New Patient Information

Name (Last)_____(First)_____(M.I.)_____

Address_____City_____State_____Zip_____

Marital Status_____ Sex: **M F** Employer_____

Birth Date _____ Age_____ Social Security Number _____

Home Phone (___) _____Work (___) _____Cell (___)_____

Emergency Contact _____ Relationship to Patient _____

Emergency Contact Phone (___)_____

Spouse's Name (If applicable) _____ Spouse's Birth Date_____

Spouse's Social Security Number _____

Person Responsible for Payment (complete only if different from patient)

Name_____ Relationship_____ Employer_____

Social Security Number_____ (Often necessary for billing)

Home Phone (___) _____Work Phone (___)_____

Insurance Information

Name of Primary Insurance_____

Contract #_____ Group #_____Effective Date_____

Request for Confidential Handling of Health Information

Complete only if you want communications regarding your health care information sent to an alternate address or telephone other than listed above. I requst that my provider handle my confidential health information as described below. All reasonable requests to receive communication of your health information by alternative means and/or locations will be granted. Please describe the alternative means below (e.g. US mail, telephone call, etc.) by which you prefer to receive your health information.

Alternate Address_____

Alternate Telephone_____ Alternate Telephone_____

Agreement

If your insurance company OR health plan requires pre-approval OR referral for your visit, it is your responsibility to obtain this referral or YOU will be personally responsible for the bill. I, the undersigned (patient or legal guardian), authorize medical treatment to be rendered by the provider and assume financial responsibility. In the event the account is not paid in full within 90 days*, the undersigned agrees to pay all costs of collection including reasonable attorney fees, and hereby waives all rights of exemption under the constitution and laws of the State of Alabama. I also authorize the release of my medical records to my physicians and insurance carriers. If the provider has a contractual arrangement with your insurance carrier, the balance refers only to the amount that you are required to pay. I understand that all of the providers in the offices at 2018 Brookwood Medical Center Drive, POB Suite 311 and POB Suite 310 are independent practitioners (not partners) although they are sharing office and staff. Your signature below also indicates you have received the Alabama Notice Form: Notice of Policies and Practices to Protect the Privacy of your Health Information and agree to its terms and serves as an acknowledgement that you have been given a copy of the HIPAA Notice Form.

Signature of Patient or Responsible Party_____Date_____

If signed by a responsible party, describe that representative's authority to act for the patient_____

Authorization to Obtain and Release Records:

2018 Brookwood Medical Center Drive Professional Office Bldg Suites 310-311 Phone: (205) 329-7805
Suite 311: Dr. Stuart Tieszen, Dr. Joel Melvin, Dr. Elena Herndon Fax: (205) 329-7806
Suite 310: Dr. Richard Azrin, Dr. Cheryl Millsaps, Margaret Smith, LCSW

Patient Name: _____ Date of Birth: _____

Social Sec. #:_____

Date(s) of requested records: □All Dates □ Specific Dates: _____

I hereby authorize the above providers to obtain and release my protected medical information, demographic information and insurance information. I have the right to restrict access to certain types of information, as indicated below:

List any restrictions on this release of information_____

Name_____Phone_____Fax_____

Address_____

City State Zip

Name_____Phone_____Fax_____

Address_____

City State Zip

Name_____Phone_____Fax_____

Address_____

City State Zip

Name_____Phone_____Fax_____

Address_____

City State Zip

Name_____Phone_____Fax_____

Address_____

City State Zip

Records to be Obtained: Please send copies of all EEG, MRI, CT, History and Physical, blood tests, medication lists and progress notes.

Release: This form when completed and signed by you, authorizes me to release, as well as to obtain, protected information from your clinical record to and from the person(s) you designate. I hereby authorize Dr. Stuart Tieszen, Dr. Joel Melvin, Margaret Smith LCSW, Dr. Elena Herndon and his/her administrative and clinical staff to release any and all contents of my chart (including at least billing information, psychotherapy/progress notes, test results/data, reports, visit information, prescriptions, medical information, documents provided by patient, insurance/third party forms/reports, records received by others). This information may be released to and/or obtained from the above individuals and my referral source. Providers and staff residing in 2018 Brookwood Med Center Dr. POB 310-311 may also obtain and release my information between each other. I am requesting my provider release this information to aid in treatment and/or assessment and/or provide information about me to others. This authorization shall remain in effect for 7 years from the date signed. However, you have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have previously taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that my provider generally may not condition mental health services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule. I hereby release the above treatment/assessment providers and their respective medical staff and office from any and all liability and claims arising out of or relating to the disclosure and/or release of confidential and/or privileged information.

_____ _____ _____

Name of patient and/or responsible party Signature of patient or responsible party Date

_____

If signed by patient's representative, please print representative's name and describe representative's authority to act for the patient

***** Please FAX records to FAX# (205) 329-7806 *****

Policy for Canceling and Rescheduling Appointments

It is the policy at this office to charge a fee of $50.00 for any appointment that is missed or broken without at least one business day notice. The payment is due prior to rescheduling your next appointment.

We make every effort to remind you of scheduled appointments. When an appointment is scheduled in our office, we provide you with the doctor's business card with the appointment time and date indicated. We also attempt to make courtesy reminder calls one business day before your appointment. Please be advised, however, that it is ultimately your responsibility to keep track of your appointments.

We appreciate your understanding of this policy. Please feel free to speak to our office staff if you have any questions.

I have read the above policy and agree to abide by the terms indicated when scheduling appointments.

Patient Signature: _____ Date: _____

Alabama Notice Form: Notice of Policies and Practices to Protect the Privacy of Your Health Information

This notice describes how psychological, psychiatric, and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

I. Uses and Disclosures for Treatment, Payment and Health Care Operations

I may use or disclose your protected health information (PHI), for treatment, payment and health care operations purposes with your consent. To help clarify these terms, here are some definitions.

- *"PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment and Health Care Operations"*
  - *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another health care provider.
  - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- *"Use"* applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- *"Disclosure"* applies to activities outside my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An *"authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing the information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. *"Psychotherapy Notes"* are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have previously relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse* – If I am treating a child and I know or suspect that child to be a victim of child abuse or neglect, I am required to report the abuse or neglect to a duly constituted authority.
- *Adult and Domestic Abuse* – If I have reasonable cause to believe an adult, who is unable to take care of himself or herself, has been subjected to physical abuse, neglect, exploitation, sexual abuse, or emotional abuse, I must report this belief to the appropriate authorities.
- *Health Oversight Activities* – If my professional state board of examiners is conducting an inquiry into my practice, then I am required to disclose PHI upon receipt of a subpoena from the Board.
- *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information may be privileged under state law, and I will not release information without the written authorization of you or your legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- *Serious Threat to Health or Safety* – I may disclose PHI to the appropriate individuals if I believe in good faith that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of you or another identifiable person(s)
- *Health research*
- *Marketing or fundraising*
- *Worker's Compensation* – I may disclose PHI as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Mental Health Professional's Duties

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of PHI. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On you request, I will send your bills to another address).
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. You may inspect and copy Psychotherapy Notes unless I make a clinical determination that access would be detrimental to your health. On your written request, I will discuss with you the details of the request and denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI. ON your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Mental Health Professional's Duties:

- I am required by law to maintain the privacy of protected health information regarding you and to provide you with notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact my office at (205) 329-7805 or (205) 329-7815.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. My office can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions, and Changes to Privacy

This notice will go into effect on April 14, 2003. I will limit the uses or disclosures that I will make as follows: I may elect to first provide a copy of my summary report, if available, when records are requested from an individual whom you have provided consent to access your records. I reserve the right to turn over the full record or to withhold from release any part of the record, especially raw test data (in order to protect test integrity if I feel that is an issue), but also assessment data, interpretations, notes, or reports that I feel may be harmful to the patient or misused in any way. I reserve the right to limit or deny disclosure of records to parents/guardians of patients under age 18 or of patients that I deem mentally impaired if I feel disclosure may in any way harm the patient or the person requesting disclosure. I reserve the right to provide PHI to individuals I am consulting or contacting as part of my assessment, treatment, or in assisting with carrying out recommendations I made orally or in written reports.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by posting in my office or by telephone, e-mail, or regular mail.

When using, disclosing or requesting PHI, I make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure or request. I recognize that the requirement also applies to covered entities that request my patients' records and require that such entities meet the standard, as required by law.

The minimum necessary requirement does not apply to disclosures for treatment purposes or when I share information with a patient. The requirement does not apply for uses and disclosures when patient authorization is given. It does not apply for uses and disclosures as required by law or to uses and disclosures that are required for compliance with the Privacy Rule.

Your signature on the Patient Information form indicates you have received a copy of the Alabama Notice Form: Notice of Policies and Practices to Protect the Privacy of Your Health Information (NPP) and agree to its terms and services as an acknowledgement that you have been given the HIPAA Notice Form to read.