Year of Last	Test/Exam	Year of Last
Tetanus		Pneumonia		Rectal/Stool		Tuberculosis	
Flu		Other_____		Cholesterol		Other_____	

Medical History

- ☐ Abdominal Pain - *Chronic*_____
- ☐ Allergies/Hayfever_____
- ☐ Anemia ☐ Bruise Easily _____
- ☐ Ankles - *Swollen* _____
- ☐ Appetite - *Loss of* _____
- ☐ Arthritis/Rheumatism_____
- ☐ Asthma/Wheezing _____
- ☐ Back Pain - *Recurrent* _____
- ☐ Bone Fracture/Joint Injury _____
- ☐ Bowel Habits - *Change in* _____
- ☐ Bronchitis/Chronic Cough_____
- ☐ Cancer_____
- ☐ Chest Pain _____
- ☐ Convulsions/Seizures _____
- ☐ Diabetes _____
- ☐ Diarrhea ☐ Constipation _____
- ☐ Diphtheria _____
- ☐ Diverticulosis ☐ Crohn's/Colitis ____
- ☐ Dizziness/Fainting _____
- ☐ Ear Infections - *Frequent* _____
- ☐ Ear - *Ringing in* _____
- ☐ Eye Infections _____
- ☐ Fatigue - *Chronic* _____
- ☐ Foot Pain ☐ Cold Numb Feet _____
- ☐ Gall Bladder Trouble _____
- ☐ Gout _____
- ☐ Hair Loss _____
- ☐ Headaches - *Frequent* _____
- ☐ Heart Murmur _____
- ☐ Hemorrhoids _____
- ☐ Hernia _____
- ☐ High Blood Pressure _____
- ☐ Indigestion or Heartburn _____
- ☐ Infections - *Frequent* _____
- ☐ Jaundice/Hepatitis _____
- ☐ Kidney Stones _____
- ☐ Lactose Intolerance _____
- ☐ Leg Pain - *Walking*_____
- ☐ Memory Loss _____
- ☐ Mental Illness_____
- ☐ Moodiness - *Excessive* _____
- ☐ Muscle Weakness _____
- ☐ Nausea/Vomiting - *Persistent* _____
- ☐ Nervousness ☐ Depression_____
- ☐ Nose Bleeds_____
- ☐ Numbness/Tingling Sensations _____
- ☐ Osteoporosis _____
- ☐ Phobias _____
- ☐ Pneumonia _____
- ☐ Prostate Disease _____
- ☐ Psoriasis ☐ Eczema_____
- ☐ Rashes ☐ Hives _____
- ☐ Sexual/Menstrual Dysfunction ____
- ☐ Sinus Trouble _____
- ☐ Stools - *Bloody or Tarry*_____
- ☐ Stroke _____
- ☐ Swallowing Difficulty _____
- ☐ Tetanus _____
- ☐ Throat - Sore - *Frequent* _____
- ☐ Thyroid Disease _____
- ☐ Tremor/Hands Shaking _____
- ☐ Ulcers - *Peptic*_____
- ☐ Urethral Discharge _____
- Urination-☐ Overnight > than twice
  - ☐ Decrease in Force/Flow
  - ☐ Painful ☐ Loss of Control
- ☐ Urine - *Blood In*_____
- ☐ Varicose Veins/Phlebitis _____
- ☐ Venereal Disease_____
- ☐ Vision - *Failing* _____
- ☐ Weight Loss - *Recent*_____
- ☐ Chicken Pox ☐ Polio ☐ Mumps
- ☐ Measles ☐ Rubella ☐ Rheumatic Fever
- ☐ Scarlet Fever ☐ Tuberculosis ☐ Herpes
- ☐ Other _____
- ☐ Other _____

Females - *Please Complete*
Pregnant? ☐ Yes ☐ No
Planning Pregnancy? ☐ Yes ☐ No
Menstrual Flow:
☐ Regular ☐ Irregular ☐ Pain/Cramps
____Days of Flow ____Length of Cycle
Date-1st day of last period_____
☐ Pain/Bleeding during or after sex
Number of:
____Pregnancies ____Abortions
____Miscarriages ____Live Births
Birth Control Method_____
B.C. Pill (Name) _____
☐ Flushing/Menopause
Date of Last PAP Test _____
☐ Normal ☐ Abnormal
Date of Last Mammogram _____
☐ Normal ☐ Abnormal

Family History

	Father	Mother	Children	Siblings	Father's Parents	Mother's Parents
Alcoholism	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy/Convulsions	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Hair Loss	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Migraine	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Other_____						

Habits

- ☐ Alcohol: Type _____
  Amount _____
- ☐ Coffee: Cups Daily _____
  Other Caffeine _____
  _____
- ☐ Diet: Salt Intake _____
  Fat Intake _____
  Other _____
- ☐ Exercise Routine: _____
  _____
- ☐ Sleep: Difficulty Falling Asleep _____
  Continuity Disturbances _____
  Early Morning Awakening _____
  Daytime Drowsiness _____
  Other _____
- ☐ Smoke: Packs Daily _____
  How Long _____
  Interested in Stopping?_____

MARK C. COOPER, MD

Jana Jackson, CRNP

Patient Manual

***Mission Statement:* Our mission is to provide excellent healthcare with Christian love, timeliness, and ethical business practices to individuals and families.**

Welcome to our clinic. We are glad you have chosen us to be your medical home and look forward to managing your care. We hope you will find us to be an excellent source of healthcare for you, and your family. We are honored that you have chosen us to care for you.

Clinic phone, address, and hours of operation:

Phone: 256-259-4100 Fax: 256-259-4104

505 Burlington Street, Scottsboro, AL 35768

We open Monday thru Friday at 8:30 am year round. Our lunch hours are 12:00 pm to 1:30 pm.

If our office is closed there will be a doctor on call to see our patients for acute illnesses. ***If there is not an immediate need for care, please call us the next day that our office is open for an appointment.*** The physicians in our call group are:

Dr. Chad Bradford Dr. Patrick Tucker

Dr. Andrew White Dr. Jennifer White Dr. Mandi Allen-Bell

Our office is closed for the following holidays: Memorial Day, Independence Day, Labor Day, Thanksgiving/day after, Christmas Eve/Day, and New Years Eve/Day.

Appointments: You have the option to see Mark C. Cooper, MD or Jana Jackson, CRNP unless you were assigned to a specific provider. If you have a preference please let the receptionist know when making an appointment, or you will be scheduled with the first appointment available regardless of provider.

Timeliness is a goal and part of our mission statement, but we **will not** sacrifice excellent patient care. Please understand that we cannot always fit you in at a desired time. When established as a patient we will make a strong effort to see you in a reasonable amount of time. Immediate attention will be given for urgent medical problems. Follow up appointments will be scheduled at check out.

No show appointments: A no show appointment is defined as a failure to come for a scheduled appointment without calling to cancel or reschedule. ***If a patient fails to show up for more than three appointments within 18 months it will result in dismissal from our practice.*** As required by law, you will receive a letter and have 30 days from the day of your missed appointment to find a new physician.

Notification of labs and other study results: We will notify you of test results unless you have an appointment to go over them. You should hear from us within two weeks (sooner if results are abnormal), but if you have not heard from us with that time frame you are welcome to call the office. You may also obtain results through your patient portal after they have been reviewed by a physician.

Prescription refills: Your healthcare provider will make every effort to give you enough medication refills to last until time for your next appointment. Most medications will require an appointment. **We will not call in antibiotics, or pain medication without an appointment.** You can also consult your pharmacist for over the counter medications and minor illnesses.

Our nurses will be available for prescription refills if you have been seen in the previous six weeks. In order to efficiently care for patients being seen in our office the nurses can only spend a small portion of their day handling phone calls/messages. If you leave a message for the nurse's desk please make sure it is a detailed message. The nurses will try their best to get in touch with you by the end of the business day, but sometimes it does require up to 24 hours for a response.

Patient conduct: Abusive language or actions toward any of the staff will not be tolerated and will result in dismissal from our practice.

Some problems are better served by using the emergency room such as chest pain, acute stroke, serious injuries, or other problems that require extensive labs or testing with immediate need for results.

Billing: See our ***Financial Policy*** for information on billing, insurance, and payments.

*REVISED 04/14/2025

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRBES HOW MEDICAL INFORMATIN ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

How we may use and disclose medical information about you: the following categories describe different ways that we use and disclose medical information. For each category of uses of disclosures we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Payment: We may use and disclose medical information about you so that the treatment and services you receive at the practice may be billed to and payment may be collected from you, your insurance company, or a third party. For Example: we may disclose your record to an insurance company so that we can get paid for treating you.

Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the practice or the hospital. For example, we may disclose medical information about you to people outside the practice who may be involved in your medical care, such as family members, clergy, or other persons that are part of your care and are listed on your privacy release.

Health Care Operations: We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other practice personnel for review and learning purposes. For Example, we may review your record to assist our quality improvement efforts.

WHO WILL FOLLOW THIS NOTICE? This notice describes our practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, and members of any volunteer group which we allow to help you, as well as all employees, staff, and other practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION: We create a record of care and services you receive at the practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the practice, whether made by practice personnel or by your personal doctor. The law requires us to make sure that medical information that identifies you is kept private, give you this notice of our legal duties and privacy practices with respect to medical information about you, and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders, as required by law, for health related benefits and services, to individuals involved in your care or payment for your care, research, to avert a serious threat to health or safety, and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors, health oversight activities, inmates, law enforcement, lawsuits and disputes, military and veterans, national security and intelligence activities, organ and tissue donation, protective services for the President and others, public health risks, and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to an accounting of disclosures: You have the right to request an "accounting of disclosures". This is a list of the disclosures we made of medical information about you to request this list of accounting of disclosures, you must submit your request in writing to the Privacy Officer.

Right to Amend: if you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to inspect and copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances. There will be a fee for copying records.

Right to a paper copy of this notice: you have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to request confidential communications: you have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing, and you must specify how or where you wish to be contacted.

Right to request restrictions: You have the right to request a restriction or limitation on the medical information that we use or disclose about you for treatment, payment, or healthcare operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment of your care, like a family member or friend. ***We are not required to agree to your request***. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.

Changes to this notice: We reserve the right to change this notice. We will post a copy of the current notice in the practice's waiting room.

Complaints: if you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department or Health and Human Services. To file a complaint with the practice contact Mark Cooper, Privacy Officer, at 256-259-4100. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

Other uses of medical information: Other uses and disclosure of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission in writing at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer