MEDICAL ASSOCIATES OF THE SHOALS, PC

PATIENT DEMOGRAPHICS

WHEN REGISTERING, PLEASE PRESENT PROOF OF INSURANCE. ALL COPAYMENTS AND OUT OF POCKET PAYMENTS ARE EXPECTED AT THE TIME OF SERVICE

PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX	MARITAL STATUS	SPOUSE'S NAME
			- -	/ /	M F	S M W D	

ADDRESS	CITY	STATE	ZIP	HOME PHONE
				( ) -

EMAIL	PREFERRED PHARMACY	CELL PHONE
		( ) -

PREFERRED METHOD OF COMMUNICATION: HOME PHONE ☐ CELL PHONE ☐ MAIL ☐ EMAIL ☐ **WORK PHONE** ( ) -

RACE: WHITE (CAUCASION) ☐ BLACK (AFRICAN AMERICAN) ☐ AMERICAN INDIAN ☐ ASIAN ☐ OTHER ☐ I DECLINE TO LIST RACE ☐

PRIMARY LANGUAGE: ENGLISH ☐ OTHER ☐ **OCCUPATION (*PATIENT*):**

INSURANCE #1 (PRIMARY INSURANCE - THIS WILL BE FILED FIRST)

INSURANCE COMPANY	CONTRACT NUMBER	GROUP NUMBER

ADDRESS	CITY	STATE	ZIP	PHONE

SUBSCRIBER'S LAST NAME	FIRST NAME	MIDDLE NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX	MARITAL STATUS	RELATIONSHIP TO PATIENT
			- -	/ /	M F	S M W D	

ADDRESS	CITY	STATE	ZIP

EMPLOYER	ADDRESS

INSURANCE #2 (SECONDARY INSURANCE - THIS WILL BE FILED AFTER PRIMARY INSURANCE PAYS)

INSURANCE COMPANY	CONTRACT NUMBER	GROUP NUMBER

ADDRESS	CITY	STATE	ZIP	PHONE

SUBSCRIBER'S LAST NAME	FIRST NAME	MIDDLE NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX	MARITAL STATUS	RELATIONSHIP TO PATIENT
			- -	/ /	M F	S M W D	

ADDRESS	CITY	STATE	ZIP

EMPLOYER	ADDRESS

EMERGENCY CONTACT INFORMATION

LAST NAME	FIRST NAME	HOME PHONE	CELL PHONE	RELATIONSHIP TO PATIENT

ADDRESS	CITY	STATE	ZIP

FINANCIALLY RESPONSIBLE PARTY

THIS IS THE PERSON WHO ACCEPTS RESPONSIBILITY FOR PAYMENT OF THE ACCOUNT. THIS MAY OR MAY NOT BE THE SAME PERSON THAT HOLDS THE INSURANCE CONTRACT. ALL BILLING WILL GO TO THE FINANCIALLY RESPONSIBLE PERSON, AND THIS FORM MUST BE SIGNED BY THE PERSON WHO IS FINANCIALLY RESPONSIBLE.

LAST NAME	FIRST NAME	MIDDLE NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX	MARITAL STATUS	RELATIONSHIP TO PATIENT
			- -	/ /	M F	S M W D	

ADDRESS	CITY	STATE	ZIP

EMPLOYER	EMPLOYER PHONE NUMBER	ADDRESS

Insurance is a contract between you and your insurance company. We are not a party to your contract. We will not become involved in disputes between you and your insurance company regarding deductibles, co-insurances, non-covered charges, pre-existing conditions, coordination of benefits, secondary insurance, or "reasonable and customary" charges, however, we will assist by filing your primary insurance and secondary insurance as a courtesy.

* **I understand and realize that failure to make timely payment and maintain financial compliance is a basis for legal action and any court cost / collection fees / attorney fees will be assumed by me.**

* **I have read the financial policy and understand I am personally responsible for payment on this account in the event that my insurance deems a service to be "non-covered".**

Signature - Financially Responsible (Guarantor)

Date

MEDICAL ASSOCIATES OF THE SHOALS, P.C.

FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to providing you with the best possible medical care at the lowest possible cost. Please understand that the payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

In order to achieve the practice goals of providing the finest medical care at the lowest possible cost, we need your assistance, and your understanding of our payment policy.

FULL PAYMENT FOR PROFESSIONAL SERVICES IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, MONEY ORDERS, DEBIT AND CREDIT CARDS.

All patients who have accounts with outstanding balances will have statements mailed on a monthly basis to their permanent address. After 90 days, if no payments have been received, necessary collection proceedings will begin.

Payments in full for services rendered to a minor are expected at time of service. Parents, guardians, or the accompanying adult will be responsible for this payment.

Returned checks will be assessed additional collection fees. If the checks are not picked up from our business office in an appropriate timeframe, you may be referred to the District Attorney for collection.

Although we are anxious to help you in receiving your maximum allowable insurance benefits, it is your responsibility to understand what your insurance benefits are. You must present your insurance cards to the receptionist prior to seeing the doctor. Any change in insurance or personal information not brought to our attention could result in claim denial by your insurance carrier. By law your insurance carrier should remit payment or deny your insurance claim within 30 days of initial notice of claim. If an insurance problem occurs, you will be asked to assist us in contacting your insurance carrier. We feel it is necessary to work together to resolve any insurance problem. Please remember that few insurance companies attempt to cover all medical costs.

ALL CO-PAYS AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communications. Thank you for understanding our Financial Policy. If you have any questions about this policy, please feel free to talk with a member of our Business Office. We will make every effort available to clarify any misunderstanding you have concerning your balance. We are here to help you.

☐ I have read, understand, and agree to this Financial Policy.

_____ _____

SIGNATURE OF RESPONSIBLE PARTY DATE

MEDICAL ASSOCIATES OF THE SHOALS, P.C.

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 IT CAREFULLY.

THE EFFECTIVE DATE OF THIS PRIVACY NOTICE IS APRIL 14, 2003, AS AMENDED ON SEPTEMBER 1, 2013.

Medical Associates of the Shoals, P.C. ("Medical Associates") (“Facility”, “us” or “we”) is required under the federal health care privacy rules (the "Privacy Rules"), to protect the privacy of your health information, which includes information about your health history, symptoms, test results, diagnoses, treatment, and claims and payment history (collectively, "Health Information"). We are also required to provide you with this Privacy Notice regarding our legal duties, policies and procedures to protect and maintain the privacy of your Health Information. We are required to follow the terms of this Privacy Notice unless (and until) it is revised. We reserve the right to change the terms of this Privacy Notice and to make the new notice provisions effective for the Health Information that we maintain and use, as well as for any Health Information that we may receive in the future. Should the terms of this Privacy Notice change, we will make a revised copy of the notice available to you. Any revised Privacy Notice will be available at our Facility(ies) for individuals to take with them and we will post a copy of a revised Privacy Notice in a prominent location in our Facility(ies). This Privacy Notice will also be posted and made available electronically on our website.

PERMITTED USES AND DISCLOSURES OF YOUR HEALTH INFORMATION.

1. **General Uses and Disclosures.** Under applicable law, we are permitted to use and disclose your Health Information for the following purposes, without obtaining your permission or Authorization:

- **Treatment.** We are permitted to use and disclose your Health Information in the provision and coordination of your healthcare. For example, we may disclose your Health Information to your primary healthcare provider(s), consulting providers, and to other health care personnel who have a need for such information for your care and treatment.

- **Payment.** We may use and disclose your Health Information so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or other third party, including determining the applicability of any health insurance coverage. For example, a bill sent to your insurance company may include information that identifies you, your medical information, and the procedures and supplies used in your treatment.

- **Healthcare Operations.** We are permitted to use and disclose your Health Information for certain administrative, legal and quality improvement activities that are necessary for us to run our practice and to support our functions of treatment and payment, including, but not limited to: quality assurance, auditing, licensing or credentialing activities, and for educational purposes. For example, we can use your Health Information to internally assess our quality of care provided to patients.

- **Uses and Disclosures Required by Law.** We may use and disclose your Health Information when required to do so by law, including, but not limited to reporting abuse, neglect and domestic violence, in response to judicial and administrative proceedings, in responding to a law enforcement request for information; or in order to alert law enforcement to criminal conduct on our premises.

- **Public Health Activities.** We may disclose your Health Information for public health reporting, including, but not limited to reporting child abuse and neglect; reporting communicable diseases and vital statistics; product recalls and adverse events; or notifying person(s) who may have been exposed to a disease.

- **Abuse, Neglect, or Domestic Violence.** We may disclose your Health Information to a local, state, or federal government authority if we have a reasonable belief of abuse, neglect or domestic violence.

- **Regulatory Agencies.** We may disclose your Health Information to a healthcare oversight agency for activities authorized by law, including, but not limited to, licensure investigations and inspections. These activities are necessary for the government and certain private health oversight agencies to monitor the healthcare system, government programs, and compliance with civil rights.

- **Judicial and Administrative Proceedings.** We may disclose your Health Information in judicial and administrative proceedings, as well as in response to an order of a court, administrative tribunal, or in response to a subpoena, summons, warrant, discovery request, or similar legal request.

- **Law Enforcement Purposes.** We may disclose your Health Information to law enforcement officials when required to do so by law.

- **Coroners, Medical Examiners, Funeral Directors.** We may disclose your Health Information to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose your Health Information to funeral directors, as necessary, to carry out their duties.

- **Organ Donation.** We may disclose your Health Information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissues.

- **Research.** Under certain circumstances, we may disclose your Health Information to researchers when their clinical research study has been approved and where certain safeguards are in place to ensure the privacy and protection of your Health Information.

- **Threats to Health and Safety.** We may use or disclose your Health Information if we believe, in good faith, that the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public, or is necessary for law enforcement to identify or apprehend an individual.

- **Specialized Government Functions.** We may disclose your Health Information to authorized federal officials for national security reasons and the Department of State for medical suitability determinations. We may also disclose your Health Information to authorized federal officials for the provision of protective services to the President of the United States or to foreign heads of state or to conduct related investigations. If you are a member of the U.S. Armed Forces, we may disclose your Health Information as required by military command authorities.

- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose your Health Information to the correctional institution or law enforcement official, where such information is necessary for the institution to provide you with healthcare; to protect your health or safety, or the health or safety of others; or for the safety and security of the correctional institution.

- **Workers' Compensation.** We may disclose your Health Information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs that provide benefits for work-related injuries or illnesses without regard to fault.

- **Fundraising.** We may use or disclose your Health Information to make a fundraising communication to you for the purpose of raising funds for our own benefit. With each fundraising communication, we will provide you with an opportunity to elect not to receive any further fundraising communications. We will also make reasonable efforts to ensure that if you opt out of such communications you are not sent future fundraising communications. We may also use, or disclose to a business associate or to an institutionally related foundation, the following Health Information for the purpose of raising funds for our own benefit: (a) demographic information relating to you, including your name, address, other contact information, age, gender, and date of birth; (b) the dates of healthcare provided to you; (c) the department or area of service that provided you treatment; (d) your treating physician; (e) outcome information; and (f) your health insurance status.

- **Marketing.** We may use or disclose your Health Information to make a marketing communication to you that occurs in a face-to-face encounter with us or which concerns a promotional gift of nominal value provided by us.

- **Refill Reminders, Care Coordination, Alternative Therapies.** We may provide you with refill reminders about a drug or biologic that is currently being prescribed for you, but only if any financial remuneration received by us in exchange for making the communication is reasonably related to our cost of making the communication. Except where we receive financial remuneration in exchange for making the communication, we may communicate with you for the following treatment and health care operations purposes: (a) for your treatment including case management or care coordination, or to direct or recommend alternative treatments, therapies, healthcare providers, or settings of care; (b) to describe a health-related product or service (or payment for such product or service) that is provided by, or included in a plan of benefits, including communications about a healthcare provider network or health plan network; replacement of or enhancements to, a health plan; and or (c) for case management or care coordination, contacting of individuals with information about treatment alternatives, and related functions to the extent these activities are not considered treatment.

- **Business Associates.** We may disclose your Health Information to business associates who provide services to us pursuant to a written agreement that contains terms regarding protection of your Health Information. Our business associates are required to protect the confidentiality of your Health Information.

- **Other Uses and Disclosures.** In addition to the reasons outlined above, we may use and disclose your Health Information for other purposes permitted by applicable law.

2. **Uses and Disclosures Which Require Patient Opportunity to Verbally Agree or Object.** Under applicable law, we are permitted to use and disclose your Health Information: (a) for the creation of facility directories, (b) to disaster relief agencies, and (c) to family members, close personal friends or any other person identified by you, if the information is directly relevant to that person's involvement in your care or treatment. Except in emergency situations, you will be notified in advance and have the opportunity to verbally agree or object to this use and disclosure of your Health Information.

3. **Uses and Disclosures Which Require Written Authorization.** As required by applicable law, all other uses and disclosures of your Health Information (not described above) will be made only with your written permission, which is called an Authorization. For example:

- **Psychotherapy Notes.** If we maintain psychotherapy notes, we must obtain your Authorization for any use or disclosure of such psychotherapy notes, except to carry out the following treatment, payment, or health care operations: (a) use by the originator of the psychotherapy notes for treatment; (b) use or disclosure by us for our own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling; or (c) use or disclosure by us to defend ourselves in a legal action or other proceeding brought by you.

- **Certain Marketing Purposes.** If we receive financial remuneration in exchange for making a marketing communication we must obtain your Authorization for any use or disclosure of Health Information other than a face-to-face communication made by us to you, or for a promotional gift of nominal value provided by us.

- **Sale of Health Information.** We must obtain your Authorization for any sale of your Health Information and such Authorization will state that the disclosure will result in our receiving remuneration.

4. **Revoking Your Authorization.** You may revoke your Authorization in writing at any time. The revocation of your Authorization will be effective immediately, except to the extent that: we have relied upon it previously for the use and disclosure of your Health Information; if the Authorization was obtained as a condition of obtaining insurance coverage where other law provides the insurer with the right to contest a claim under the policy or the policy itself; or where your Health Information was obtained as part of a research study and is necessary to maintain the integrity of the study.

PATIENT RIGHTS

You have the following rights concerning your Health Information:

1. **Right to Receive Written Notification of a Breach of Your Unsecured Health Information**. You have the right to receive written notification of a breach of your unsecured Health Information if it has been accessed, used, acquired, or disclosed in a manner not permitted by the Privacy Rules. We will provide this notification by first-class mail or, if necessary, by such other substituted forms of communication allowable by law or you may request in writing to receive a notification of a breach by electronic mail.

2. **Right to Inspect and Copy Your Health Information.** Upon written request, you have the right to inspect and copy your own Health Information contained in a designated record set maintained by or for us. A "designated record set" contains medical and billing records and any other records that we use for making decisions about you. However, we are not required to provide you access to all the Health Information that we maintain. For example, this right of access does not extend to psychotherapy notes, or information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative proceeding. Where permitted by the Privacy Rules, you may request that we review certain denials to inspect and copy your Health Information. Instead of copies, we can provide you with a summary of your Health Information if you agree to the form and cost of such summary. If you request a paper copy or summary explanation of your Health Information, we may charge you a reasonable fee for copying costs, postage, and any other costs associated with preparing the summary or explanation. Instead of paper copies, if your Health Information is maintained in an electronic health record, you may request that we provide the information in electronic form to either you or to a designated third-party if such designation is clear, conspicuous, and specific. We may charge you a reasonable cost-based fee for an electronic copy, which shall not exceed our labor costs in responding to the request. We may, in some cases, deny your request to inspect and copy your Health Information and will notify you in writing of the reasons for our denial and provide you with information regarding your rights to have our denial reviewed.

3. **Right to Request Restrictions on the Use and Disclosure of Your Health Information.** You have the right to request restrictions on the use and disclosure of your Health Information for treatment, payment and healthcare operations. We will consider, but do not have to agree to, such requests. However, we must agree to restrict a disclosure of Health Information about you to a health plan if: (a) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and (b) the Health Information pertains solely to a healthcare item or service for which you, or someone other than the health plan on your behalf, has paid in full.

4. **Right to Request an Amendment of Your Health Information.** You have the right to request an amendment of your Health Information. We may deny your request if we determine that you have asked us to amend information that: was not created by us, unless the person or entity that created the information is no longer available; is not Health Information maintained by or for us; is Health Information that you are not permitted to inspect or copy; or we determine that the information is accurate and complete. If we disagree with your requested amendment, we will provide you with a written explanation of the reasons for the denial, an opportunity to submit a statement of disagreement, and a description of how you may file a complaint.

5. **Right to an Accounting of Disclosures of Your Health Information.** You have the right to receive an accounting of disclosures of your Health Information made by us. With respect to Health Information contained in paper form, our accounting will not include: disclosures related to treatment, payment or healthcare operations; disclosures to you; disclosures based upon your Authorization; disclosures to individuals involved in your care; incidental disclosures; disclosures to correctional institutions or law enforcement officials; disclosures for facility directories; disclosures that are part of a Limited Data Set; or disclosures that occurred prior to April 14, 2003 or as otherwise allowed by the Privacy Rules. With respect to Health Information contained in an electronic health record, unless otherwise specified by law, the accounting will not contain disclosures made to you upon your request; based upon your Authorization; to individuals involved in your care; or as allowed by law. You may request an accounting of applicable disclosures made by us within six (6) years prior to the date of your request for Health Information stored in paper form and made within three (3) years prior to the date of your request (but not for any disclosures made prior to implementation of our electronic health records system) for Health Information stored in an electronic health record. If you request an accounting more than once in a 12-month period, we may charge you the reasonable cost-based expenses incurred to comply with your additional request.

6. **Right to Alternative Communications.** You have the right to receive confidential communications of your Health Information by a different means or at a different location than currently provided. For example, you may request that we only contact you at home or by mail. Such requests must be made in writing.

7. **Right to Receive a Paper Copy of this Notice of Privacy Practices.** You have the right to receive a paper copy of this Notice of Privacy Practices upon request.

If you want to exercise any of these rights, have any questions, or feel that your privacy rights have been violated, please contact us. All requests must be submitted to us in writing and returned to the address below.

Medical Associates of the Shoals, P.C.
Attn: Privacy Officer - Dorinda Littrell
1100 South Jackson Highway
Suite 150
Sheffield, AL 35660

256-383-4447 Ext 134

If you believe that your privacy rights have been violated or that we have violated our own privacy practices, you may file a complaint with our Privacy Officer. You may also file a complaint with the Office of Civil Rights, U.S. Department of Health and Human Services. Our Privacy Officer can provide you with the address.

BY SIGNING BELOW, I HEREBY ACKNOWLEDGE RECEIPT OF THIS NOTICE OF PRIVACY PRACTICES.

_____ _____

Printed Name of Patient Date

_____

Signature of Patient

_____

Printed Name of Parent/Patient's Representative (If Applicable)

_____

Signature of Parent/Patient's Representative (If Applicable)

MEDICAL ASSOCIATES OF THE SHOALS

E-MAIL CONSENT FORM

Patient Name:	E-mail address
Social Security or Account Number:	Date of Birth:

***Please read the following statements carefully**:*

1. **RISKS OF USING E-MAIL.** Transmitting patient information by E-mail has many significant risks that you should consider before asking us to use E-mail as a means of communicating your personal health information. These risks include, but are not limited to, the following:

a. E-mail can be circulated, forwarded and stored in numerous paper and/or electronic files without your knowledge;
b. E-mail can be sent immediately worldwide and received by large numbers of unintended individuals;
c. E-mail addresses can be misaddressed causing the information to be sent to the wrong individuals; or
d. E-mail can be intercepted, changed and redistributed to others.

2. **OUR CONDITIONS FOR USE OF E-MAIL.** We will use reasonable means to protect the security and confidentiality of E-mail sent and received. However, because of the risks, some of which are outlined above, we cannot guarantee the security and confidentiality of E-mail communications, and will not be responsible for improper disclosures of your health information. Accordingly, you must consent to the use of E-mail for sending your personal health information. Consent to the use of E-mail includes your agreement with the following conditions:

a. All E-mails concerning your diagnosis or treatment will be printed out and made part of your medical record. Because they are a part of the medical record, other individuals authorized to access the medical record will have access to these E-mails;
b. We may forward E-mails internally to our staff and agents as necessary for diagnosis, treatment, reimbursement, and other appropriate purposes. We will not, however, forward E-mails to independent third parties without your prior written consent, except as authorized by law;
c. We cannot guarantee that any particular E-mail from you will be read and responded to within any particular time. Thus, you should not use E-mail for medical emergencies or other time sensitive matters;
d. If your E-mail requires or invites a response from us, and you have not received a response from us within a reasonable period of time, it is your responsibility to follow-up to determine whether the intended recipient received the E-mail and when the recipient will respond;
e. You should not use E-mail for communication of sensitive medical information including, without limitation, sexually transmitted diseases, HIV/AIDS, mental health conditions, substance abuse or other developmental disabilities;
f. You are responsible for informing us of any type of information that you do not want sent by E-mail;
g. We shall not engage in unlawfully practicing medicine across state lines; and
h. We will not be responsible for the occurrence of any of the items set forth in Paragraph 1 above.

BY SIGNING THIS FORM ON THE BOTTOM/LEFT, I HEREBY ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THIS CONSENT TO USE AND/OR DISCLOSE MY HEALTH INFORMATION VIA E-MAIL. I UNDERSTAND THE RISKS AND CONSENT TO THE CONDITIONS OUTLINED HEREIN AND ANY OTHER INSTRUCTIONS OR CONDITIONS MEDICAL ASSOCIATES OF THE SHOALS, P.C. MAY IMPOSE CONCERNING THE USE OF E-MAIL COMMUNICATIONS.

_____ _____
Signature of Patient or Patient's Representative Date

_____
Printed Name of Patient's Representative (*if applicable*)

_____
Representative's Relationship to Patient (*if applicable)*

OR: ***I DENY CONSENT TO USE E-MAIL***

_____
Signature to Deny & Date

MEDICAL ASSOCIATES OF THE SHOALS, P.C.

PHARMACY BENEFIT MANAGEMENT (PBM) CONSENT FORM

(E)LECTRONIC-PRESCRIBING

E-Prescribing - is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care.

Medication History Transactions – Provides the physician with information about medications that the patient is already taking prescribed by any provider, to minimize the number of adverse drug events.

By signing this consent you are agreeing that Medical Associates of the Shoals can request and use your prescription medication history from other healthcare providers and/ or third party pharmacy benefit payors for treatment purposes.

_____ _____

Patient Name (print) Patient Date of Birth

_____ _____

Patient Signature Date

☐ I DENY CONSENT

_____ _____

Patient Signature Date