

John G. Wideman, MD
Women's Medical Plaza Suite 214
2006 Brookwood Medical Center Plaza
Birmingham, Alabama 35209
205-877-5199

Thank you for scheduling an appointment. Please complete this online **PRIOR** to your visit.

In order to enhance the level of service that we provide you, Dr. JOHN WIDEMAN requests that you complete your patient history forms in advance through a new online service called **digiChart** Patient Portal. Using **digiChart** Patient Portal will save you time at your appointment and ensure that your history information is organized beforehand. This thorough history enables your healthcare providers to more effectively discuss your current health and healthcare concerns.

If you have a computer connected to the Internet and go to the website:
<https://patients.digichart.com>

1. At the Patient Portal login prompt, enter the following:
Username:
Password:
2. When you first login, you will be prompted to change your Username to your email address. The email address that you enter will now be what you use to login for future visits. *Please note that we will only use your email address for support-related communication.*
3. On the same screen, you will also be required to type your current password (from this letter) and then change your password to something easier for you to remember.
4. After you have entered your email address as your Username and your new Password, the above Username and Password will no longer be valid.

If you are interrupted while entering your information, you can return to **it** at your convenience and pick up where you left off. This will ensure you have adequate time to complete your history questionnaire. Typically, it takes 30 minutes to complete this process. If you are a returning patient, you will only need to update any changes in your medical history. Your information is stored securely and it remains confidential. No one outside of our practice will have access to your information. All government healthcare privacy regulations are met, to ensure privacy of your medical information.

Please complete at least 48 hours before your appointment. If this is not possible, please arrive 30 minutes early to complete your questionnaire before seeing Dr. Wideman.

If you have any questions about the Patient Portal, please email us at portalsupport@digichart.com or call digiChart's Support Desk, toll free at (866) 811-5217, Monday through Friday, 7:00 AM - 6:00 PM (CST).

Thank you again,

Dr. John Wideman & Staff

Notice of Privacy Practices

- We receive explicit authorization from you to release individually identifiable information. This authorization must be in writing and give exact details regarding to whom the disclosure applies, the nature of the data to be released, the applicable dates and signed by the patient (or guardian). You may revoke this authorization by providing a written statement to the John Wideman M.D., P.O Privacy Officer.
- Federal, state or other applicable law requires us to share protected information or records.

We are obligated to abide by the terms of this notice. If, at any time in the future, it is necessary to disclose any of your personal information in a way that is materially different from this policy, John Wideman M.D., P.O will give you notice of the change through a mailed announcement or on your visit following the change.

With some exceptions, you have right to review and obtain a copy of your health information. This request must be in writing and there may be a reasonable charge to provide you with a copy of your information. You also have the rights to request your records be amended, to request special accommodations and restrictions of your health information and to receive an accounting of the disclosures of your information. You have the right to request to receive confidential communications of your information. John Wideman M.D., P.O is not obligated to agree to a requested restriction. We must receive a written request from you to administer these rights. Please speak to the receptionist for further information or to begin the process to exercise any of these rights.

If you have a complaint about the management of your health information or believe your privacy rights have been violated, contact Paula Engle at (205-877-5199). You have the right to file a complaint with the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. There will be no retaliation for filing a complaint.

Other uses of PHI:

- Your medical information may be reviewed by our medical staff for possible inclusion and referral in research studies. You will be contacted prior the use of your information in a research study.
- We may leave a message on your answering machine or voice mail to contact you about appointments or to have you call our office.
- Our practice participates with Blue Cross and Blue Shield of Alabama InfoSolutions® and we will provide protected health information about you to this database if they manage your claim benefits.

Authorization for Release of Medical Information

Patient Name

Phone Number

Date of Birth

Social Security Number

I hereby authorize:

Name of physician/clinic/hospital

City/State

Phone Number

To release a copy of any and all of my Medical Records including the diagnosis, progress notes, etc. and any additional information related to my treatment.

I understand that my medical record may contain information regarding HIV testing and/or treatment, Drug or Alcohol testing and/or treatment, Psychological testing and/or treatment, or Sexually Transmitted Disease testing and/or treatment and I authorize their release.

I request that a copy of my medical records be forwarded to the following address:

John Wideman, M.D.
WMP Suite 214
2006 Brookwood Medical Center Drive
Birmingham, Alabama 35209
Phone 205-877-5199
Fax 205-877-5489

I understand this authorization may be revoked by me in writing at any time except to the extent that action has been taken in reliance of this authorization. Unless otherwise revoked, this authorization will expire one year from the date signed.

I hereby release John Wideman M.D., P.C. or any of their agents from legal responsibility for disclosure of the above information to the extent indicated and authorized.

Signature of Patient _____ Date Signed _____

John Wideman M.D., P.C.
PATIENT CONTACT INFORMATION SHEET

Patient Name: _____

Social Security Number: _____

Any physician, staff, employee or representative of **John Wideman M.D., P.C.** has my permission to discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information with the following persons in order to facilitate and coordinate my care, treatment and payment:

_____ Name _____ Relationship _____ Phone Number(s) _____

_____ Name _____ Relationship _____ Phone Number(s) _____

_____ Name _____ Relationship _____ Phone Number(s) _____

_____ Name _____ Relationship _____ Phone Number(s) _____

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment, I can refuse to sign this form. I can revoke it by writing to **John Wideman M.D., P.C.** or completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individuals it may be subject to redisclosure by the individual(s).

Patient Signature: _____ **Date:** _____

WE APPRECIATE THE OPPORTUNITY OF SERVING YOU

I authorize the release and disclosure of any or all of my medical and treatment records to any other health care provider who may be of assistance in the opinion of John Wideman, MD, PC and or for assisting in any reimbursement or medical benefits to which patient may be entitled. I allow fax transmittal of my medical records if necessary. I further authorize and request that insurance payments be made directly to John Wideman MD, PC should they elect to receive such payment. This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original.

I acknowledge full financial responsibility for services rendered by John Wideman MD, PC. I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges.

I authorize treatment by John Wideman MD, PC, physicians and personnel.

I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

I have read the above and accept financial responsibility in full for this account.

Signed _____ date _____
Patient, parent or guardian

____ I have received the Notice of Privacy Practices for John Wideman MD, PC
____ I have declined the Notice of Privacy Practices.

Signed _____ date _____

In case of emergency please contact:

Name _____

Phone number _____

Address _____

Relationship _____

PATIENT INFORMATION

PATIENT NAME: LAST _____ FIRST _____ MIDDLE _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____
WORK PHONE #: _____ CELL PHONE #: _____

EMAIL ADDRESS: _____
Education (highest Level obtained) _____
Occupation _____

DATE OF BIRTH: ____/____/____ SOCIAL SECURITY NUMBER: _____ -

MARITAL STATUS: (circle one) SINGLE MARRIED DIVORCED WIDOWED OTHER

PATIENT RELATIONSHIP TO THE RESPONSIBLE PARTY :(circle one)
SELF SPOUSE CHILD OTHER

SEX: (circle one) FEMALE MALE
PRIMARY CARE PHYSICIAN: _____ REFERRED BY: _____

Patient's EMPLOYER INFORMATION:
COMPANY: _____
CITY: _____ PHONE #: _____

RESPONSIBLE (OR INSURED) PARTY INFORMATION

PARTY NAME: LAST _____ FIRST _____ MIDDLE _____
ADDRESS: _____
DATE OF BIRTH: ____/____/____
SEX: (circle one) FEMALE MALE
HOME PHONE: (____) _____ WORK PHONE: (____) _____

SOCIAL SECURITY NUMBER: _____ - _____ - _____
RESPONSIBLE PARTY'S EMPLOYER INFORMATION:
COMPANY: _____
CITY: _____ PHONE: _____

PRIMARY INSURANCE COMPANY: _____
ADDRESS: _____ PHONE: _____

CONTRACT (ID#) NUMBER: _____
SUBSCRIBER'S NAME: _____
PATIENT RELATIONSHIP TO SUBSCRIBER: (circle one) SELF SPOUSE CHILD OTHER
GROUP NAME: _____ GROUP NUMBER: _____

COPAYMENT AMOUNT: \$ _____ INSURED'S DATE OF BIRTH: ____/____/____ PRIMARY INSURANCE
COMPANY: _____
ADDRESS: _____ PHONE: _____

SECONDARY Insurance Company _____
CONTRACT (ID#) NUMBER: _____
SUBSCRIBER'S NAME: _____
PATIENT RELATIONSHIP TO SUBSCRIBER: (circle one) SELF SPOUSE CHILD OTHER
GROUP NAME: _____ GROUP NUMBER: _____

COPAYMENT AMOUNT: \$ _____ INSURED'S DATE OF BIRTH: ____/____/____