HOMETOWN MEDICAL GROUP

1705 Main Ave SW Ste B, Cullman, AL 35055 | Phone: (256) 965-0340 | Fax: (256) 965-0341

PATIENT INFORMATION SHEET

NAME: _____ **DOB:** _____ /_____ / _____ **GENDER:** MALE / FEMALE

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:**_____**SSN:** _____ - _____ - _____

PRIMARY PHONE #: (_____) _____ - _____ **SECONDARY PHONE#:** (_____) _____ - _____

EMAIL ADDRESS: _____

CONTACT PREFERENCE: PHONE / EMAIL / MAIL

RACE: ASIAN / BLACK / WHITE / HISPANIC / AMERICAN INDIAN **LANGUAGE:** _____

MARITAL STATUS: SINGLE / MARRIED / DIVORCED / WIDOWED **SPOUSE NAME:** _____

OCCUPATION: _____ **EMPLOYER:**

_____

EMERGENCY CONTACTS

NAME: _____ **PHONE#:** _____ **RELATIONSHIP:** _____

NAME: _____ **PHONE#:** _____ **RELATIONSHIP:** _____

PARENT/GUARDIAN (IF MINOR)

NAME: _____ **PHONE#:** _____ **RELATIONSHIP:** _____

INSURANCE INFORMATION

PRIMARY INSURANCE CO.: _____ **POLICY HOLDER NAME:** _____

RELATIONSHIP TO PATIENT: _____ **POLICY HOLDER DOB:** _____

CONTRACT #: _____ **GROUP #:** _____

SECONDARY INSURANCE CO.: _____ **POLCY HOLDER NAME:** _____

RELATIONSHIP TO PATIENT: _____ **POLICY HOLDER DOB:** _____

CONTRACT #: _____ **GROUP #:** _____

PATIENT NAME:_____ **DOB:** _____ **DATE:** _____

PATIENT MEDICAL HISTORY

******Please circle ALL conditions that you currently have / have had in the past******

NONE

Acid Reflux/GERD	Cancer_____	Gout	High Cholesterol	Osteoporosis
Alzheimer's	COPD	Migraines	Thyroid Disease	Parkinson's Disease
Arthritis	Depression/Anxiety	Heart Attack	Insomnia	Seizures
Asthma	Diabetes	Heart Disease	Kidney Disease	Skin Disease
Bipolar Disorder	Diverticulitis	Heart Failure	Multiple Sclerosis	Sleep Apnea
Atrial Fibrillation	Fibromyalgia	Hypertension	Neuropathy	Stroke

OTHER (PLEASE LIST): _____

PATIENT SURGICAL HISTORY

******Please list ALL surgical procedures you have had in the past******

FAMILY HISTORY

***** PLEASE CHECK ALL THAT APPLY *****

	Father	Mother	Brother	Sister	Son	Daughter	Maternal Grandparent	Paternal Grandparent	Other
Arthritis									
Cancer (Type)									
Depression									
Diabetes									
Heart disease									
High Blood Pressure									
High Cholesterol									
Stroke									
Thyroid disease									
None									
Other (Explain)									

PATIENT NAME:_____ **DOB:** _____ **DATE:** _____

SOCIAL HISTORY

EDUCATION HISTORY: GED HS Diploma College degree Post-Grad

ALCOHOL: Current Former Never **WHAT TYPE / HOW OFTEN:** _____

RECREATIONAL DRUGS: Current Former Never **WHAT TYPE / HOW OFTEN:** _____

TOBACCO: Current Former Never **WHAT TYPE / HOW OFTEN:** _____

MEDICATION LIST

PHARMACY: _____ **PHONE #:** _____

ALLERGIES: _____

***** Please list ALL medications including, prescription, herbal, and over the counter *****

MEDICATION NAME	DOSAGE	FREQUENCY

PATIENT NAME:_____ DOB: _____ DATE: _____

PAYMENT & APPOINTMENT POLICY:

We kindly ask that you cancel or reschedule appointments at least 24 hours in advance. Missed appointments ("No Shows"), for any reason, will result in a $50 fee charged to your account. Changes made to appointments with less than 24 hours' notice, for any reason, will result in a $25 fee charged to your account. Please note this fee is the patient's responsibility and cannot be billed to insurance.

Please be aware that we have a **Strict No-Show Policy**. After three (3) missed appointments without proper notice, a formal warning will be issued. A fourth (4^{th}) no-show will result in dismissal from our practice.

All copayments and outstanding balances are due at the time of service. Patients who arrive without payment for their copay or outstanding balance will not be seen until payment is made in full. To ensure fairness and consistency for all our patients, no exceptions will be made to this policy. We appreciate your cooperation in helping us maintain efficient and timely care for all patients.

Patient / Guardian Signature: _____ Today's Date: _____

HIPAA AUTHORIZATION

I acknowledge that I have received and reviewed the Notice of Privacy Practices from Hometown Medical Group. I authorize the use and disclosure of my health information for the purposes of treatment, payment, and healthcare operations, as described in the notice. I understand that I have the right to request restrictions and that I may revoke this authorization in writing at any time, except to the extent that action has already been taken.

Please list the family members or other persons, if any, we may inform about your general medical condition and your diagnosis, which might include medical history, treatment, laboratory reports, and treatment.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Initial all that apply below:

_____ I consent to receiving appointment confirmations or health-related information via phone call, email, & text.

_____ I authorize Hometown Medical Group to leave confidential messages on my voicemail.

_____ I give permission for Hometown Medical Group to access my external prescription records & medical history.

_____ I consent to the use of HIPAA-compliant Sunoh AI Scribe during my visits to help with clinical documentation.

CONSENT TO TREAT AND BILL FOR SERVICES RENDERED

I understand that payment is due at the time of service. I authorize Hometown Medical Group to receive payment directly for any medical benefits otherwise payable to me and understand that I am financially responsible for any charges not covered by my insurance. Insurance claims are filed as a courtesy only, and I am ultimately responsible for payment of all charges, including any testing ordered outside of the clinic that is not covered by my insurance. If my account is not paid in full, I agree to pay all costs associated with collection, including collection fees of 33 1/3% of the unpaid balance, attorney fees if referred for legal collection, court costs, postage, and credit card processing fees. I authorize verification of my employment for billing purposes and consent to being contacted by phone, text, email (including automated systems) regarding my care and account by this medical provider and its business associates. I agree to receive billing statements through my patient portal or at the physical address I have provided.

If patient is under 19, I hereby give permission for _____ to be treated at Hometown Medical Group.

Patient / Guardian Signature: _____ Today's Date: _____

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AUTHORIZATION TO RELEASE OR OBTAIN PROTECTED HEALTH INFORMATION

PATIENT NAME:_____ **DOB:** _____ **SS#:** _____-_____-_____

PREVIOUS NAME: _____**ADDRESS:** _____

To Whom It May Concern:

I authorize _____

To release my protected health information to and/or from:

Name: Hometown Medical Group – Dr. William R. Turner, Jr. / Leigha Lentini, CRNP / Rebekah Taylor, CRNP

Address: 1705 Main Ave SW Ste B, Cullman, AL 35055

Medical records dated from _____ to _____

Please initial all that apply:

_____ **Complete Medical Record** – Includes, but is not limited to, demographics, medical history, office notes, hospital records, laboratory reports, test results, radiology images, referrals, consultations, prescription information, and records received from other healthcare providers.

_____**Records Related to Behavioral Health and Substance Use** – Includes documentation related to drug or alcohol treatment and/or mental health services.

_____**Sensitive Health Information** – Includes STD test results and HIV/AIDS testing results (whether negative or positive). I understand that I must provide written permission before this information is released, and those receiving the information will be made aware of this requirement.

I authorize Hometown Medical Group to release all relevant information, without limitation, regarding any care, treatment, examination, or condition related to me, including any medical, psychiatric, or counseling records.

This authorization shall remain in effect for one (1) year from the date signed below unless revoked in writing. A copy of this authorization shall be considered as valid as the original.

_____	_____	_____
Print Name	Signature	Today's Date

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NOTICE OF PRIVACY PRACTICES

This notice describes how your medical information may be used and disclosed, and how you can access this information. Please review it carefully. Hometown Medical Group is committed to protecting your personal health information (PHI). This notice applies to all records of your care generated by our clinic, whether made by clinic staff or your provider.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

We may use and disclose your PHI without your written permission in the following ways:

- **Treatment:** To provide, coordinate, or manage your medical care.
- **Payment:** To bill and collect payment for services provided to you.
- **Healthcare Operations:** For activities such as quality assessment, training, and administrative purposes.

OTHER USES AND DISCLOSURES

We may also use or disclose your information in the following situations, when permitted or required by law:

- Public health and safety issues (e.g., reporting diseases, abuse, or threats)
- Legal proceedings or law enforcement
- Workers' compensation claims
- Health oversight activities
- Appointment reminders or follow-up communications

All other uses and disclosures not described in this notice will require your written authorization. You may revoke that authorization in writing at any time.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the right to:

- Request a copy of your medical records
- Request corrections to your records
- Request confidential communications
- Request restrictions on certain uses or disclosures
- Obtain a list of disclosures we have made (for purposes other than treatment, payment, or operations)
- Receive a paper copy of this notice upon request

OUR RESPONSIBILITIES

We are required by law to:

- Maintain the privacy of your health information
- Provide this notice describing our legal duties and privacy practices
- Abide by the terms of this notice
- Notify you if a breach of unsecured PHI occurs

CHANGES TO THIS NOTICE

We reserve the right to change the terms of this notice. Updates will be posted in our office, and the revised notice will apply to all health information we maintain.

QUESTIONS OR COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our Administrative Assistant or with the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

Meet Our Providers

Dr. Randy Turner, MD

Dr. Turner grew up in Fort Payne, earned his engineering degree from Auburn, and later completed his medical degree at UAB. After finishing Family Medicine residency in 2020, he moved to Cullman and founded Hometown Medical Group in 2022 to bring better primary care to the community.

Leigha Lentini, CRNP

Leigha is a Cullman native who earned her BSN from UAB and MSN from Troy University. With experience in critical care, primary and urgent care, occupational medicine, and aesthetics, she now serves as both a provider and Director of Clinical Operations at Hometown Medical Group, proudly caring for the community she grew up in.

Rebekah Taylor, CRNP

Rebekah earned her BSN and MSN from The University of Alabama and has a strong focus in women's health and hormone optimization. A certified pelvic health clinician and active member of The Menopause Society, she is known for delivering compassionate, evidence-based care to women in all stages of life.