Winfield Family & Occupational Medicine, PC

Gary Fowler, MD ● Alyssa Webb, CRNP ● Christina Casas, CRNP

New Patient Packet

Thank you for considering Winfield Family & Occupational Medicine to serve your medical needs. We are honored to care for you and your family.

- Please complete this entire packet and return it to our office with all items listed below so that we can schedule your appointment as soon as possible.

- Please bring a copy of your photo ID, insurance card, and a current list of medications from your pharmacy, including any over the counter medications, vitamins, or supplements that you take daily.

- No-Show Policy – We understand that life happens! However, missed appointments take away valuable time that could be given to other patients in need. To promote accountability and consideration for others, a $50 fee will be assessed for missed appointments without notice, which will have to be paid prior to any future appointments. Full policy available by request at the front desk.

191 Carraway Drive ● Suite A ● Winfield ● AL ● 35594
(205) 487-1586 ● windoc@drgaryfowler.com

Winfield Family & Occupational Medicine, PC

Patient Registration Form

Last Name: _____ First name _____ Middle Initial: ____

Sex: M or F Date of Birth: _____ Social Sec #: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile: _____ Work: _____

Email Address: _____

Race:

- ☐ White/Caucasian
- ☐ Black/African American
- ☐ Native hawaiian
- ☐ Other Pacific Islander
- ☐ Asian
- ☐ American Indian
- ☐ Alaska native
- ☐ Other
- ☐ Unknown
- ☐ Decline

Ethicity:

- ☐ Not Hispanic Or Latino
- ☐ Hispanic or latino
- ☐ Decline

Marital Status:

- ☐ married
- ☐ Single
- ☐ Widowed
- ☐ Divorced

EMERGENCY CONTACT INFORMATION:

Name: _____ Relationship: _____

Cell Phone: _____ Work Phone: _____ Home Phone: _____

Please provide a copy of the front and back of your insurance card (OR) complete the information below.

Primary Insurance: _____ Policy #: _____

Insured's Employer: _____ Group #: _____

Insured's Name: _____ Insured's Social Sec #: _____

Insured's Date of Birth: _____ Policy Effective Date: _____

Secondary Insurance: _____ Policy #: _____

Insured's Employer: _____ Group #: _____

Insured's Name: _____ Insured's Social Sec #: _____

Insured's Date of Birth: _____ Policy Effective Date: _____

Winfield Family & Occupational Medicine, PC
Disclosures & Consents

Patient Name: _____ **Date of Birth:** _____
First Name Middle Initial Last name

ASSIGNMENT OF INSURANCE BENEFITS
I hereby authorize direct payment of my insurance benefits to Winfield Family & Occupational Medicine, PC for services rendered to me or my dependents by the physician or providers under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Winfield Family & Occupational Medicine, PC is unable to collect from my insurance carrier for whatever reason.

MEDICARE / MEDICAID / CHAMPUS INSURANCE BENEFITS
I certify that the information given by me in applying for payment under these programs is true and correct. I authorize the release of records requested by these programs and direct payment of authorized benefits to Winfield Family & Occupational Medicine, PC.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION
I certify that I have received and reviewed the Notice of Privacy Practices. I authorize Winfield Family & Occupational Medicine, PC, its providers, employees, business associates, contracted service providers, care management vendors, and authorized representatives to use and disclose protected health information as necessary for treatment, payment, healthcare operations, care coordination, chronic care management, telehealth services, insurance processing, and other activities permitted by law.

NO-SHOW AND LATE CANCELLATION POLICY ACKNOWLEDGEMENT
I understand and agree that if I fail to cancel or reschedule my appointment within a reasonable time frame, preferably 24 hours in advance, the practice reserves the right to assess a no-show fee in accordance with office policy.

AUTHORIZATION FOR ELECTRONIC COMMUNICATIONS, TELEHEALTH, TEXT MESSAGING, AND AI-ASSISTED SERVICES
I authorize WFOM, its providers, employees, business associates, contracted service providers, care management vendors, telehealth vendors, and authorized representatives to contact me regarding healthcare services, treatment, care coordination, chronic care management, preventive care, billing, scheduling, referrals, diagnostic testing, prescriptions, and related healthcare matters.

I consent to communications through telephone calls, voicemail messages, SMS/text messages, email communications, patient portal messages, electronic forms and signatures, telehealth platforms, automated telephone dialing systems, automated text messaging systems, and other electronic communication technologies permitted by law.

I understand that some communications may be generated, assisted, recorded, transcribed, summarized, or facilitated by automated technologies or artificial intelligence (AI) systems used in compliance with applicable privacy and healthcare laws.

I understand that electronic communications may contain protected health information. Standard message and data rates may apply. I may revoke this authorization at any time by providing written notice to the practice.

(Continued on next page)

Additional Consents and Acknowledgements

Additional Telehealth Consent

I understand that telehealth services may involve secure audio, video, electronic communications, remote monitoring devices, or other telecommunications technologies. I consent to receive telehealth services when deemed appropriate by my provider.

Chronic Care Management (CCM) and Remote Services Consent

I understand that WFOM may utilize contracted care management service providers to assist with chronic care management, care coordination, remote patient monitoring, annual wellness visits, preventive health services, transitional care management, and other Medicare-approved care management programs. I authorize such service providers to contact me on behalf of WFOM using telephone calls, text messages, email communications, telehealth technologies, automated communication systems, and electronic enrollment processes as permitted by law.

Lab / X-Ray / Diagnostic Services

I understand that I may receive a separate bill if my medical care includes laboratory, radiology, or diagnostic services and that I remain responsible for applicable patient balances.

Consent to Treatment

I hereby consent to evaluation, testing, treatment, telehealth services, care coordination services, chronic care management services, and related healthcare services as directed by my provider or designee.

Patient Signature: _____ **Date:** _____

Or

Guarantor Signature: _____ **Date:** _____

Print Guarantor Name: _____

Revised June 2026

Winfield Family & Occupational Medicine, PC

Pharmacy & Medication Information

Patient Name: _____ Date of Birth: _____
First Name Middle Initial Last name

Current Medications

Please list all prescriptions, vitamins, supplements, and over the counter medications

Medication Name	Strength	Times per day
Example: Ibuprofen	200 mg	2 tablets twice per day

DRUG ALLERGIES:

Drug: _____ Reaction to Drug: _____

Drug: _____ Reaction to Drug: _____

Drug: _____ Reaction to Drug: _____

Drug: _____ Reaction to Drug: _____

Pharmacy Information

Pharmacy Name: _____ Phone: _____

Pharmacy Address: _____

Winfield Family & Occupational Medicine, PC

Gary Fowler, MD ● Alyssa Webb, CRNP ● Christina Casas, CRNP

Phone (205) 487-1586 ● Fax (205) 487-1589

Authorization for Release of Information

_____ I DO NOT wish to have test results or other information released to any person other than myself

_____ I DO wish to have test results or other information released to the following:

Name: _____ Relation to Patient: _____

Name: _____ Relation to Patient: _____

Name: _____ Relation to Patient: _____

Name: _____ Relation to Patient: _____

Signature: _____ Date: _____
(patient or legal guardian)

*If the patient is 14 years of age or older they have the right, by law, to determine who has authorization for themselves. Parent/Guardians may witness but may not sign for patient.

**This authorization will expire 10 years from the date of the signature. It is the responsibility of the patient to notify this office of any changes in the information. If changes do occur, the patient must complete another Authorization for Release of Information.

Winfield Family & Occupational Medicine, PC

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. PLEASE REVIEW THIS INFORMATION CAREFULLY. This notice applies to Winfield Family & Occupational Medicine, PC, the doctors and other healthcare providers practicing at this facility.

It is our legal duty to protect the privacy of your information. We are providing this notice to you so that we can explain what our privacy practices are. We follow the practices described in this notice or the current notice in effect. We reserve the right to change our policies and notice of privacy practices at any time. If we make a significant change in our policies, we will change this notice and post the new notice. You can also request a copy of our notice at any time. For more information about our privacy practices or to place a complaint or report a concern or conflict regarding our privacy practices, call the number listed below:

Winfield Family & Occupational Medicine, PC - Privacy Officer: (205) 487-1586 - Ext #100

You may also send a written complaint to the United States Department of Health and Human Services by completing their Health Information Privacy Complaint Form Package, which is available at https://www.hhs.gov/hipaa/filing-a-complaint-process/index.html, if you feel we have not properly handled your complaint. Print and mail the completed complaint and consent to: Centralized Case Management Operations, US DHHS, 200 Independence Ave SW, Room 509F HHH Bldg., Washington, DC 20201. Under no circumstance will you be retaliated against for filing a complaint.

We may use health information about you for your treatment purposes, to obtain payment, or for healthcare operations and other administrative purposes. For example, we may use your information in treatment situations if we need to send your medical record information to a specialist or physician as part of a referral for continuity of care. We may send your health information and other identifying information to Medicare, Medicaid or other health insurance plans for our billing purposes. Your information will be used when processing your medical records for completeness and comparing patient data during our efforts to continually improve our treatment methods.

Under certain circumstances we may be required to disclose your health information without your specific authorization. Examples of these disclosures are requirements by state and Federal laws to report cases of abuse, neglect, or other certain law enforcement purposes; for public health issues; to health oversight agencies; for judicial and administrative proceedings; for death and funeral arrangements; for organ donation; for special government functions including military and veteran requests, and to prevent serious threat to health or public safety. We may also contact you after your current visit for future appointment reminders or to provide you with information regarding treatment alternatives or other health related services that may be of benefit to you. We will obtain your written authorization for any other disclosures beyond the reasons listed above. Do remember, if you do authorize us to release your information, you always have the right to revoke that authorization later. We will be happy to honor that request except to the extent that we may have already acted.

As a patient you have rights regarding how your information can be used and disclosed. These rights include access to your health information. In most cases, you have the right to look at or receive a copy of your health information. This may take up to 30 days to prepare and there may be a preparation fee associated with making any copies. You can also ask for an accounting of disclosures. This is a list of instances in which we have disclosed your information for reasons other than treatment, payment and operations. We can provide you with one list per year without charge; all additional requests in the same year will be subject to a nominal charge. If you believe that the information we have about you is incorrect or if important information is missing, you have the right to request that we amend or correct the existing information. There may be some reasons that we cannot honor your request for which you submit a statement of disagreement. You can request that your health information be communicated to you at an alternate location or address. Finally, you can request in writing that we do not use or disclose your information for any reason described in this notice except to people involved in your care or when required by law, or in emergency circumstances. We are not legally required to abide by such a request, but we will try to honor any reasonable requests.

Signature: _____ **Date:** _____
(Patient or Legal Guardian)

Revised 2/25/25

Winfield Family & Occupational Medicine, PC

DRUG SCREEN PROTOCOL

If you are taking a controlled substance, be advised that you will be required to undergo routine drug screening. This protocol is part of our medication monitoring program. These results allow our providers to properly prescribe medication as part of your treatment plan. Your provider will determine when you will be tested based on your medical needs.

My signature below signifies that I have read and understand the drug screen protocol of Winfield Family & Occupational medicine, PC.

_____ _____

Patient/Guardian/Caregiver Signature **Date**

Winfield family & Occupational Medicine, PC

Patient Medical History

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

Please check all diagnosis that apply, past or present

- ☐ ADD/ADHD
- ☐ ALCOHOL USE? HOW OFTEN? _____
- ☐ ALCOHOL DEPENDENCY
- ☐ ALLERGIC RHINITIS
- ☐ ALLERGIES
- ☐ ALZHEIMERS
- ☐ ANEMIA
- ☐ ANXIETY
- ☐ ARTHRITIS
- ☐ ASTHMA
- ☐ ATRIAL FIB
- ☐ AUTOIMMUNE DISEASE
- ☐ BACK PAIN
- ☐ BARRETT'S ESOPHAGITIS
- ☐ BIPOLAR
- ☐ BREAST CANCER
- ☐ CANCER, TYPE: _____
- ☐ CARDIOMYOPATHY
- ☐ CARDIOMYOPATHY ISCHEMIC
- ☐ CLAUSTROPHOBIC
- ☐ COPD
- ☐ COLON CANCER
- ☐ CONGESTIVE HEART FAILURE
- ☐ CORONARY ARTERY DISEASE
- ☐ CROHN'S DISEASE
- ☐ DEGENERATIVE DISC DISEASE
- ☐ DEMENTIA
- ☐ DEPRESSION
- ☐ DERMATITIS
- ☐ DIABETES TYPE 1 OR 2
- ☐ DIABETIC NEPHROPATHY
- ☐ DIABETIC NEUROPATHY
- ☐ DIVERTICULOSIS
- ☐ DRUG ADDICTION
- ☐ ENLARGED PROSTATE
- ☐ ERECTILE DISFUNCTION
- ☐ EROSIVE ESOPHAGITIS
- ☐ FIBROCYSTIC BREAST
- ☐ FIBROMYALGIA
- ☐ GASTRIC BYPASS
- ☐ GASTROESOPHAGEAL REFLUX DISEASE (GERD)
- ☐ GOUT
- ☐ HEART ATTACK
- ☐ HEMACHROMATOSIS
- ☐ HEPATITIS B
- ☐ HEPATITIS C
- ☐ HIGH BLOOD PRESSURE
- ☐ HYPERCHOLESTEROLEMIA
- ☐ HYPERTHYROIDISM
- ☐ HYPOTHYROIDISM
- ☐ IRRITABLE BOWEL SYNDROME
- ☐ LIVER FAILURE
- ☐ LUPUS
- ☐ METABOLIC SYNDROME
- ☐ MIGRAINES
- ☐ OBESITY
- ☐ OSTEOARTHRITIS
- ☐ OSTEOPENIA
- ☐ OSTEOPOROSIS
- ☐ OVARIAN CYSTS
- ☐ PARKINSONS DISEASE
- ☐ PERIPHERAL NEUROPATHY
- ☐ RHEUMATOID ARTHRITIS
- ☐ SLEEP APNEA
- ☐ TOBACCO USE - HOW LONG? _____
- ☐ THYROID DISEASE
- ☐ ULCER, DUODENAL
- ☐ ULCER, PEPTIC
- ☐ ULCERATIVE COLTITIS
- ☐ OTHER _____

Please list any other medical conditic

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Patient Medical History (continued)

Previous Surgical Procedures with Dates:

☐ _____ Date: _____

☐ _____ Date: _____

☐ _____ Date: _____

Please complete the following:

What is your occupation? _____

Do you live alone? _____

Date of last Colonoscopy: _____

Date of last Flu Vaccine: _____

Date of last Tetanus Shot: _____

Date of last Covid Vaccine: _____

Date of last Pneumonia Vaccine: _____

Date of last Eye Exam: _____

STUDENTS ONLY > What Grade? _____

Ladies only

Date of last Mammogram: _____

Date of last Menstrual Cycle: _____

Date of last Pap Smear: _____

Date of last Dexa Scan/Bone Density: _____

How many Pregnancies? _____

How many Living Children? _____

Any Abortions? Y / N If YES, how many? _____

Do you have an Advanced Directive? _____YES _____NO

- If Yes, please bring a copy for your medical record

_____ _____

Patient/Legal Guardian Signature Date

Winfield Family Occupational Medicine , PC

Family Medical History

Patient Name: _____ Date of Birth: _____

Please complete the following based on your family history:

	Dad	Mom	Sibliing	Your Child	Your Mom's Parents	Your Dad's Parents
High Blood Pressure						
Diabetes						
Stroke						
Asthma						
Heart Disease						
High Cholesterol						
Seizures						
Crohns Disease						
Cancer						
If so, type of Cancer:						

_____ _____

Patient/Legal Guardian Signature Date

Winfield Family & Occupational Medicine, PC

Controlled Substance Prescription Rules:

- Our primary goal at Winfield Family & Occupational Medicine, P.C. is to provide excellent care for our patients. To do this, we have made a set of policies and guidelines to ensure we operate efficiently, as well as deliver excellent patient care in a timely manner.

  I. Patients must get their prescription medications from only one doctor while under the care of this office. Receiving medications from multiple doctors is very dangerous and will not be allowed. If it is discovered that a patient is getting multiple prescriptions, they will be dismissed from the practice. This office will provide your needed medication prescriptions unless another arrangement has been made. Generally, issues should be addressed during normal business hours.

  II. Prescriptions or medications that are lost, stolen, or otherwise misplaced will be the responsibility of the patient. **WE WILL NOT REPLACE THEM**.

  III. When calling the office, please call **ONE TIME**. Messages and phone calls are reviewed and returned twice a day. Multiple calls and voicemails slow down our process and response time. In the event of a **TRUE** emergency, you should go to the nearest emergency room or call 911.

  IV. Chronic pain, while very unpleasant, is an ongoing problem and not an "emergency". It is the responsibility of the patient or their caregiver to tell us **AT LEAST 2-3 DAYS IN ADVANCE** when they are running low on medications.

  V. Medications are to be taken exactly as prescribed. You are not to take more than originally prescribed without orders to do so from our office.

  VI. If you abuse or ignore these rules, **YOU WILL BE DISMISSED AS A PATIENT FROM THIS OFFICE.**

- ❖ By signing below, you are acknowledging that you have read, understand, and agree to follow the policies and guidelines listed above concerning controlled substance medications. Any concerns with the above policies and procedures should be discussed with your physician or his designee.

_____ _____

Patient or Caregiver Signature Date

Winfield Family & Occupational Medicine, PC

Important Notice

No-Show & Late Cancellation Policy

At Winfield Family & Occupational Medicine, PC we understand that life happens! However, missed appointments take away valuable time that could be given to other patients in need. To ensure fair access to care, we kindly ask for **at least 24 hours' notice** if you need to cancel or reschedule your appointment.

What Happens If You Miss Your Appointment?

If you do not show up or cancel with **less than 24 hours' notice**, a **No-Show Fee** will apply. This fee will be charged to the **payment method on file** as follows:

- **$50** per missed appointment.
- If no card is on file, the fee must be paid before scheduling future appointments.
- Repeated no-shows may result in limited scheduling options or dismissal from our practice.

Exceptions for Emergencies

We understand that certain emergencies may arise, including:

✅ **Medical emergencies** (hospitalization, sudden illness requiring urgent care)

✅ **Family emergencies** (serious illness or loss of an immediate family member)

✅ **Unavoidable circumstances** (severe weather, car accidents, unexpected transportation issues)

If an emergency prevents you from attending, please contact our office as soon as possible so we can assess the circumstances and determine the appropriate next steps.

Questions? We're Here to Help!

If you have any questions or concerns about this policy, our team is happy to assist you. Thank you for helping us keep appointments available for all patients! *Full policy available by request at the front desk.*

Patient Medical History (continued)

Previous Surgical Procedures with D/ _____

☐ _____ **Date:** _____

☐ _____ **Date:** _____

☐ _____ **Date:**

Please complete the following: ___

What is your occupation? _____

Do you live alone? _____

Date of last Colonoscopy: _____

Date of last Flu Vaccine: _____

Date of last Tetanus Shot: _____

Date of last Covid Vaccine: _____

Date of last Pneumonia Vaccine: _____

Date of last Eye Exam: _____

STUDENTS ONLY > What Grade? _____

<u>Ladies only</u> ___

Date of last Mammogram: _____

Date of last Menstrual Cycle: _____

Date of last Pap Smear: _____

Date of last Dexa Scan/Bone Density: _____

How many Pregnancies? _____

How many Living Children? _____

Any Abortions? Y / N If YES, how many? _____

Do you have an Advanced Directive? _____YES _____NO

- If Yes, please bring a copy for your medical record

_____ **Date**

_____

Patient/Legal Guardian Signature