NAAMAN CLINIC

TODAY'S DATE:

Prefix Mr. Mrs. Miss Ms. Dr. Preferred Name:

Patient's Name

First Middle Last

Address:

Street & Apt # City State Zip

SS# Birthdate Age: Sex: ❑ Female ❑Male

Marital Status: ❑ Single ❑ Married to: ❑ Other:

Home Phone: Cell Phone: Other Phone:

Preferred Contact: ❑Home ❑ Work ❑Cell ❑Text **E-mail:**

Any restrictions for contacting you? ❑No ❑ Yes If yes, please describe:

Emergency Contact: Relationship to Patient: Phone#:

Patient's Employer: Occupation:

Work Phone: Ext: Is it okay to call you at work? ❑ Yes ❑ No

Ethnicity: ❑Hispanic ❑Non-Hispanic **Language:**

Race: ❑African-American ❑Asian ❑ American Indian/Native Alaskin ❑Native Hawaiian or Other Pacific Islander ❑White

Referring Dr.: **Primary Care Dr.:**

INSURANCE INFORMATION

Primary Ins. ID # Group #

Insured: Name DOB SS#

Relationship to the insured? ❑Self ❑Child ❑Spouse ❑Other

Secondary Ins. ID # Group #

Insured: Name DOB SS#

Relationship to the insured? ❑Self ❑Child ❑Spouse ❑Other

PHARMACY INFORMATION

Preferred Pharmacy: **Phone:**

Street Name/City/St/Zip:

By signing below, I acknowledge the above information provided is true & correct.

Signature of Patient/Guardian: **Date:**

PATIENT FINANCIAL POLICY AND CONSENT FOR TREATMENT

Thank you for choosing Naaman Clinic for your skin care needs. The Patient Financial Policy and Consent for Treatment has been developed to assist in answering your questions regarding patient and insurance responsibility for services rendered. Your understanding of and compliance with our Patient Financial Policy and Consent for Treatment is important. Please read the policy below and ask the staff any questions you may have and sign as indicated. The original will be maintained in your file and a copy may be provided to you upon your request.

1. **CONSENT FOR TREATMENT:** I consent to treatment necessary or desirable to the care of the patient first mentioned above, including but not restricted to, whatever drugs, medicine, performance of operations and conduct of laboratory, x-ray or other studies that may be used by the attending doctor, his nurse or qualified designate.
2. **PROOF OF INSURANCE:** All patients must verify their insurance information before seeing the physician. Naaman Clinic participates with a large variety of insurance plans, including Medicare. Please confirm with our staff that we participate with your specific insurance plan. If you are not insured by a plan that we participate with, we will be happy to file your claim for you. It is your responsibility to ensure that we have your correct information and an up-to-date copy of your insurance card.
3. **UPDATED CHANGE OF INFORMATION & COVERAGE:** We will ask you to update this whenever you have a change in address, employment, insurance, etc, and annually. However, it is your responsibility to make us aware of these changes and if you fail to provide us with the correct updated information, you will be responsible for the entire cost of the services rendered and immediate payment will be expected.
4. **CO-PAYMENTS, DEDUCTIBLES & CO-INSURANCE:** All co-payments, deductibles & co-insurance must be paid at the time of service. Payment of your copayments, deductibles & co-insurance is part of your contract agreement with your insurance plan. Our failure to collect payment may be a violation of billing compliance and may be considered as an act of fraud by your insurance plan.
5. **NON-COVERED SERVICES:** Please be aware that some or perhaps all of the services you receive may not be covered or considered reasonable or necessary by your insurance plan. If you elect to have these services, you will be asked to sign a waiver and payment in full at the time of service will be expected.
6. **REFERRALS:** Some insurance plans require a referral from a primary care physician to obtain services of a specialist, such as a dermatologist. These health plans will not pay for services rendered without a referral. It is **'YOUR'** responsibility to obtain a referral prior to treatment. If you have not obtained the necessary referral, you may either reschedule your appointment or, if allowed by your insurance company, sign a waiver agreeing to pay for the service at the time it is rendered.
7. **AUTHORIZATIONS:** Obtaining a prior authorization for services is not a guarantee of payment of benefits. A prior authorization means that the information given at that time meets the medical necessity for the services; not a guarantee of payment. Your insurance plan will confirm to you that even though the services may be authorized, the services may not be covered under your plan and a decision for payment will not be rendered until a claim is submitted.
8. **CLAIMS SUBMISSION:** We will submit your claims and assist you in any way we can to help get your claims paid. Your insurance plan may request information directly from you. Your failure to timely respond to your insurance plan's request may result in your claim denial and if so, will result in our seeking full reimbursement from you for services rendered; even if we are a participating provider with your plan. Your insurance benefit is a contract between you and your insurance plan.
9. **SELF-PAY:** If you do not have valid health care coverage, you will be considered as self-pay. Payment in full is due at the time of service.

10. **NON-PAYMENT:** If your account is over 60 days past due, you will receive a statement indicating that you have 30 days to pay your account in full. Partial payments will not be accepted unless you have contacted our office and otherwise negotiated. Please be aware that if a balance remains unpaid, we will turn your account over to a collection agency after the 90th day past due.
11. **PAYMENT METHODS:** We accept cash, personal checks, money orders, MasterCard, Visa, Discover, American Express and CareCredit as payment for services rendered.
12. **RETURNED CHECKS:** A returned check fee of $30 will be added to your account for every check returned for insufficient funds, stopped payment or closed accounts. After the second occurrence, only cash, money orders, cashier's check or credit card payments will be accepted.
13. **NO SHOW POLICY:** If you miss 3 or more visits without canceling or rescheduling 24 hours in advance you may be charged a fee of $20.00 and/or dismissed from our practice.
14. **OUTSIDE LABORATORY CHARGES**: Any outside laboratory testing will be billed by the separate laboratories to you and/or your insurance company. Alternatively, Naaman Clinic LLC offers an in-house dermatopathology laboratory to provide a more timely, accurate diagnosis, rather than sending to an outside laboratory. Depending on your insurance company, you may receive a separate charge for laboratory services performed by our in-house dermatopathology laboratory.

*****Knowing your insurance benefits is your responsibility. Please contact your insurance plan with questions you may have regarding your coverage*****

This is an agreement between Naaman Clinic LLC and the patient/responsible party signed below. By executing this agreement, you are agreeing to pay for all services that are received.

I HAVE READ AND UNDERSTAND THE PAYMENT POLICY AND AGREE TO ABIDE BY ITS GUIDELINE.

Patient's Name:

_____

Responsible Party
(If not the Patient):

_____ _____

Signature of Patient or Responsible Party **Date**

NAAMAN CLINIC
PATIENT CONTACT INFORMATION SHEET

Patient Name: _____

Date of Birth: _____

Any physician, staff, employee or representative of Naaman Clinic, LLC 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 Naaman Clinic LLC 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 re-disclosure by the individual(s).

Patient Signature: _____ Date: _____

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 READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your personal health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this would include referring you to a retina specialist.

- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.

- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.

- The practice may also disclose your PHI for law enforcement and other legitimate reasons although we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You may have the following rights with respect to your PHI.

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information by alterative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.

- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your Protected Health Information and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice if effective as of September 1, 2013 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with office and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer, Rodney Collins at 100 Concourse Parkway Suite 240, Hoover, AL 35244 or by phone at 205-453-4195 for more information.

Signature of Patient or Legal Representative	Date
If signed by Legal Representative, relationship to patient	Signature of Witness

Medical History

Patient Name: **Date:**

Are you allergic to any medications? No Yes (if yes, please list)

1. _____
2. _____
3. _____

List all medications you are currently taking (including prescriptions, over the counter medications, vitamins and herbs)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Chronic Medical Conditions:

1. _____
2. _____
3. _____
4. _____
5. _____

Past Surgical Procedures:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Social History:

1. Do you drink alcohol? No Yes If yes, how many drinks/day or week _____
2. Do you smoke? No Previous Quit (year) _____ Yes If yes, what _____
3. Have you had or been exposed to HIV? No Yes
4. History of skin cancer? No Yes (type) _____
5. Family history of skin cancer? No Yes (who, type) _____
6. Did you get a Flu shot? No Yes When?_____ Pneumonia Vaccine? No Yes When?_____

What is your occupation? _____

Completed by: patient parent/guardian spouse other _____ (relationship)