Please List ALL Current Medications, Vitamins, Supplements, & Allergies

Your Name:	Today's Date:
Your Phone Number:	DOB:
Preferred Pharmacy, Location, & Phone Number:	
Alternate Pharmacy, Location, & Phone Number:	

Name of Medication	What do you take this medication for?	Color/Shape	Doctor	Dose	Instructions
Example: Aspirin	heart	White round	Jones	12 mg	Take one at bedtime

Do you have any allergies ? ☐ **YES** ☐ **NO** **If YES, please list below:**

Medication or substance which caused the allergic reaction	What kind of reaction did you experience?	When did this reaction first occur?

Christopher Jenkins, M.D., L.L.C. & Recovery Medical, L.L.C.

New Patient Information

Thank you for choosing our office! In order to serve you properly, we need the following information.
Please print. All information will be confidential.

Today's Date: _______________

Patient's Full Name: ____

Name you go by: ______________________________ **Age** ____________ **Gender (circle)**: M F

Social Security #__________-________-____________ **Date of Birth**____________________________

Marital Status (circle) Minor Single Married Divorced Widowed

Address____

City__________________________________ **State**___________________ **Zip** ___________________

Primary Phone (______) _______________________ Cellular Home Work Other:_________

Secondary Phone (_____) ____________________ Cellular Home Work Other: _________

Fax (______) ________________________________ Email: ___________________________________

Employment Status: Disabled Employed Retired Student Unemployed

School or Employer: __________________________________Occupation ________________________

Emergency Contact

Name ____Relationship _____________________

Home number (______) ____________________________Cell Phone (______) ____________________

Physician and Pharmacy Information

Primary Physician: ________________________________ Phone number (______)_______________

Address____

Pharmacy:_______________________________________ Phone number (______) ________________

Address____

Optional Patient Information Primary Language:_______________________________________

Race: American Indian or Alaskan Native Asian Black or African American

Native Hawaiian or Other Pacific Islander White or Caucasian

Ethnicity (circle): Hispanic or Latino Not Hispanic or Latino

Other:____

Christopher Jenkins, M.D., L.L.C. & Recovery Medical, L.L.C.
New Patient Information

Thank you for choosing our office! In order to serve you properly, we need the following information.
Please print. All information will be confidential.

Today's Date: _______________

Responsible Party (If Not Patient)

Full Name____ Relationship ____________________

Address ____________________________________City____________ State___________ Zip ________

Home Phone (______) __________________________ Cell Phone (______) ________________________

Social Security #____________-____________-____________ Date of Birth______________________

<u>ALL PATIENTS INCLUDING CASH / PRIVATE PAY</u>

For medication purposes, please assist our office in keeping current insurance coverage information on file

Does the patient have health insurance coverage: YES NO

Primary Insurance Information

Primary Insurance ____

Member/Contract ID # ______________________________ Group # ______________________________

Authorization #____ Start Date _________________________

If Insured is other than SELF Insured's Gender: M F

Full Name of Insured ______________________________________ Relationship____________________

Insured's Employer________________________________ Occupation _____________________________

Insured's Date of Birth_________________Insured's Social Security #_________-_______ -_________

Secondary Insurance Information

Secondary Insurance ____

Member/ Contract ID # _____________________________________ Group # _____________________

Authorization #____ Start Date______________________

If Insured is other than SELF Insured's Gender: M F

Full Name of Insured _______________________________ Relationship__________________________

Insured's Employer_______________________________Occupation _____________________________

Insured's Date of Birth ____________________ Insured's Social Security #______-________-_______

Christopher L. Jenkins, M.D., LLC.
576 Azalea Rd. Ste 105
Mobile, AL 36609
Ph: 251-665-5360 Fax: 251-665-5361

Controlled Substances: Patient Agreement

I, ____, understand and voluntarily agree that (initial each statement after reviewing):

______ I will keep and be on time for all my scheduled appointments with the doctor or I am aware I may incur additional fees for no shows not rescheduled within 24 hours of appointment.

______ I will participate in all other types of treatment that I am asked to participate in.

______ I will keep the medicine safe, secure and out of the reach of children. If the medicine is lost or stolen, I understand it will not be replaced until my next appointment, and may not be replaced at all.

______ I will take my medication as instructed and not change the way I take it without first talking to the doctor or other member of the treatment team. I will not stop my medication abruptly as I am aware that I may become very sick due to withdrawal.

______ I will not call between appointments, or at night or on the weekends looking for refills. I understand that prescriptions may be filled only during scheduled office visits with the treatment team.

______ I will make sure I have an appointment for refills. If I am having trouble making an appointment, I will tell a member of the treatment team immediately.

______ I will treat the staff at the office respectfully at all times. I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment will be stopped.

______ I will not sell this medicine or share it with others, otherwise known as diversion. I understand that if I do, my treatment will be stopped.

______ I will allow the doctor speak to all other doctors or providers that I see.

______ I will tell the doctor all other medicines that I take, and let him know right away if I have a prescription for a new medicine from any provider.

______ I will use only one pharmacy to get all of my medicines: ____________________________
Pharmacy name/phone#

______I will not get any opioid pain medicines or other medicines that can be addictive such as benzodiazepines (klonopin, xanax, valium) or stimulants (amphetamine, ritalin) without telling a member of the treatment team **before I fill that prescription**. I understand that the only exception to this is if I need pain medicine for an emergency at night or on the weekends.

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______ I will not use illegal drugs such as heroin, cocaine, marijuana, or amphetamines. I understand that if I do, my treatment may be stopped.

______ I will come in for drug testing and counting of my pills within 24 hours of being called. I understand that I must make sure the office has current contact information in order to reach me, and that any missed tests will be considered positive for drugs.

______I will keep up to date with any bills from the office and tell the doctor or member of the treatment team immediately if I lose my insurance or can't pay for treatment anymore.

______ I will comply with my doctors plan to taper and discontinue any addictive medications I may be currently taking.

______ I understand that I may lose my right to treatment in this office if I break any part of this agreement.

______________________	______________________	______________________
Patient signature	Patient name printed	Date
______________________	Christopher L. Jenkins, M.D.	______________________
Provider signature	Provider name printed	Date

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Christopher L. Jenkins, M.D., L.L.C. & Recovery Medical, L.L.C.
576 Azalea Road, Suite 105, Mobile, Alabama 36609-1516
Phone: (251) 665-5360 Fax: (251) 665-5361

Patient Payment & Privacy Agreement

FEES MAY BE PERIODICALLY ADJUSTED.

Please **Initial:** ✍_____ each line to express your consent and understanding.

_____ **ALL SALES FINAL:** Except as expressly set forth in this Agreement, all sales are final, and no returns, replacements, or refunds are permitted.

_____ I hereby consent to engage in diagnostic and/or therapeutic mental health services by one or more staff members of Christopher L. Jenkins, M.D., L.L.C. and/or Recovery Medical, L.L.C.

_____ The Patient agrees to pay for all professional medical services provided to the Patient by Dr. Jenkins. All payments and fees, regardless of insurance coverage are due at time of service and/or presentation of a statement. A $25.00 service charge may be added if any payment including co-pay, co-insurance, deductible, and/or previous balance is not paid in full.

_____ Nonpayment of fees may result in termination of professional services.
If Patient's insurance denies payment, Patient agrees to be personally and fully responsible for all charges. If insurance coverage cannot be confirmed, or amount of deductible or co-pay cannot be determined, the Patient must pay the full amount at time of visit. When insurance coverage is determined, any excess payments will be credited to the Patient's account or refunded. To prevent submission of any claims to Medicare, Medigap, or other Medicare supplemental insurance plans, ALL MEDICARE ELIGIBLE PATIENTS will be given receipts, upon request, but may not receive a superbill - see separate private contract consent form for Medicare patients.

_____ This office accepts cash,Visa, American Express, MasterCard, & Discover credit/debit cards. If the credit card holder or check holder is not the patient, credit card holder, with valid identification, must be present with the patient. Checks may be accepted from established patient's with accounts in good standing and no history of bounced checks. There is a $30.00 NSF/insufficient (bounced check) fee if the check does not clear the bank, in addition to the amount of the check. New patients must pay for their first visit with cash or credit/ debit card, no checks.

_____ Patient agrees to schedule and keep regular follow-up appointments within the time frame specified by Dr. Jenkins. Maintenance Patients agree to keep monthly appointments. ADHD patients agree to keep quarterly appointments. Patients who are not seen at directed intervals may be held personally, financially responsible for missed appointments. Failure to keep regular follow-up appointments will result in termination of treatment.

_____ THE FEE for “No-Show” or cancellation less than 24 hours in advance is $115.00. The fee will be waived if the appointment is rescheduled and kept within a week. “No-Show” fees are not covered by insurance and must be paid prior to the Patient’s next appointment.

_____ **Patient agrees to call the main office number: (251) 665-5360 for all appointments, medication refills, and medical questions during office business hours.** Due to HIPPA Privacy Practices, Dr. Jenkins does not communicate to patients via text messaging or email. In the event of a life-threatening or severe condition, Patient agrees to call 911 or go directly to the nearest Hospital Emergency Department (ER).

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PRESCRIPTION REFILL REQUESTS, PAPERWORK, & PRIOR AUTHORIZATIONS

_____ Patient understands that it is his or her responsibility to safeguard medication.
An office visit and/or police report may be required to replace or re-write lost or stolen prescriptions.
Lost or stolen controlled substance prescriptions will not be replaced. No early refills will be given on controlled substances.

_____ Prescription refill requests can take up to ten days to process.
Patient agrees to request that the pharmacy fax prescription refill requests or reminders to (251) 665-5361 in advance of running out of the medication. During business hours, controlled substance prescription refill request messages can be left with the appointment desk or office voice-mail at (251) 665-5360.

_____ **An office visit and/or a $30.00 office processing charge may be required to complete forms, letters, paperwork requests.** Medication prior authorizations may require up to two weeks. The Patient is responsible for providing all necessary forms and following up if there are hold-ups.

MEDICAL RELEASE AUTHORIZATION & EXPRESS PRIOR CONSENT

_____ In order to service the Patient's account, I, the undersigned, give Christopher L. Jenkins, M.D., L.L.C. and/or Recovery Medical, L.L.C.'s medical practice, its employees and/or agents “express prior consent” to contact me by telephone at any telephone number associated with Patient's account, including wireless telephone numbers, which could result in charges to me. This medical practice may also contact me, the undersigned, by sending text messages or emails, using any email address provided. Methods of contact may include using prerecorded voice messages and/or use of automatic dialing devices, as applicable, for the purpose of treatment, insurance, payment, and collections. I, the undersigned, agree to notify and update the office of all changes to contact and insurance information and fill out a Patient Update form at least twice a year.

I, the undersigned, authorize the release of any medical or other information necessary to process insurance claims. I also request payment of benefits by insurance or any other third-party to be paid directly to Christopher L. Jenkins, M.D., L.L.C.

_____ **AGREEMENT TO PAY:** I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs, if such be necessary. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other State. Payment will be made on any balance within 30 days of billing. If payment is not received within 30 days of the date such balance is due, the bill may be turned over to an attorney or collection agency.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE TO PRIVACY PRACTICES

Please sign and print your name and date on this acknowledgment form below that you were given a copy of our Notice of Privacy Practices for your review. Copies are also kept in the lobby.

I certify that I have read and understand the above, and I accept all specified terms and fees therein:

______________________	______________________	______________________
Print Patient Name	Signature of Patient/Guardian	Date

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