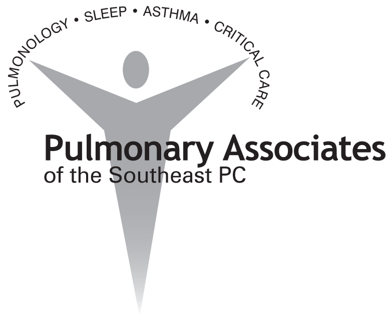
Main Office
880 Montclair Road, Suite 270
Birmingham, AL 35213-2437

St. Vincent's Blount
150 Gilbreath Drive
Oneonta, AL 35121

Northside Medical Center
70 Plaza Drive
Pell City, AL 35125



Gardendale Clinic
2215 Decatur Highway, Suite 117
Gardendale, AL 35071

Sylacauga Clinic
Medical Arts Building, Suite 124
120 South Anniston Avenue
Sylacauga, AL 35150

Chelsea Clinic
16691 Hwy 280
Chelsea, AL 35043

Russell G. Beaty, M.D • Sandra K. Gilley, M.D. • Allan R. Goldstein, M.D. • W. Bishop Kelley, M.D. • Karl T. Schroeder, M.D. • Alan Q. Thomas, M.D.

205-802-2000 or 1-866-877-LUNG (5864) Option 1 – Appointments Option 2 – Prescription Refills Option 3 – Doctor's Medical Assistant

PATIENT INFORMATION

Scheduled Physician__________ Referring Physician__________ Preferred Pharmacy__________

Last Name__________ First Name__________ Middle__________

DOB__________ Sex__________ SSN__________

Marital Status__________ Driver License #__________

Address__________

ZIP__________ City__________ State__________ County__________ Country__________

Home Phone__________ Work__________ Cell__________

Fax__________ Pager__________ Email__________

Preferred Communication__________

EMPLOYER

Name__________ Status__________

Occupation__________ Phone (w/ extension)__________

ASSOCIATED PARTY (POLICY HOLDER)

Name__________ Type__________

Relationship__________ DOB__________

EMERGENCY CONTACT AND AUTHORIZED CONTACT

Emergency Contact Name__________ Phone Number__________

Authorized Contact Name & Number for Personal Health/Billing__________

Authorized 1.__________ Authorized 2.__________

Authorized 3.__________ Authorized 4.__________

INSURANCE

Do you have insurance coverage? ☐Yes ☐No

☐Employer ☐Exchange ☐Individual ☐ Worker's Compensation

Insurance Cards Provided? ☐Yes ☐No

I HAVE READ THE ABOVE AND AGREE THAT THE INFORMATION IS CORRECT.

CONSENT FOR TREATMENT – I consent to necessary treatment, including drugs, medicine, performance of operations and of X-ray, or other studies that may be used by the attending physician, his/her nurse or staff.________

I (aka) authorize Pulmonary Associates of the SE to utilize the medical information obtained during the course of my treatment in medical research and education programs as long as my name & likeness are not revealed and my privacy is completely protected.________

AUTHORIZATION FOR RELEASE OF INFORMATION – I authorize the release of any and all my treatment and service information to third parties to facilitate billing, collection or referrals for services to other providers. This includes psychological or psychiatric care, attention and treatment.________

ASSIGNMENT – I hereby assign Pulmonary Associates of the SE, P.C. all payments for medical and/or surgical services rendered to my dependents due or received from third-party providers. I agree to be responsible for any amount not covered by insurance or other providers. I agree to pay all cost of collection including a reasonable attorney's fee (should this account be placed with an attorney for collection).________

Signature__________ **Date**__________